



Santa Barbara County Department of Behavioral Wellness Provider Credentialing and Re-Credentialing Attestation

I, _____, understand and acknowledge my responsibility to disclose and attest to the Santa Barbara County Department of Behavioral Wellness (MHP and DMC-ODS Plan) any information that applies to the below referenced criteria.

Instructions- Please complete each section below. Answer "N/A" if it is not applicable. If you answer "Yes" to any question, please provide a detailed explanation on a separate page. The explanation should include dates, circumstances of the incident, final outcome, current disposition, etc.

1. Any limitations or inabilities that affect the provider's ability to perform any of the position's essential functions, with or without accommodation.
Yes No N/A
2. A history of loss of license or felony conviction.
Yes No N/A
3. A history of loss or limitation of privileges or disciplinary activity.
Yes No N/A
4. Current illegal drug use.
Yes No N/A

If not specified above, none of the applicable history and/or limitations exist. I hereby attest that all statements on this disclosure form are true and complete to the best of my knowledge. Should the Behavioral Wellness Credentialing Team discover material proving otherwise, my approved credentials may be subjected to reconsideration and/or denial. Additionally, I understand that any false statement or relevant omissions may constitute grounds for reduced, suspended and/or terminated ability to render services under the Behavioral Wellness system of care.

Signature

Date

Refusal to sign does not exempt compliance with Behavioral Wellness Credentialing Policy nor the applicable regulations.