BHRS NETWORK PROVIDERS ATTESTATION

Rendering Provider Full Name: Agency Name:

I have reviewed the Marin County Behavioral Health and Recovery Services (BHRS) Credentialing Policy. As a service provider for Marin County BHRS, I understand that BHRS Policy requires me to be able to provide services for which Medicare and Medi-Cal will pay directly or indirectly, including services which are clinical or administrative/managerial in nature, including support services and I attest to the following:

I am able to provide services under federally funded health care programs. Specifically:

a. ☐ I have* ☐ I have not (*please check one*) been convicted of a felony offense related to health care, or
b. ☐ I have* ☐ I have not (*please check one*) been debarred, excluded or otherwise made ineligible to provide services under federally funded health care programs, by a State or a federal agency.
c. ☐ I have* ☐ I do not have (*please check one*) a history of loss or limitation of privileges or disciplinary activity;
d. ☐ I do** ☐ I do not (please check one) have limitations that affect my ability to perform any of my position's essentials job functions with or without reasonable accommodation.
e. ☐ I am ☐ I am not (please check one) using illegal drugs.

**If you have been convicted of a felony offence related to health care, have been debarred, excluded or are otherwise ineligible, or have a history of loss or limitation of privileges or disciplinary action please provide a detailed explanation on the back of this form.*

*** If you require reasonable accommodations to perform your job functions please provide a detailed explanation on the back of this form.*

I understand that it is my responsibility to notify my immediate Supervisor or higher-level manager of any change in my ability to provide services under federally funded health care programs, including suspension or exclusion. Further, I understand that Marin County BHRS will verify my ability to participate in federally funded health care programs on not less than a tri-annual basis.

BY SIGNING I CERTIFY THAT I HAVE COMPLETED THIS ATTESTATION ACCURATELY AND COMPLETELY AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, SERVICES RENDERED BY ME AS A PROVIDER OF MARIN COUNTY BEHAVIORAL HEALTH AND RECOVERY SERVICES' NETWORK OF CARE MAY BE BILLED TO MEDI-CAL AND MEDICARE AS APPROPRIATE.

Date	Provider Name	Provider Signature
Date	Supervisor Name	Supervisor Signature