MHSUD Provider Directory &

Master Provider File (MPF) Monthly Updates Form

**Program Name:** Choose an item. **Date:** Click or tap to enter a date.

Type of program (Check box(es) that apply):

New Program MH Program SUD Program Enter ASAM designation & CalOMS #

*Please indicate any changes to the program information*

**If no changes on the program information for the month, check box and proceed to practitioner section.**

**Remove entire program  Program name change:** Enter new program name

**Address:** Enter new address w/ full 9 digit zip code **Phone Number:** Enter new phone number **Office Hours:** Enter new office hours **Website:** Enter updated website information **Non-English Languages Spoken:** Enter updated non-English languages Spoken

**Cultural Competencies:** Enter updated cultural competencies (eg. Veterans, TAY, Children, LGBT, Older Adults)

**Populations Served:** Enter updated population served by program.

**Services/Modalities Program Provides:** Enter updated services provided by program

**Other:** Enter other changes such as director, director’s phone #, or corporate office address/phone #

*Please indicate any changes to practitioner information*

**If there are no changes to the practitioner information, check the box and stop here.**

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| --- | --- | --- | --- | --- | --- | --- |
| **Add/Remove/**  **Change** | **Last Name** | **First Name** | **NPI** | **Type of License** | **License #** | **Cultural**  **Competency** |
| Choose an item. | Practitioner 1 Last Name | Practitioner 1 First Name | Practitioner 1 NPI # | Practitioner 1 CA License Type | Practitioner 1 CA License # | Training Completed? (Select one) |
| Choose an item. | Practitioner 2 Last Name | Practitioner 2 First Name | Practitioner 2 NPI # | Practitioner 2 CA License Type | Practitioner 2 CA License # | Training Completed? (Select one) |
| Choose an item. | Practitioner 3 Last Name | Practitioner 3 First Name | Practitioner 3 NPI # | Practitioner 3 CA License Type | Practitioner 3 CA License # | Training Completed? (Select one) |
| Choose an item. | Practitioner 4 Last Name | Practitioner 4 First Name | Practitioner 4 NPI # | Practitioner 4 CA License Type | Practitioner 4 CA License # | Training Completed? (Select one) |

\*\*Complete for each program (subunit) and submit to [QSEmail@stanbhrs.org](mailto:QSEmail@stanbhrs.org) by the 15th of each month.