

CORRECT NUMBERS
AND LETTERS

A B C 1 2 3

CORRECT
MARKINCORRECT
MARKSCAQH AUTOMATICALLY APPLIES MIXED-CASE FORMATTING,
COMMON ABBREVIATIONS, AND ZIP CODE MATCHING. PLEASE
MAKE CORRECTIONS ONLINE OR CALL THE HELP DESK.**Instructions**

Read all instructions carefully prior to submitting your application.

Tips to avoid processing delays

1. Complete only this application and its supplemental forms. **Do not use another provider's application.**
2. Use a blue or black ink ball-point pen only. Do not use a pencil or a felt-tip pen.
3. Print legibly and inside the boxes provided based upon the examples given above.
4. Do not enter more than 1 character per box. If necessary, write outside the provided spaces.
5. Complete all sections that are applicable to you.
6. Some fields use "codes" to help you easily report information (e.g., schools, languages). Code lists are found on pages 36 - 43.

NOTE: Fields with asterisks (*) indicate that a response is required. All other fields will be considered not applicable if left blank.

SECTION 1**Personal Information and Professional IDs****Provider Type**

ABA

Code list is found on page 36. Enter the associated 3-digit code in the space provided.*

YES

NO

DO YOU PRACTICE EXCLUSIVELY WITHIN THE INPATIENT SETTING?
(E.G. PATHOLOGISTS, ANESTHESIOLOGISTS, ER PHYSICIANS, NURSE PRACTITIONER, RADIOLOGISTS, PHYSICIAN ASSISTANT, ETC.)**Name**

Do not use nicknames or initials, unless they are part of your legal name.

Blalack

LAST NAME*

SUFFIX (JR, III)

Julia

FIRST NAME*

S

HAVE YOU EVER USED ANOTHER NAME?*

YES

NO

MIDDLE NAME

IF YES, PLEASE LIST ALL OTHER NAMES USED AND THEIR DATES OF USE BELOW.

OTHER LAST NAME

SUFFIX (JR, III)

OTHER FIRST NAME

OTHER MIDDLE NAME

DATE STARTED USING OTHER NAME

DATE STOPPED USING OTHER NAME

General Information

Only enter a Foreign National Identification Number if you do not have a SSN. Do not enter National Provider Identification (NPI) Number here.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

GENDER* MALE FEMALE

DATE OF BIRTH* 10/25/1993

CITY OF BIRTH

STATE OF BIRTH

COUNTRY OF BIRTH

ssn* 635-94-1236

FOREIGN NATIONAL IDENTIFICATION NUMBER (FNIN)

FNIN COUNTRY OF ISSUE

ENTER ALL NON-ENGLISH LANGUAGES YOU SPEAK

LANGUAGE CODE

LANGUAGE CODE

LANGUAGE CODE

LANGUAGE CODE

LANGUAGE CODE

Home Address

4434 White Birch Ct

STREET

Milton

FL

32571-2796

CITY

STATE

ZIP CODE

TELEPHONE

NOTE: CAQH will use this method for application follow-up.

E-MAIL jshjblalack@hotmail.com

FAX

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* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 1		Personal Information and Professional IDs (Continued)		
Professional IDs Include all state licenses, DEA Registration and State Controlled Dangerous Substance (CDS) certification numbers. Provide all current and previous licenses/certifications. Non-licensed professionals should enter certification/registration number in the space provided for license number. If you have additional Professional IDs to report, use the Professional IDs Supplemental Form on page 19.	FEDERAL DEA NUMBER		DEA ISSUE DATE	
	DEA STATE OF REGISTRATION		DEA EXPIRATION DATE	
	CDS CERTIFICATE NUMBER		CDS ISSUE DATE	
	CDS STATE OF REGISTRATION		CDS EXPIRATION DATE	
	1-25-83165		FL	
	STATE LICENSE NUMBER		LICENSE ISSUING STATE	LICENSE ISSUE DATE
	IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		07/30/2027	
	LICENSING STATUS CODE Code list is found on page 36; use license status codes. Enter 3-digit code in space provided.		LICENSE TYPE ABA	Code list is found on page 36; use provider type codes. Enter 3-digit code in space provided.
	STATE LICENSE NUMBER		LICENSE ISSUING STATE	LICENSE ISSUE DATE
	IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		LICENSING EXPIRATION DATE	
LICENSING STATUS CODE Code list is found on page 36; use license status codes. Enter 3-digit code in space provided.		LICENSE TYPE	Code list is found on page 36; use provider type codes. Enter 3-digit code in space provided.	
Other ID Numbers If you have additional Professional IDs to report, use the Professional IDs Supplemental Form on page 19.	ARE YOU A PARTICIPATING MEDICARE PROVIDER?* <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		MEDICARE NUMBER	
	ARE YOU A PARTICIPATING MEDICAID PROVIDER?* <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		MEDICAID NUMBER	
	1063057891			MEDICAID STATE
	NATIONAL PROVIDER IDENTIFICATION (NPI) NUMBER		USMLE NUMBER (WITHOUT HYPHENS)	
	WORKERS COMPENSATION NUMBER			
ECFMG NUMBER (NON-U.S./CANADIAN GRADUATE ONLY)		ECFMG CERTIFICATE ISSUE DATE (NON-U.S./CANADIAN GRADUATE ONLY)		

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Section 2		Education and Training		
Undergraduate School(s) <p>Provide the appropriate information for the school that issued your undergraduate degree and all schools attended.</p> Professional School(s) <p>Provide the appropriate information for the school that issued your professional degree.</p> <p>Fifth Pathway Graduates please complete the following sections: U.S. School that issued your certificate, the Non-U.S. School where you attended, and the Fifth Pathway institution where you completed your training on Supplemental Page 20.</p> <p>Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.</p> <p>If you have additional Undergraduate or Professional Schools to report, use the Education Supplemental Form on page 20.</p>	UNDERGRADUATE SCHOOL			
	OFFICIAL NAME OF UNDERGRADUATE SCHOOL			
	ADDRESS			
	CITY	STATE	ZIP/POSTAL CODE	
	COUNTRY CODE	TELEPHONE	FAX	
	START DATE	END DATE (GRADUATION DATE)	DEGREE AWARDED	
	DID YOU COMPLETE YOUR UNDERGRADUATE EDUCATION AT THIS SCHOOL?	<input checked="" type="checkbox"/> YES	<input type="checkbox"/> NO	
	GRADUATE TYPE*:			
	<input checked="" type="checkbox"/> U.S. OR CANADIAN GRADUATE	<input type="checkbox"/> NON-U.S./CANADIAN GRADUATE	<input type="checkbox"/> FIFTH PATHWAY GRADUATE	
	PROFESSIONAL/MEDICAL SCHOOL			
SCHOOL CODE (U.S./CANADIAN ONLY)	NAME OF U.S./CANADIAN SCHOOL:			
Arizona State University				
P.O. Box 8782				
ADDRESS	STATE	COUNTRY	POSTAL CODE	
Tempe	AZ	United States	85287	
CITY	STATE	COUNTRY	POSTAL CODE	
06/2019	12/2020	MED		
START DATE*	END DATE (GRADUATION DATE)*	DEGREE AWARDED		
DID YOU COMPLETE YOUR GRADUATE EDUCATION AT THIS SCHOOL?	<input checked="" type="checkbox"/> YES	<input type="checkbox"/> NO		
NON - U.S. OR CANADIAN SCHOOL				
OFFICIAL NAME OF NON-U.S. PROFESSIONAL SCHOOL				
ADDRESS	CITY			
COUNTRY	POSTAL CODE	TELEPHONE	FAX	
START DATE*	END DATE (GRADUATION DATE)*	DEGREE AWARDED		
DID YOU COMPLETE YOUR GRADUATE EDUCATION AT THIS SCHOOL?	<input type="checkbox"/> YES	<input type="checkbox"/> NO		

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Section 3		Professional / Medical Specialty Information						
Primary Specialty Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.	SPECIALTY CODE	Behavior Analyst	INITIAL CERTIFICATION DATE	07/30/2025	DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?	HMO	<input checked="" type="checkbox"/> YES	<input type="checkbox"/> NO
	BOARD CERTIFIED?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	RECERTIFICATION DATE (IF APPLICABLE)	07/30/2025	PPO	<input checked="" type="checkbox"/> YES	<input type="checkbox"/> NO	
	CERTIFYING BOARD CODE	Behavior Analyst Certification Board	EXPIRATION DATE (IF APPLICABLE)	07/30/2027	POS	<input checked="" type="checkbox"/> YES	<input type="checkbox"/> NO	
	IF NOT BOARD CERTIFIED (SELECT ONE)	<input type="checkbox"/> I HAVE TAKEN EXAM, RESULTS PENDING FOR	<input type="checkbox"/> I INTEND TO SIT FOR AN EXAM ON	<input type="checkbox"/> I DO NOT INTEND TO TAKE A CERTIFYING BOARD EXAM.				
	CERTIFYING BOARD CODE							
	IF YOU INDICATED THAT YOU DID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE FOLLOWING SPACE TO EXPLAIN, OTHERWISE LEAVE THE SPACE BLANK.							
Secondary Specialty Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided. If you have additional Professional / Medical Specialties to report, use the Additional Specialties Supplemental Form on page 22.	SPECIALTY CODE		INITIAL CERTIFICATION DATE		DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?	HMO	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	BOARD CERTIFIED?	<input type="checkbox"/> YES <input type="checkbox"/> NO	RECERTIFICATION DATE (IF APPLICABLE)		PPO	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
	CERTIFYING BOARD CODE		EXPIRATION DATE (IF APPLICABLE)		POS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
	IF NOT BOARD CERTIFIED (SELECT ONE)	<input type="checkbox"/> I HAVE TAKEN EXAM, RESULTS PENDING FOR	<input type="checkbox"/> I INTEND TO SIT FOR AN EXAM ON	<input type="checkbox"/> I DO NOT INTEND TO TAKE A CERTIFYING BOARD EXAM.				
	CERTIFYING BOARD CODE							
	IF YOU INDICATED THAT YOU DID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE FOLLOWING SPACE TO EXPLAIN, OTHERWISE LEAVE THE SPACE BLANK.							

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Section 3		Professional / Medical Specialty Information (Continued)											
Certifications		Do you hold the following certifications? If yes, provide expiration dates.											
		EXPIRATION DATE					EXPIRATION DATE						
BASIC LIFE SUPPORT?*		<input checked="" type="checkbox"/>	YES	<input type="checkbox"/>	NO	12/01/2025			ADV LIFE SUPPORT IN OB?*	<input type="checkbox"/>	YES	<input checked="" type="checkbox"/>	NO
CPR?*		<input type="checkbox"/>	YES	<input checked="" type="checkbox"/>	NO				ADV TRAUMA LIFE SUPPORT?*	<input type="checkbox"/>	YES	<input checked="" type="checkbox"/>	NO
ADV CARDIAC LIFE SPT?*		<input type="checkbox"/>	YES	<input checked="" type="checkbox"/>	NO				PEDIATRIC ADVANCED LIFE SPT?*	<input type="checkbox"/>	YES	<input checked="" type="checkbox"/>	NO
NEONATAL ADVANCED LIFE SPT?*		<input type="checkbox"/>	YES	<input checked="" type="checkbox"/>	NO								
Practice Interests													
Primary Credentialing Contact		<p>Toney <small>LAST NAME</small> Tawnya <small>FIRST NAME</small> 231 Blue Stream Way Apt 5101 <small>NUMBER</small> <small>STREET</small> Inlet Beach <small>CITY</small> <small>TELEPHONE</small> <small>FAX</small> <small>E-MAIL ADDRESS</small></p>											
<small>CHECK HERE TO USE THE OFFICE MANAGER AND ADDRESS OF THE PRIMARY PRACTICE LOCATION AS THE CREDENTIALING INFORMATION.</small>		<small>M.I.</small> <small>SUITE/BUILDING</small> FL 32461 <small>STATE</small> ZIP CODE											
NOTE: Even if you checked the boxes above, please provide the e-mail address, if available.													

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Section 4 Practice Location Information			
<p>Primary Practice Location</p> <p>If you have additional practice locations, use the Supplemental Practice Location Information Form on pages 25-29.</p> <p>NOTE: "General Correspondence" refers to any correspondence that might be sent to the provider that does not solely relate to credentialing or billing information.</p> <p>TIP Your Individual Tax ID is assumed to be your Primary Tax ID unless you specify otherwise to the right.</p>	<p>NOTE: IF YOU INDICATED THAT YOU PRACTICE EXCLUSIVELY WITHIN THE INPATIENT SETTING ON PAGE 1, YOU ARE ONLY REQUIRED TO COMPLETE THE CREDENTIALING CONTACT QUESTION ABOVE. SECTION 4 MAY BE LEFT BLANK. YOU MAY PROCEED TO SECTION 5 ON PAGE 11.</p> <p>CURRENTLY PRACTICING AT THIS ADDRESS?* <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO PREVIOUS OR FUTURE START DATE? 08/11/2025</p>		
	<p>Seaside Behavior Services, LLC</p> <p>PHYSICIAN GROUP / PRACTICE NAME TO APPEAR IN DIRECTORY (DO NOT ABBREVIATE)* Seaside Behavior Services, LCC</p> <p>GROUP / CORPORATE NAME AS IT APPEARS ON W-9, IF DIFFERENT FROM ABOVE (DO NOT ABBREVIATE)</p>		
	NUMBER*	STREET*	SUITE/BUILDING
	CITY*	STATE*	ZIP CODE*
	SEND GENERAL CORRESPONDENCE HERE?* <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	850-896-3873	855-508-6637
		TELEPHONE*	FAX
	OFFICE E-MAIL ADDRESS -	88-3709212	PRIMARY TAX ID (ONE ONLY)* <input type="checkbox"/> USE INDIVIDUAL TAX ID <input checked="" type="checkbox"/> USE GROUP TAX ID
	INDIVIDUAL TAX ID	GROUP TAX ID	M.I.
	Office Manager or Business Office Staff Contact	<p>Toney</p> <p>LAST NAME* Ivonne</p> <p>FIRST NAME* </p> <p>TELEPHONE* FAX</p> <p>IToney@Seasidebehavior.com</p> <p>E-MAIL ADDRESS</p>	
	Billing Contact	<p>CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS BILLING INFORMATION <input type="checkbox"/></p> <p>NOTE: Even if you checked the box above, please provide the E-mail Address of the Billing Contact. </p> <p>LAST NAME*</p> <p>FIRST NAME* M.I.</p> <p>NUMBER* STREET* SUITE/BUILDING</p> <p>CITY* STATE* ZIP CODE*</p> <p>TELEPHONE* FAX</p> <p>E-MAIL ADDRESS</p>	

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Section 4		Practice Location Information (Continued)													
Payment and Remittance		<p>ELECTRONIC BILLING CAPABILITIES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>BILLING DEPARTMENT (IF HOSPITAL-BASED)</p> <p>CHECK PAYABLE TO*</p>													
		<p>YOUR "CHECK PAYABLE TO" INFORMATION SHOULD BE CONSISTENT WITH YOUR W-9.</p> <p>CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS PAYEE INFORMATION <input type="checkbox"/></p> <p>NOTE: Even if you checked the box above, please provide the E-mail Address of the Payee Contact. <input type="checkbox"/></p>													
		LAST NAME*		FIRST NAME*		M.I.		NUMBER*		STREET*		SUITE/BUILDING			
												CITY*		STATE*	ZIP CODE*
												TELEPHONE*		FAX	
												E-MAIL ADDRESS			
Office Hours		(USE HHMM FORMAT AND ROUND TO THE NEAREST HALF-HOUR)													
		MONDAY	9:00	A	6:30	P	FRIDAY	9:00	A	6:30	P				
		TUESDAY	9:00	A	6:30	P	SATURDAY	None							
		WEDNESDAY	9:00	A	6:30	P	SUNDAY	None							
		THURSDAY	9:00	A	6:30	P									
			24/7 PHONE COVERAGE?* <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	IF YES <input type="checkbox"/> ANSWERING SERVICE <input type="checkbox"/> VOICE MAIL WITH INSTRUCTIONS TO CALL ANSWERING SERVICE <input type="checkbox"/> VOICE MAIL WITH OTHER INSTRUCTIONS	AFTER HOURS BACK OFFICE TELEPHONE										
Open Practice Status		ACCEPT NEW PATIENTS INTO THIS PRACTICE?* <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				ACCEPT ALL NEW PATIENTS?* <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO									
		ACCEPT EXISTING PATIENTS WITH CHANGE OF PAYOR?* <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				ACCEPT NEW MEDICARE PATIENTS?* <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO									
		ACCEPT NEW PATIENTS WITH PHYSICIAN REFERRAL?* <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				ACCEPT NEW MEDICAID PATIENTS?* <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
		IF ANY OF THE ABOVE INFORMATION VARIES BY PLAN, EXPLAIN (USE BOTH LINES IF REQUIRED)													
ARE THERE ANY PRACTICE LIMITATIONS?* <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		IF YES		GENDER LIMITATIONS <input type="checkbox"/> MALE ONLY <input type="checkbox"/> FEMALE ONLY		AGE LIMITATIONS <input type="checkbox"/> NONE		MINIMUM AGE		MAXIMUM AGE		LIST OTHER LIMITATIONS			

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Section 4 Practice Location Information (Continued)		
Mid-Level Practitioners	DO MID-LEVEL PRACTITIONERS (NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, ETC.) CARE FOR PATIENTS IN YOUR PRACTICE?*	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
	(IF YES, PLEASE PROVIDE THE INFORMATION BELOW)	
	PRACTITIONER LAST NAME	
	PRACTITIONER FIRST NAME	M.I. PRACTITIONER TYPE (E.G., PA, CNP, NP)
PRACTITIONER LICENSE / CERTIFICATE NUMBER	PRACTITIONER STATE	
PRACTITIONER LAST NAME		
PRACTITIONER FIRST NAME	M.I. PRACTITIONER TYPE (E.G., PA, CNP, NP)	
PRACTITIONER LICENSE / CERTIFICATE NUMBER	PRACTITIONER STATE	
PRACTITIONER LAST NAME		
PRACTITIONER FIRST NAME	M.I. PRACTITIONER TYPE (E.G., PA, CNP, NP)	
PRACTITIONER LICENSE / CERTIFICATE NUMBER	PRACTITIONER STATE	
PRACTITIONER LAST NAME		
PRACTITIONER FIRST NAME	M.I. PRACTITIONER TYPE (E.G., PA, CNP, NP)	
PRACTITIONER LICENSE / CERTIFICATE NUMBER	PRACTITIONER STATE	

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Section 4	Practice Location Information (Continued)							
Languages	LANGUAGES NON-ENGLISH LANGUAGES SPOKEN BY OFFICE PERSONNEL Code lists are found on pages 37. Enter the associated 3-digit code in the space provided.							
	INTERPRETERS AVAILABLE?*	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	LANGUAGE CODE	LANGUAGE CODE	LANGUAGE CODE	LANGUAGE CODE	LANGUAGE CODE	
			LANGUAGES INTERPRETED	LANGUAGE CODE	LANGUAGE CODE	LANGUAGE CODE	LANGUAGE CODE	
				LANGUAGE CODE	LANGUAGE CODE	LANGUAGE CODE	LANGUAGE CODE	
Accessibilities	DOES THIS OFFICE MEET ADA ACCESSIBILITY REQUIREMENTS?* <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO DOES THIS SITE OFFER HANDICAPPED ACCESS FOR THE FOLLOWING BUILDING?* <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO TEXT TELEPHONY (TTY)* <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO ACCESSIBLE BY PUBLIC TRANSPORTATION?* <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PARKING?* <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO AMERICAN SIGN LANGUAGE* <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO BUS* <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO RESTROOM?* <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO MENTAL/PHYSICAL IMPAIRMENT SERVICES* <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO SUBWAY* <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO REGIONAL TRAIN* <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
	OTHER HANDICAPPED ACCESS			OTHER DISABILITY SERVICES			OTHER TRANSPORTATION ACCESS	
Services	Does this location provide any of the following services? LABORATORY SERVICES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, PROVIDE ACCREDITING/CERTIFYING PROGRAM (E.G., CLIA, COLA, MLE) RADIOLOGY SERVICES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, PROVIDE X-RAY CERTIFICATION TYPE EKG? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO ALLERGY INJECTIONS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO ALLERGY SKIN TESTING? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO ROUTINE OFFICE GYNECOLOGY (PELVIC/PAP)? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO DRAWING BLOOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO AGE APPROPRIATE IMMUNIZATIONS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO FLEXIBLE SIGMOIDOSCOPY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO TYMPANOMETRY/AUDIOLOGY SCREENING? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO ASTHMA TREATMENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO OSTEOPATHIC MANIPULATION? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IV HYDRATION/TREATMENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO CARDIAC STRESS TEST? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PULMONARY FUNCTION TESTING? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PHYSICAL THERAPY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO CARE OF MINOR LACERATIONS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
	IS ANESTHESIA ADMINISTERED IN YOUR OFFICE? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, WHAT CLASS/CATEGORY DO YOU USE? IF YES, WHO ADMINISTERS IT?							
	LAST NAME				FIRST NAME			
	TYPE OF PRACTICE (SELECT ONE ONLY)*		<input type="checkbox"/> SOLO PRACTICE		<input type="checkbox"/> SINGLE SPECIALTY GROUP		<input type="checkbox"/> MULTI-SPECIALTY GROUP	
	ADDITIONAL OFFICE PROCEDURES PROVIDED (INCLUDING SURGICAL PROCEDURES)							

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 Std. App. v6.0
 Implemented in 04/2025

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Section 4	Practice Location Information (Continued)		
Partners/ Associates Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided. If you have additional partners/associates at THIS location, use the Partner/Associate Supplemental Form on page 23. Photocopy as necessary. Be certain to check "Primary Location" at the top of the page.	LIST ALL PARTNERS/ASSOCIATES AT THIS PRACTICE		
	LAST NAME	SPECIALTY CODE	<input type="checkbox"/> COVERING COLLEAGUE (Y/N)?
	FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)
	LAST NAME	SPECIALTY CODE	<input type="checkbox"/> COVERING COLLEAGUE (Y/N)?
FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)	
LAST NAME	SPECIALTY CODE	<input type="checkbox"/> COVERING COLLEAGUE (Y/N)?	
FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)	
Covering Colleagues Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided. If you have additional covering colleagues that are not partners at THIS location, use the Covering Colleagues Supplemental Form on page 24. Photocopy as necessary. Be certain to check "Primary Location" at the top of the page.	LIST ALL COVERING COLLEAGUES THAT ARE <u>NOT</u> PARTNERS/ASSOCIATES AT THIS PRACTICE		
LAST NAME	SPECIALTY CODE		
FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)	
LAST NAME	SPECIALTY CODE		
FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)	
LAST NAME	SPECIALTY CODE		
FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)	
Section 5	Hospital Affiliations		
Admitting Arrangements	DO YOU HAVE HOSPITAL PRIVILEGES?* <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	IF YOU DO NOT ADMIT PATIENTS, WHAT TYPE OF ADMITTING ARRANGEMENTS DO YOU HAVE?	

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Section 5 Hospital Affiliations (Continued)			
Hospital Privileges <p>If applicable, list all hospital affiliations. List primary hospital, then other current affiliations, followed by previous affiliations in chronological order.</p> <p>If you have additional hospital privileges, use the Supplemental Hospital Privileges Form on page 30.</p> <p>TIP Be certain your admission percentages add up to 100% for current hospitals. Otherwise, you will have to correct this error.</p>	PRIMARY HOSPITAL		
	HOSPITAL NAME		
	NUMBER STREET	SUITE/BUILDING	
	CITY	STATE	
	TELEPHONE	FAX	
	DEPARTMENT NAME		
	DEPARTMENT DIRECTOR'S LAST NAME		
	DEPARTMENT DIRECTOR'S FIRST NAME		M.I.
	AFFILIATION START DATE	AFFILIATION END DATE	FULL, UNRESTRICTED PRIVILEGES? <input type="checkbox"/> YES <input type="checkbox"/> NO ARE PRIVILEGES TEMPORARY? <input type="checkbox"/> YES <input type="checkbox"/> NO
	ADMITTING PRIVILEGE STATUS (E.G. NONE, FULL UNRESTRICTED, PROVISIONAL, TEMPORARY)		%
OTHER HOSPITAL			
HOSPITAL NAME			
NUMBER STREET	SUITE/BUILDING		
CITY	STATE	ZIP CODE	
TELEPHONE	FAX		
DEPARTMENT NAME			
DEPARTMENT DIRECTOR'S LAST NAME			
DEPARTMENT DIRECTOR'S FIRST NAME		M.I.	
AFFILIATION START DATE	AFFILIATION END DATE	FULL, UNRESTRICTED PRIVILEGES? <input type="checkbox"/> YES <input type="checkbox"/> NO ARE PRIVILEGES TEMPORARY? <input type="checkbox"/> YES <input type="checkbox"/> NO	
ADMITTING PRIVILEGE STATUS (E.G. NONE, FULL UNRESTRICTED, PROVISIONAL, TEMPORARY)		%	
PLEASE EXPLAIN TERMINATED AFFILIATION			

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Section 6		Professional Liability Insurance Carrier					
Professional Liability Insurance Carrier <small>IMPORTANT IF YOU DO NOT CARRY MALPRACTICE INSURANCE, CHECK THIS BOX AND SKIP THIS SECTION.</small>	Lexington Insurance Company						SELF-INSURED?* <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
	CARRIER OR SELF-INSURED NAME*						
	100 Summer Street						
	NUMBER*	STREET*	SUITE/BUILDING				
	Boston		MA				
	CITY*		STATE*	ZIP CODE*			
	01/31/2025	01/31/2025	01/31/2026	EXPIRATION DATE			
	ORIGINAL EFFECTIVE DATE*	EFFECTIVE DATE*	AMOUNT OF COVERAGE PER OCCURRENCE		AMOUNT OF COVERAGE AGGREGATE		
	DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER?* <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	\$ 1,000,000.00	\$ 3,000,000.00				
	POLICY INCLUDES TAIL COVERAGE? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO						
6799172							
POLICY NUMBER*							
Professional Liability Insurance Carrier <small>List other current, future, or previous carrier(s) if current carrier is less than ten (10) years.</small> <small>NOTE: A longer period may be required by your healthcare entity.</small> <small>If you have additional Insurance, use the Supplemental Insurance Form on page 31.</small>	Philadelphia Indemnity Ins Co						SELF-INSURED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
	CARRIER OR SELF-INSURED NAME						
	306 E Lancaster Ave						
	NUMBER*	STREET*	SUITE/BUILDING				
	Wynnewood		PA				
	CITY*		STATE*	ZIP CODE*			
	09/01/2024	09/01/2025	EXPIRATION DATE				
	ORIGINAL EFFECTIVE DATE*	EFFECTIVE DATE*	AMOUNT OF COVERAGE PER OCCURRENCE		AMOUNT OF COVERAGE AGGREGATE		
	DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	\$ 10,000.00	\$ 3,000,000.00				
	POLICY INCLUDES TAIL COVERAGE? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						
AR231506							
POLICY NUMBER*							
Section 7		Work History and References					
Military Duty <small>Include a chronological work history for the past 10 years.</small> <small>A longer period may be required by your healthcare entity.</small> <small>If you have additional work history, use the Supplemental Work History Form on page 32.</small>	Are you currently on active military duty or military reserve?* <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						
	WORK HISTORY						
	Seaside Behavior Services, LLC						
	PRACTICE / EMPLOYER NAME						
	231 Blue Stream Way Apt 5101						
	NUMBER	STREET	SUITE/BUILDING				
	Inlet Beach		FL	32413			
	CITY		STATE	ZIP/POSTAL CODE			

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* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Page 13

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UPS

Section 7		Work History and References (Continued)				
<p>Work History Do not list current positions. Those should be listed in Section 4.</p> <p>Include a chronological work history for the past 10 years.</p> <p>A longer period may be required by your healthcare entity</p> <p>If you have additional work history, use the Supplemental Work History Form on page 32.</p>	TELEPHONE United States 08/2025		FAX PRESENT			
	COUNTRY CODE	START DATE	END DATE			
	REASON FOR DEPARTURE (IF APPLICABLE)					
	WORK HISTORY					
	Positive Behavior Supports Corporation - Emerald Coast PRACTICE / EMPLOYER NAME 495 Grand Boulevard Suite 206					
NUMBER	STREET	SUITE/BUILDING				
Miramar Beach		FL	32550-1408			
CITY		STATE	ZIP/POSTAL CODE			
TELEPHONE	FAX					
United States	08/2025	PRESENT				
COUNTRY CODE	START DATE	END DATE				
REASON FOR DEPARTURE (IF APPLICABLE)						
WORK HISTORY						
West Florida Area Health Education Center PRACTICE / EMPLOYER NAME 1455 S Ferdon Blvd #B1						
NUMBER	STREET	SUITE/BUILDING				
Crestview		FL	32536			
CITY		STATE	ZIP/POSTAL CODE			
TELEPHONE	FAX					
United States	10/2024	08/2025				
COUNTRY CODE	START DATE	END DATE				
REASON FOR DEPARTURE (IF APPLICABLE)						
New Opportunity						

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* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

*** REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.**

Section 7		Work History and References (Continued)			
Gaps in Professional / Work History If you have additional professional / work history gaps, use the Supplemental Professional Work History Gaps Form on page 33.	PLEASE EXPLAIN ANY TIME PERIODS OR GAPS IN TRAINING OR WORK HISTORY THAT HAVE OCCURRED SINCE GRADUATION FROM PROFESSIONAL SCHOOL AND ARE LONGER THAN THREE MONTHS IN DURATION OR OF A SHORTER DURATION IF REQUIRED BY THE ORGANIZATION FOR WHICH YOU ARE BEING CREDENTIALLED.				
	GAP START DATE	06/2019		GAP END DATE	12/2020
	Academic/Training leave				
Professional References Provide three professional references to whom you are not related or are not partners in your practice. Code lists are found on pages 36-43. Enter the associated 3-digit code for provider type. NOTE: You are required to provide exactly 3 references. Your application will not be complete without this information. Please check with credentialing entity for any special requirements.	Sims				
LAST NAME*	Tori				ABA
FIRST NAME*					PROVIDER TYPE (CODE PG 36)
NUMBER*	STREET*				APT/SUITE/BUILDING
CITY*			STATE*	ZIP CODE*	
630-546-3049					
TELEPHONE			FAX		
<hr/>					
LAST NAME*					PROVIDER TYPE (CODE PG 36)
FIRST NAME*					APT/SUITE/BUILDING
NUMBER*	STREET*				STATE*
CITY*			ZIP CODE*		
TELEPHONE			FAX		
<hr/>					
LAST NAME*					PROVIDER TYPE (CODE PG 36)
FIRST NAME*					APT/SUITE/BUILDING
NUMBER*	STREET*				STATE*
CITY*			ZIP CODE*		
TELEPHONE			FAX		

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* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 8	Disclosure Questions
Disclosure Questions <p>Answer all questions. For any "Yes" response, provide an explanation on the Supplemental Disclosure Question Explanation Form on page 34.</p> Allied Health Providers <p>If you are an Allied Health Provider and you do not believe a question is applicable to you, you should answer the question "NO".</p>	LICENSURE
	1. <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Has your license, registration or certification to practice in your profession, ever been voluntarily or involuntarily relinquished, denied, suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation or any conditions or limitations by any state or professional licensing, registration or certification board?*
	2. <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Has there been any challenge to your licensure, registration or certification?*
	HOSPITAL PRIVILEGES AND OTHER AFFILIATIONS
	3. <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Have your clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board?*
	4. <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Have you voluntarily or involuntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?*
	5. <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)?*
	EDUCATION, TRAINING AND BOARD CERTIFICATION
	6. <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign?*
	7. <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Have you ever, while under investigation or to avoid an investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?*
	8. <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Have any of your board certifications or eligibility ever been revoked?*
	9. <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation?*
	DEA OR STATE CONTROLLED SUBSTANCE REGISTRATION
	10. <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Have your Federal DEA and/or State Controlled Dangerous Substances (CDS) certificate(s) or authorization(s) ever been challenged, denied, suspended, revoked, restricted, denied renewal, or voluntarily or involuntarily relinquished?*
	MEDICARE, MEDICAID OR OTHER GOVERNMENTAL PROGRAM PARTICIPATION
	11. <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental healthcare plans or programs?*
	OTHER SANCTIONS OR INVESTIGATIONS
	12. <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Are you currently the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program or a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?*
13. <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?*	
14. <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)?*	
15. <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Have you ever been convicted of, pled guilty to, pled nolo contendere to, sanctioned, reprimanded, restricted, disciplined or resigned in exchange for no investigation or adverse action within the last ten years for sexual harassment or other illegal misconduct?*	
16. <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Are you currently being investigated or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation or in exchange for no investigation by a hospital or healthcare facility of any military agency?*	
PROFESSIONAL LIABILITY INSURANCE INFORMATION AND CLAIMS HISTORY	
17. <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history?*	
18. <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your individual liability history?*	

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* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

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* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 8	Disclosure Questions (Continued)
Disclosure Questions Answer all questions. For any "Yes" response, provide an explanation on the Supplemental Disclosure Question Explanation Form on page 34. IMPORTANT If you answered "Yes" to question #19, you must complete the Supplemental Malpractice Claims Explanation Form on page 35 for each malpractice claim.	<p>MALPRACTICE CLAIMS HISTORY</p> <p>19. <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Have you had any professional liability actions (pending, settled, arbitrated, mediated or litigated) within the past 10 years?* If yes, provide information for each case.</p> <p>CRIMINAL/CIVIL HISTORY</p> <p>20. <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony?*</p> <p>21. <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO In the past ten years have you been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor (excluding minor traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?*</p> <p>22. <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Have you ever been court-martialed for actions related to your duties as a medical professional?*</p> <p>Note: A criminal record will not necessarily be a bar to acceptance. Decisions will be made by each health plan or credentialing organization based upon all the relevant circumstances, including the nature of the crime.</p> <p>ABILITY TO PERFORM JOB</p> <p>23. <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Are you currently engaged in the illegal use of drugs?* ("Currently" means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one's ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. § 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.)</p> <p>24. <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?*</p> <p>25. <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Do you have any reason to believe that you would pose a risk to the safety or well being of your patients?*</p> <p>26. <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Are you unable to perform the essential functions of a practitioner in your area of practice even with reasonable accommodation?*</p>

Section 9 Race and Ethnicity

Race and Ethnicity

The following options are based on the industry standard, FHIR (available at <https://www.hl7.org/fhir/>). Select all that apply.

NCQA-accredited/certified organizations must comply with all applicable federal and state civil rights laws that prohibit discrimination on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex, and make decisions in a nondiscriminatory manner. Providing race, ethnicity or language information is optional. CAQH does not participate in the organization's credentialing decision.

RACE AND ETHNICITY

- AMERICAN INDIAN OR ALASKA NATIVE - For example, Navajo Nation, Blackfeet Tribe of the Blackfeet Indian Reservation of Montana, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community, Aztec, Maya, etc.
- ASIAN - For example, Chinese, Asian Indian, Filipino, Vietnamese, Korean, Japanese, etc.
- BLACK OR AFRICAN AMERICAN - For example, African American, Jamaican, Haitian, Nigerian, Ethiopian, Somali, etc.
- HISPANIC OR LATINO - For example, Mexican, Puerto Rican, Salvadoran, Cuban, Dominican, Guatemalan, etc.
- MIDDLE EASTERN OR NORTH AFRICAN - For example, Lebanese, Iranian, Egyptian, Syrian, Iraqi, Israeli, etc.
- NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER - For example, Native Hawaiian, Samoan, Chamorro, Tongan, Fijian, Marquesese, etc.
- WHITE - For example, English, German, Irish, Italian, Polish, Scottish, etc.
- PREFER NOT TO SAY
- I DO NOT HAVE THE INFORMATION TO ANSWER

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* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Additional Credentialing Contacts

Other Credentialing Contact	Helenius		
LAST NAME	Christian		M.I.
FIRST NAME	7108 S Kanner Hwy?		
NUMBER	STREET		SUITE/BUILDING
Stuart			34997-7462
CITY		STATE	ZIP CODE
855-832-6727	772-675-9100		
TELEPHONE	FAX		
chelenius@teampbs.com			
E-MAIL ADDRESS			

Practice Location Information Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4		Practice Location Information - Page 1 of 5																																																																	
Additional Practice Location IMPORTANT <p>In the box provided, indicate to which practice location this page belongs. For example, if you practice at three locations, the primary location is reported in the main application and remaining locations would be reported on Supplemental Forms as Location 2 and Location 3.</p> <p>TIP Your Individual Tax ID is assumed to be your Primary Tax ID unless you specify otherwise to the right.</p>	<p style="margin-top: 0;">→ LOCATION* # 2</p> <hr/> <p>CURRENTLY PRACTICING AT THIS ADDRESS?* <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO PREVIOUS OR FUTURE START DATE? 08/11/2025</p> <p>Positive Behavior Supports Corporation - Emerald Coast</p> <p>PHYSICIAN GROUP / PRACTICE NAME TO APPEAR IN DIRECTORY (DO NOT ABBREVIATE)* Positive Behavior Supports Corporation</p> <p>GROUP / CORPORATE NAME AS IT APPEARS ON W-9, IF DIFFERENT FROM ABOVE (DO NOT ABBREVIATE) 495 Grand Blvd Ste 206</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">NUMBER*</td> <td style="width: 25%;">STREET*</td> <td style="width: 25%;">SUITE/BUILDING</td> <td style="width: 25%;">STATE*</td> </tr> <tr> <td>Miramar Beach</td> <td></td> <td>FL</td> <td>32550-1897</td> </tr> <tr> <td>SEND GENERAL CORRESPONDENCE HERE?*</td> <td><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</td> <td>ZIP CODE*</td> <td></td> </tr> <tr> <td></td> <td>855-832-6727</td> <td>772-675-9100</td> <td></td> </tr> <tr> <td></td> <td>TELEPHONE*</td> <td>FAX</td> <td></td> </tr> <tr> <td></td> <td>RrPinero@teampbs.com</td> <td></td> <td></td> </tr> <tr> <td>OFFICE E-MAIL ADDRESS</td> <td>20-5268843</td> <td>PRIMARY TAX ID (ONE ONLY)*</td> <td><input type="checkbox"/> USE INDIVIDUAL TAX ID <input checked="" type="checkbox"/> USE GROUP TAX ID</td> </tr> <tr> <td>INDIVIDUAL TAX ID</td> <td>GROUP TAX ID</td> <td></td> <td></td> </tr> </table> <hr/> <p>Office Manager or Business Office Contact</p> <p>List each contact separately. You may use the check boxes below for convenience. Do not write instructions like "see above". These responses will be rejected and will require follow-up.</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">LAST NAME*</td> <td style="width: 25%;">FIRST NAME*</td> <td style="width: 25%;">M.I.</td> </tr> <tr> <td>Pinero</td> <td>Rafael</td> <td></td> </tr> <tr> <td>TELEPHONE*</td> <td>772-675-9100</td> <td></td> </tr> <tr> <td>E-MAIL ADDRESS</td> <td>RrPinero@teampbs.com</td> <td></td> </tr> </table> <hr/> <p>Billing Contact</p> <p>CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS BILLING INFORMATION <input type="checkbox"/></p> <p>NOTE: Even if you checked the boxes above, please provide the e-mail address of the Billing Contact, if available.</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">LAST NAME*</td> <td style="width: 25%;">FIRST NAME*</td> <td style="width: 25%;">M.I.</td> </tr> <tr> <td></td> <td></td> <td></td> </tr> <tr> <td>NUMBER*</td> <td>STREET*</td> <td>SUITE/BUILDING</td> </tr> <tr> <td>CITY*</td> <td></td> <td>STATE*</td> </tr> <tr> <td>TELEPHONE*</td> <td>FAX</td> <td>ZIP CODE*</td> </tr> <tr> <td>E-MAIL ADDRESS</td> <td>3100</td> <td></td> </tr> </table>					NUMBER*	STREET*	SUITE/BUILDING	STATE*	Miramar Beach		FL	32550-1897	SEND GENERAL CORRESPONDENCE HERE?*	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	ZIP CODE*			855-832-6727	772-675-9100			TELEPHONE*	FAX			RrPinero@teampbs.com			OFFICE E-MAIL ADDRESS	20-5268843	PRIMARY TAX ID (ONE ONLY)*	<input type="checkbox"/> USE INDIVIDUAL TAX ID <input checked="" type="checkbox"/> USE GROUP TAX ID	INDIVIDUAL TAX ID	GROUP TAX ID			LAST NAME*	FIRST NAME*	M.I.	Pinero	Rafael		TELEPHONE*	772-675-9100		E-MAIL ADDRESS	RrPinero@teampbs.com		LAST NAME*	FIRST NAME*	M.I.				NUMBER*	STREET*	SUITE/BUILDING	CITY*		STATE*	TELEPHONE*	FAX	ZIP CODE*	E-MAIL ADDRESS	3100	
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Practice Location Information Supplemental Form

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Section 4		Practice Location Information - Page 2 of 5																																																										
Add'l Practice Location (Cont.) Payment and Remittance <small>YOUR "CHECK PAYABLE TO" INFORMATION SHOULD BE CONSISTENT WITH YOUR W-9.</small> <small>CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS BILLING INFORMATION</small>	LOCATION* #² ELECTRONIC BILLING CAPABILITIES?* <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO PBS Corp Billing Department? <small>BILLING DEPARTMENT (IF HOSPITAL-BASED)</small> Positive Behavior Supports Corp? <small>CHECK PAYABLE TO*</small> <input type="checkbox"/> <small>LAST NAME*</small> <small>FIRST NAME*</small> <small>M.I.</small> <small>NUMBER*</small> <small>STREET*</small> <small>SUITE/BUILDING</small> <small>CITY*</small> <small>STATE*</small> <small>ZIP CODE*</small> <small>TELEPHONE*</small> <small>FAX</small> <small>E-MAIL ADDRESS</small>																																																											
	NOTE: <small>Even if you checked the boxes above, please provide the E-mail Address, Department Name, Electronic Billing and Check Payable To, if applicable.</small>																																																											
	Office Hours <small>(USE HHMM FORMAT AND ROUND TO THE NEAREST HALF-HOUR)</small> <table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th></th> <th>START</th> <th>A=AM P=PM</th> <th>END</th> <th>A=AM P=PM</th> <th></th> <th>START</th> <th>A=AM P=PM</th> <th>END</th> <th>A=AM P=PM</th> </tr> </thead> <tbody> <tr> <td>MONDAY</td> <td>9:00</td> <td>A</td> <td>5:00</td> <td>P</td> <td>FRIDAY</td> <td>9:00</td> <td>A</td> <td>5:00</td> <td>P</td> </tr> <tr> <td>TUESDAY</td> <td>9:00</td> <td>A</td> <td>5:00</td> <td>P</td> <td>SATURDAY</td> <td>None</td> <td></td> <td>None</td> <td></td> </tr> <tr> <td>WEDNESDAY</td> <td>9:00</td> <td>A</td> <td>5:00</td> <td>P</td> <td>SUNDAY</td> <td>None</td> <td></td> <td>None</td> <td></td> </tr> <tr> <td>THURSDAY</td> <td>9:00</td> <td>A</td> <td>5:00</td> <td>P</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>											START	A=AM P=PM	END	A=AM P=PM		START	A=AM P=PM	END	A=AM P=PM	MONDAY	9:00	A	5:00	P	FRIDAY	9:00	A	5:00	P	TUESDAY	9:00	A	5:00	P	SATURDAY	None		None		WEDNESDAY	9:00	A	5:00	P	SUNDAY	None		None		THURSDAY	9:00	A	5:00	P					
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	MONDAY	9:00	A	5:00	P	FRIDAY	9:00	A	5:00	P																																																		
	TUESDAY	9:00	A	5:00	P	SATURDAY	None		None																																																			
	WEDNESDAY	9:00	A	5:00	P	SUNDAY	None		None																																																			
	THURSDAY	9:00	A	5:00	P																																																							
	NOTE: <small>After hours back office telephone will be used only by the health plan and will not be published under any circumstances.</small>																																																											
	24/7 PHONE COVERAGE?* <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO ANSWERING SERVICE <input type="checkbox"/> VOICE MAIL WITH INSTRUCTIONS TO CALL ANSWERING SERVICE <input checked="" type="checkbox"/> VOICE MAIL WITH OTHER INSTRUCTIONS AFTER HOURS BACK OFFICE TELEPHONE																																																											
Open Practice Status <small>ACCEPT NEW PATIENTS INTO THIS PRACTICE?*</small> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO ACCEPT ALL NEW PATIENTS?* <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <small>ACCEPT EXISTING PATIENTS WITH CHANGE OF PAYOR?*</small> <input checked="" type="checkbox"/> YES <input checked="" type="checkbox"/> NO ACCEPT NEW MEDICARE PATIENTS?* <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <small>ACCEPT NEW PATIENTS WITH PHYSICIAN REFERRAL?*</small> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO ACCEPT NEW MEDICAID PATIENTS?* <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <small>IF ANY OF THE ABOVE VARIES BY PLAN, EXPLAIN</small> <small>ARE THERE ANY PRACTICE LIMITATIONS?*</small> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES <table style="margin-left: 100px; border-collapse: collapse;"> <tr> <td><input type="checkbox"/> MALE ONLY</td> <td><input type="checkbox"/> NONE</td> <td>GENDER LIMITATIONS</td> <td>AGE LIMITATIONS</td> <td>LIST OTHER LIMITATIONS</td> </tr> <tr> <td><input type="checkbox"/> FEMALE ONLY</td> <td></td> <td></td> <td>MINIMUM AGE</td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td>MAXIMUM AGE</td> <td></td> </tr> </table>										<input type="checkbox"/> MALE ONLY	<input type="checkbox"/> NONE	GENDER LIMITATIONS	AGE LIMITATIONS	LIST OTHER LIMITATIONS	<input type="checkbox"/> FEMALE ONLY			MINIMUM AGE					MAXIMUM AGE																																					
<input type="checkbox"/> MALE ONLY	<input type="checkbox"/> NONE	GENDER LIMITATIONS	AGE LIMITATIONS	LIST OTHER LIMITATIONS																																																								
<input type="checkbox"/> FEMALE ONLY			MINIMUM AGE																																																									
			MAXIMUM AGE																																																									
3101																																																												

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Practice Location Information Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4	Practice Location Information - Page 3 of 5		
Additional Practice Location <small>(Continued)</small> IMPORTANT In the box provided, indicate to which practice location this page belongs.	→ LOCATION* # 2		
	DO MID-LEVEL PRACTITIONERS (NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, ETC.) CARE FOR PATIENTS IN YOUR PRACTICE?*		
	<input type="checkbox"/> YES <input checked="" type="checkbox"/> X <input type="checkbox"/> NO		
	<small>(IF YES, PLEASE PROVIDE THE INFORMATION BELOW)</small>		
PRACTITIONER LAST NAME PRACTITIONER FIRST NAME M.I. PRACTITIONER TYPE (E.G., PA, CNP, NP) PRACTITIONER LICENSE / CERTIFICATE NUMBER PRACTITIONER STATE			
PRACTITIONER LAST NAME PRACTITIONER FIRST NAME M.I. PRACTITIONER TYPE (E.G., PA, CNP, NP) PRACTITIONER LICENSE / CERTIFICATE NUMBER PRACTITIONER STATE			
PRACTITIONER LAST NAME PRACTITIONER FIRST NAME M.I. PRACTITIONER TYPE (E.G., PA, CNP, NP) PRACTITIONER LICENSE / CERTIFICATE NUMBER PRACTITIONER STATE			
PRACTITIONER LAST NAME PRACTITIONER FIRST NAME M.I. PRACTITIONER TYPE (E.G., PA, CNP, NP) PRACTITIONER LICENSE / CERTIFICATE NUMBER PRACTITIONER STATE			

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* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Page 27

Practice Location Information Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4	Practice Location Information - Page 4 of 5																																													
Additional Practice Location <small>(Continued)</small>	LOCATION* #2																																													
	LANGUAGES <small>NON-ENGLISH LANGUAGES SPOKEN BY OFFICE PERSONNEL</small> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">INTERPRETERS AVAILABLE?*</td> <td style="width: 15%; text-align: center;"><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</td> <td style="width: 15%; text-align: center;">LANGUAGE CODE</td> </tr> <tr> <td></td> <td></td> <td colspan="2" style="text-align: center;">LANGUAGES INTERPRETED</td> <td colspan="2"></td> <td></td> </tr> <tr> <td></td> <td></td> <td style="text-align: center;">LANGUAGE CODE</td> </tr> </table>								INTERPRETERS AVAILABLE?*	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	LANGUAGE CODE	LANGUAGE CODE	LANGUAGE CODE	LANGUAGE CODE	LANGUAGE CODE			LANGUAGES INTERPRETED							LANGUAGE CODE	LANGUAGE CODE	LANGUAGE CODE	LANGUAGE CODE	LANGUAGE CODE																	
INTERPRETERS AVAILABLE?*	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	LANGUAGE CODE	LANGUAGE CODE	LANGUAGE CODE	LANGUAGE CODE	LANGUAGE CODE																																								
		LANGUAGES INTERPRETED																																												
		LANGUAGE CODE	LANGUAGE CODE	LANGUAGE CODE	LANGUAGE CODE	LANGUAGE CODE																																								
IMPORTANT <small>In the box provided, indicate to which practice location this page belongs.</small>	ACCESSIBILITIES <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;">DOES THIS OFFICE MEET ADA ACCESSIBILITY REQUIREMENTS?*</td> <td style="width: 33%; text-align: center;"><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</td> <td style="width: 33%; text-align: center;">ACCESSIBLE BY PUBLIC TRANSPORTATION?*</td> </tr> <tr> <td>DOES THIS SITE OFFER HANDICAPPED ACCESS FOR THE FOLLOWING</td> <td style="text-align: center;">YES <input type="checkbox"/> NO</td> <td style="text-align: center;"><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</td> </tr> <tr> <td>BUILDING?*</td> <td style="text-align: center;"><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</td> <td>TEXT TELEPHONY (TTY)*</td> <td style="text-align: center;"><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</td> <td>ACCESSIBLE BY BUS*</td> </tr> <tr> <td>PARKING?*</td> <td style="text-align: center;"><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</td> <td>AMERICAN SIGN LANGUAGE*</td> <td style="text-align: center;"><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</td> <td>SUBWAY*</td> </tr> <tr> <td>RESTROOM?*</td> <td style="text-align: center;"><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</td> <td>MENTAL/PHYSICAL IMPAIRMENT SERVICES*</td> <td style="text-align: center;"><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</td> <td>REGIONAL TRAIN*</td> </tr> </table>								DOES THIS OFFICE MEET ADA ACCESSIBILITY REQUIREMENTS?*	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	ACCESSIBLE BY PUBLIC TRANSPORTATION?*	DOES THIS SITE OFFER HANDICAPPED ACCESS FOR THE FOLLOWING	YES <input type="checkbox"/> NO	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	BUILDING?*	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	TEXT TELEPHONY (TTY)*	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	ACCESSIBLE BY BUS*	PARKING?*	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	AMERICAN SIGN LANGUAGE*	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	SUBWAY*	RESTROOM?*	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	MENTAL/PHYSICAL IMPAIRMENT SERVICES*	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	REGIONAL TRAIN*																	
	DOES THIS OFFICE MEET ADA ACCESSIBILITY REQUIREMENTS?*	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	ACCESSIBLE BY PUBLIC TRANSPORTATION?*																																											
DOES THIS SITE OFFER HANDICAPPED ACCESS FOR THE FOLLOWING	YES <input type="checkbox"/> NO	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO																																												
BUILDING?*	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	TEXT TELEPHONY (TTY)*	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	ACCESSIBLE BY BUS*																																										
PARKING?*	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	AMERICAN SIGN LANGUAGE*	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	SUBWAY*																																										
RESTROOM?*	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	MENTAL/PHYSICAL IMPAIRMENT SERVICES*	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	REGIONAL TRAIN*																																										
OTHER HANDICAPPED ACCESS				OTHER DISABILITY SERVICES		OTHER TRANSPORTATION ACCESS																																								
Services	Does this location provide any of the following services? <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">LABORATORY SERVICES?</td> <td style="width: 15%; text-align: center;"><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</td> <td style="width: 60%;">IF YES, PROVIDE ACCREDITING/CERTIFYING PROGRAM (E.G., CLIA, COLA, MLE)</td> </tr> <tr> <td>RADIOLOGY SERVICES?</td> <td style="text-align: center;"><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</td> <td>IF YES, PROVIDE X-RAY CERTIFICATION TYPE</td> </tr> <tr> <td>EKGs?</td> <td style="text-align: center;"><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</td> <td>ALLERGY INJECTIONS?</td> <td style="text-align: center;"><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</td> <td>ALLERGY SKIN TESTING?</td> <td style="text-align: center;"><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</td> <td>ROUTINE OFFICE GYNECOLOGY (PELVIC/PAP)?</td> <td style="text-align: center;"><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</td> </tr> <tr> <td>DRAWING BLOOD?</td> <td style="text-align: center;"><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</td> <td>AGE APPROPRIATE IMMUNIZATIONS?</td> <td style="text-align: center;"><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</td> <td>FLEXIBLE SIGMOIDOSCOPY?</td> <td style="text-align: center;"><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</td> <td>TYMPANOMETRY/AUDIOMETRY SCREENING?</td> <td style="text-align: center;"><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</td> </tr> <tr> <td>ASTHMA TREATMENT?</td> <td style="text-align: center;"><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</td> <td>OSTEOPATHIC MANIPULATION?</td> <td style="text-align: center;"><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</td> <td>IV HYDRATION/TREATMENT?</td> <td style="text-align: center;"><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</td> <td>CARDIAC STRESS TEST?</td> <td style="text-align: center;"><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</td> </tr> <tr> <td>PULMONARY FUNCTION TESTING?</td> <td style="text-align: center;"><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</td> <td>PHYSICAL THERAPY?</td> <td style="text-align: center;"><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</td> <td>CARE OF MINOR LACERATIONS?</td> <td style="text-align: center;"><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</td> <td></td> <td></td> </tr> </table>								LABORATORY SERVICES?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	IF YES, PROVIDE ACCREDITING/CERTIFYING PROGRAM (E.G., CLIA, COLA, MLE)	RADIOLOGY SERVICES?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	IF YES, PROVIDE X-RAY CERTIFICATION TYPE	EKGs?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	ALLERGY INJECTIONS?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	ALLERGY SKIN TESTING?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	ROUTINE OFFICE GYNECOLOGY (PELVIC/PAP)?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	DRAWING BLOOD?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	AGE APPROPRIATE IMMUNIZATIONS?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	FLEXIBLE SIGMOIDOSCOPY?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	TYMPANOMETRY/AUDIOMETRY SCREENING?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	ASTHMA TREATMENT?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	OSTEOPATHIC MANIPULATION?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	IV HYDRATION/TREATMENT?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	CARDIAC STRESS TEST?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	PULMONARY FUNCTION TESTING?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	PHYSICAL THERAPY?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	CARE OF MINOR LACERATIONS?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
	LABORATORY SERVICES?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	IF YES, PROVIDE ACCREDITING/CERTIFYING PROGRAM (E.G., CLIA, COLA, MLE)																																											
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EKGs?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	ALLERGY INJECTIONS?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	ALLERGY SKIN TESTING?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	ROUTINE OFFICE GYNECOLOGY (PELVIC/PAP)?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																																							
DRAWING BLOOD?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	AGE APPROPRIATE IMMUNIZATIONS?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	FLEXIBLE SIGMOIDOSCOPY?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	TYMPANOMETRY/AUDIOMETRY SCREENING?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																																							
ASTHMA TREATMENT?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	OSTEOPATHIC MANIPULATION?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	IV HYDRATION/TREATMENT?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	CARDIAC STRESS TEST?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																																							
PULMONARY FUNCTION TESTING?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	PHYSICAL THERAPY?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	CARE OF MINOR LACERATIONS?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																																									
IS ANESTHESIA ADMINISTERED IN YOUR OFFICE? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, WHO ADMINISTERS IT? LAST NAME _____ FIRST NAME _____ TYPE OF PRACTICE (SELECT ONE ONLY)* <input type="checkbox"/> SOLO PRACTICE <input checked="" type="checkbox"/> SINGLE SPECIALTY GROUP <input type="checkbox"/> MULTI-SPECIALTY GROUP																																														
ADDITIONAL OFFICE PROCEDURES PROVIDED (INCLUDING SURGICAL PROCEDURES)																																														

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* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Page 28

Practice Location Information Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4	Practice Location Information - Page 5 of 5			
Additional Practice Location <small>(Continued)</small> <hr/> IMPORTANT <p>In the box provided, indicate to which practice location this page belongs.</p> <p>If you have additional partners/associates at THIS location, use the Partner/Associate Supplemental Form on page 23. Photocopy as necessary. Be certain to indicate the Practice Location Number at the top of the page.</p> <p>Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.</p>	<p style="margin-left: 20px;">→ LOCATION* #²</p> <hr/> <p>LIST ALL PARTNERS/ASSOCIATES AT THIS PRACTICE</p>			
	LAST NAME	SPECIALTY CODE	<input type="checkbox"/> COVERING COLLEAGUE (Y/N)?	
	FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)	
	LAST NAME	SPECIALTY CODE	<input type="checkbox"/> COVERING COLLEAGUE (Y/N)?	
	FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)	
	LAST NAME	SPECIALTY CODE	<input type="checkbox"/> COVERING COLLEAGUE (Y/N)?	
	FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)	
	LAST NAME	SPECIALTY CODE	<input type="checkbox"/> COVERING COLLEAGUE (Y/N)?	
	FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)	
	LAST NAME	SPECIALTY CODE	<input type="checkbox"/> COVERING COLLEAGUE (Y/N)?	
FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)		
<p>Covering Colleagues</p> <p>Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.</p> <p>If you have additional covering colleagues that are not partners at THIS location, use the Covering Colleagues Supplemental Form on page 24. Photocopy as necessary. Be certain to indicate the Practice Location Number at the top of the page.</p>				
<p>LIST ALL COVERING COLLEAGUES THAT ARE <u>NOT</u> PARTNERS/ASSOCIATES AT THIS PRACTICE</p>				
LAST NAME	SPECIALTY CODE			
FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)		
LAST NAME	SPECIALTY CODE			
FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)		
LAST NAME	SPECIALTY CODE			
FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)		
LAST NAME	SPECIALTY CODE			
FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)		

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* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Page 29

 Std. App. v6.0
 Implemented in 04/2025

Professional Liability Insurance Carrier Supplemental Form

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 6	Professional Liability Insurance Carrier							
Other Professional Liability Insurance Carrier List secondary / second layer / future or previous carrier(s). For second layer coverage list name of hospital/organization providing coverage If you need additional space for Insurance Coverage, photocopy this page as needed and submit as instructed.	Philadelphia Indemnity Ins Co CARRIER OR SELF-INSURED NAME 306 E Lancaster Ave NUMBER* STREET* Wynnewood				SELF-INSURED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO STATE* PA SUITE/BUILDING ZIP CODE* TYPE OF COVERAGE?* <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> SHARED			
	ORIGINAL EFFECTIVE DATE*		EFFECTIVE DATE*		EXPIRATION DATE			
	09/01/2024		09/01/2025					
	DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER?		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		AMOUNT OF COVERAGE PER OCCURRENCE		AMOUNT OF COVERAGE AGGREGATE	
					\$ 1,000.00		\$ 3,000.00	
	POLICY INCLUDES TAIL COVERAGE?		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
	AR231506							
	POLICY NUMBER*							
	Xs/Group Inc. CARRIER OR SELF-INSURED NAME 2750 Killarney Drive NUMBER* STREET* Woodbridge	SELF-INSURED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO STATE* VA SUITE/BUILDING ZIP CODE* TYPE OF COVERAGE?* <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> SHARED						
		ORIGINAL EFFECTIVE DATE*		EFFECTIVE DATE*		EXPIRATION DATE		
04/19/2021		04/19/2022						
DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER?		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		AMOUNT OF COVERAGE PER OCCURRENCE		AMOUNT OF COVERAGE AGGREGATE		
				\$ 1,000,000.00		\$ 3,000,000.00		
POLICY INCLUDES TAIL COVERAGE?		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						
20B01333-458								
POLICY NUMBER*								

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* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Page 31

Std. App. v6.0
Implemented in 04/2025

Work History Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 7	Work History					
Work History Use this form to continue listing work history. If you need additional space for Work History, photocopy this page as needed and submit as instructed.	WORK HISTORY Cortica PRACTICE / EMPLOYER NAME 6160 Cornerstone Ct					
	NUMBER	STREET				SUITE/BUILDING
	San Diego		CA	92121		
	CITY		STATE	ZIP/POSTAL CODE		
	TELEPHONE		FAX			
	United States	01/2024	07/2024			
	COUNTRY CODE	START DATE	END DATE			
	REASON FOR DEPARTURE (IF APPLICABLE)					
	Moved to FL					
WORK HISTORY Autism Learning Partners PRACTICE / EMPLOYER NAME 4025 Camino del Rio	WORK HISTORY Autism Learning Partners PRACTICE / EMPLOYER NAME 4025 Camino del Rio					
	NUMBER	STREET				SUITE/BUILDING
	San Diego		CA	92108		
	CITY		STATE	ZIP/POSTAL CODE		
	TELEPHONE		FAX			
	United States	10/2023	12/2023			
	COUNTRY CODE	START DATE	END DATE			
	REASON FOR DEPARTURE (IF APPLICABLE)					
	Reduced Hours					

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* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Page 32

Std. App. v6.0
Implemented in 04/2025

Work History Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 7	Work History			
Work History Use this form to continue listing work history. If you need additional space for Work History, photocopy this page as needed and submit as instructed.	WORK HISTORY			
	MTR Child & Family Services, LLC			
	PRACTICE / EMPLOYER NAME			
	7373 University Ave Unit 116			
	NUMBER	STREET	SUITE/BUILDING	
	San Diego		CA	91942
	CITY		STATE	ZIP/POSTAL CODE
	TELEPHONE	FAX		
	United States	10/2022	09/2023	
	COUNTRY CODE	START DATE	END DATE	
REASON FOR DEPARTURE (IF APPLICABLE)				
Seeking new opportunities.				
WORK HISTORY Mau Loa Learning, LLC PRACTICE / EMPLOYER NAME waimanalo	WORK HISTORY			
	Mau Loa Learning, LLC			
	PRACTICE / EMPLOYER NAME			
	waimanalo			
	NUMBER	STREET	SUITE/BUILDING	
	Waimanalo		HI	96795
	CITY		STATE	ZIP/POSTAL CODE
	TELEPHONE	FAX		
	United States	05/2021	08/2022	
	COUNTRY CODE	START DATE	END DATE	
REASON FOR DEPARTURE (IF APPLICABLE)				
Moved				

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* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Page 32

Work History Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 7	Work History				
Work History Use this form to continue listing work history. If you need additional space for Work History, photocopy this page as needed and submit as instructed.	WORK HISTORY				
	Windward Synergy Center				
	PRACTICE / EMPLOYER NAME				
	330 Uluniu St #13				
	NUMBER	STREET			SUITE/BUILDING
	Kailua		HI	96734	
	CITY		STATE		ZIP/POSTAL CODE
	TELEPHONE		FAX		
	United States	10/2020	07/2021		
	COUNTRY CODE	START DATE	END DATE		
REASON FOR DEPARTURE (IF APPLICABLE)					
New opportunity					
Work History All About Behavior	WORK HISTORY				
	PRACTICE / EMPLOYER NAME				
	203 Kapaa Quarry Pl #5002				
	NUMBER	STREET			SUITE/BUILDING
	Kailua		HI	96734	
	CITY		STATE		ZIP/POSTAL CODE
	TELEPHONE		FAX		
	United States	11/2019	05/2020		
	COUNTRY CODE	START DATE	END DATE		
	REASON FOR DEPARTURE (IF APPLICABLE)				
COVID					

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* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Page 32

Std. App. v6.0
Implemented in 04/2025

Work History Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 7	Work History				
Work History Use this form to continue listing work history. If you need additional space for Work History, photocopy this page as needed and submit as instructed.	WORK HISTORY School of Science & Technology PRACTICE / EMPLOYER NAME 6633 Evans Rd.				
	NUMBER	STREET	STATE	SUITE/BUILDING	
	Corpus Christi		TX	78413	
	CITY		STATE	ZIP/POSTAL CODE	
	TELEPHONE		FAX		
	United States	04/2019	10/2019		
	COUNTRY CODE	START DATE	END DATE		
	REASON FOR DEPARTURE (IF APPLICABLE) Moved to Hawaii				
WORK HISTORY Flour Bluff ISD PRACTICE / EMPLOYER NAME 2505 Waldron Road	NUMBER	STREET	SUITE/BUILDING		
	Corpus Christi		TX	78418	
	CITY		STATE	ZIP/POSTAL CODE	
	TELEPHONE		FAX		
	United States	08/2018	04/2019		
	COUNTRY CODE	START DATE	END DATE		
	REASON FOR DEPARTURE (IF APPLICABLE) New opportunity				

3107

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

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Work History Supplemental Form

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Section 7	Work History			
Work History Use this form to continue listing work history. If you need additional space for Work History, photocopy this page as needed and submit as instructed.	WORK HISTORY			
	Lolly's Learn & Grow Center			
	PRACTICE / EMPLOYER NAME			
	9450 S Padre Island Dr Suite 2B			
	NUMBER	STREET	SUITE/BUILDING	
	Corpus Christi		TX	78418
	CITY		STATE	ZIP/POSTAL CODE
	TELEPHONE	FAX		
	United States	08/2018	12/2018	
	COUNTRY CODE	START DATE	END DATE	
REASON FOR DEPARTURE (IF APPLICABLE)				
Moved				
Work History Coastal Bend Blood Center	WORK HISTORY			
	Coastal Bend Blood Center			
	PRACTICE / EMPLOYER NAME			
	209 N Padre Island Dr			
	NUMBER	STREET	SUITE/BUILDING	
	Corpus Christi		TX	78406
	CITY		STATE	ZIP/POSTAL CODE
	TELEPHONE	FAX		
	United States	02/2017	08/2018	
	COUNTRY CODE	START DATE	END DATE	
REASON FOR DEPARTURE (IF APPLICABLE)				
New Opportunity				

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Provider: Julia S Blalack , ABA

Provider CAQH ID: 15141507

Date Generated: 09/01/2025

Last Attestation Date: 09/01/2025

List of Authorized Plans

Affiliated:

Aetna

New Directions Behavioral Health/Lucet

United Behavioral Health/US Behavioral Health Plan, California/LifeEra, Inc.

AND to any healthcare organization that in the future represents to CAQH either that I am a participating provider or that I am in the process of being credentialed as a participating provider.