



Behavioral Health Provider Areas of Expertise Form

Please send this completed form, along with the Behavioral Health Provider Data Form, to Vibra Health Plan at ProviderSupport@vibrahealthplan.com.

This information may be used in the referral of members.

Provider Information

Provider Name: _____

Gender: Male Female

Languages:

Please list languages for which you are fluent, and are able to conduct treatment:

English (Native Speaker) Yes No

American Sign Language: Yes No

Native Speaker of Other language(s):

Other(s) languages in which you can conduct treatment: _____

Access to Care Guidelines

Level of Care

Emergency

Non-Life Threatening Emergency

Urgent

Initial Visit for Routine Care

Routine/Follow Up

After Hours

Access Guidelines

Immediate

Within 6 hours

Within 48 hours

Within 10 business days

Within 10 business days

24 hours, 7 days/week

I attest that I will fulfill these Access Guidelines

_____ Provider Initials

Clinical Scope of Practice Information

Please check area(s) within your scope of practice for which you have training and experience.

By checking the box(es) below, you are attesting that you have completed training in and have the clinical practice experience allowing you to provide treatment for each designated Behavioral Health Area of Expertise, and will continue ongoing practice and training in this area.

Behavioral Health Areas of Expertise:

- | | |
|--|---|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Geriatric Issues – Dementia/Cognitive Impairment |
| <input type="checkbox"/> Alcohol/Substance Use Disorders | <input type="checkbox"/> Grief/Bereavement |
| <input type="checkbox"/> Anger/Stress Management | <input type="checkbox"/> HIV/AIDs Related Issues |
| <input type="checkbox"/> Anxiety and Panic Disorders | <input type="checkbox"/> Infertility/Fertility Counseling |
| <input type="checkbox"/> Autism and Autism Spectrum Disorders | <input type="checkbox"/> LGBTQ2 Issues |
| <input type="checkbox"/> Bariatric/Weight Loss Surgery Evaluation and Counseling | <input type="checkbox"/> Obsessive Compulsive Disorders |
| <input type="checkbox"/> Bipolar/Other Mood Disorders | <input type="checkbox"/> Pain Management |
| <input type="checkbox"/> Chronic Illness/Chronic Pain | <input type="checkbox"/> Personality Disorders |
| <input type="checkbox"/> Conversion Disorder | <input type="checkbox"/> Phobias |
| <input type="checkbox"/> Cultural/Ethnic Issues | <input type="checkbox"/> Pregnancy/Menopause |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Relationship/Separation/Divorce Issues |
| <input type="checkbox"/> Dialectical Behavioral Therapy | <input type="checkbox"/> Schizophrenic Disorders |
| <input type="checkbox"/> Dissociative Identify Disorder | <input type="checkbox"/> Sexual Disorders/Dysfunctions/Compulsions |
| <input type="checkbox"/> Domestic Violence and Abuse | <input type="checkbox"/> Sleep Disorders |
| <input type="checkbox"/> End of Life Issues | <input type="checkbox"/> Survivor Counseling – Rape and Violent Crime |
| <input type="checkbox"/> Gambling Disorder | <input type="checkbox"/> Trauma/Post Traumatic Stress |
| <input type="checkbox"/> Gender Reassignment Counseling | |

Type of Therapy:

- | | |
|--|--|
| <input type="checkbox"/> Child Therapy | <input type="checkbox"/> Family Counseling |
| <input type="checkbox"/> Couples/Relationship Counseling | <input type="checkbox"/> Group Therapy |
| <input type="checkbox"/> Faith Based Counseling | <input type="checkbox"/> Individual Counseling |

Populations Served:

- | | |
|--|---|
| <input type="checkbox"/> Young Children < 5 | <input type="checkbox"/> Seniors/Geriatric > 65 |
| <input type="checkbox"/> Older Children 6-12 | <input type="checkbox"/> LGBTQ2 |
| <input type="checkbox"/> Adolescents | <input type="checkbox"/> Men's Issues |
| <input type="checkbox"/> Adults 18-64 | <input type="checkbox"/> Women's Issues |

Services:

- | | |
|--|--|
| <input type="checkbox"/> Electroconvulsive Therapy | <input type="checkbox"/> Neuro Psych Testing |
| <input type="checkbox"/> Medication Management | <input type="checkbox"/> Psych Testing |

Modes of Therapy:

- | | |
|--|--|
| <input type="checkbox"/> Applied Behavioral Analysis | <input type="checkbox"/> Cognitive Behavioral |
| <input type="checkbox"/> Behavior Modification | <input type="checkbox"/> Trauma Informed Therapy |

Provider Signature

Date