

Individual Applicant Information

Practices with 5 or more counselors should call (651) 383-8473 for further instruction.

Group Practice Name _____ Office Location to Add to _____

Personal Demographics

First Name _____ Last Name _____

Date of Birth _____ Gender _____

Languages other than English spoken _____

Statistical Demographics

This following information will be entered in our database and used as statistical data for our yearly Provider Network Analysis. Your participation in answering these questions help us create a Provider Network that is a reflection of our unique customer needs.

Sexual Orientation

Bisexual Gay/Lesbian Heterosexual Transgender Other _____

Are you willing to identify your sexual orientation for clients requesting an EAP counselor with your specific orientation?

Yes No

Ethnic Background

African American Asian, Pacific Islander Caucasian Arab/Arabian Native American Latino/ a Other _____

Are you willing to identify your ethnicity and/or nationality for clients requesting an EAP counselor with your specific background?

Yes No

Religious Background

Christian Eastern Religion Islam Jewish Other _____

Are you willing to identify your religious background for clients requesting an EAP counselor with your specific religious background?

Yes No

Military Experience

Special Disabled Veteran Vietnam Era Veteran Newly Separated Veteran Protected Veteran Other _____

Are you willing to identify your military experience for clients requesting your background?

Yes No

Required Demographics

Number of years of post-Master degree clinical experience _____ Number of years Employee Assistance experience _____

Graduate Degree _____ Date of Graduation _____

License/Certification Information (Please submit a copy of all licenses with application)

Licensure	State	License Number	Expiration Date

Clinical Preferences/Expertise (Check all that apply)

You Can Provide the Following (Please provide all corresponding licenses/certificates)

- | | |
|---|--|
| <input type="checkbox"/> Certified Substance Abuse Professional (SAP) Assessment to comply with DOT Regulations | <input type="checkbox"/> CISM/Critical Incident Response |
| <input type="checkbox"/> Chemical Health Assessment | <input type="checkbox"/> EMDR |
| | <input type="checkbox"/> Trainings |

Able to Provide Counseling in the Following Modalities

- | | |
|---|--|
| <input type="checkbox"/> HIPAA Compliant Telehealth Counseling | <input type="checkbox"/> Face-to-Face Counseling |
| <input type="checkbox"/> via telephone counseling <input type="checkbox"/> via video/web counseling | |

Client Focus

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> Adult | <input type="checkbox"/> Couples |
| <input type="checkbox"/> Adolescent | <input type="checkbox"/> Family |
| <input type="checkbox"/> Children 1-3 years old | <input type="checkbox"/> GLBTQ/LGBTQ |
| <input type="checkbox"/> Children 3-6 years old | <input type="checkbox"/> Group |
| <input type="checkbox"/> Children 6-10 years old | |

Client Specific Population Specialist

(Extensive personal experience, background or knowledge in the following)

- | | |
|--|---|
| <input type="checkbox"/> Medical Residency Setting, Medical Students, Doctors, Nurses, Surgeons, Dental Students, Healthcare | <input type="checkbox"/> Law Enforcement, Corrections, Probations, Sherriff's Department Experience, Emergency Responders |
| <input type="checkbox"/> Judicial Members, Lawyers, Law Students | <input type="checkbox"/> Military Experience or Working with Military Population |
| <input type="checkbox"/> Athletes, Coaches, Umpires | <input type="checkbox"/> Pregnancy, Prenatal, Postpartum, Infertility, Conception Complication |
| <input type="checkbox"/> Faculty College Staff, Professors, Academia Setting | |
| <input type="checkbox"/> Department of Transportation (DOT) Laborers, Construction, Trades | |

Areas of Competencies

- | | |
|--|--|
| <input type="checkbox"/> Anger Management | <input type="checkbox"/> Interpersonal Violence |
| <input type="checkbox"/> Career Related Concerns | <input type="checkbox"/> Physical/Sexual Abuse |
| <input type="checkbox"/> Christian Counseling | <input type="checkbox"/> Relationship/Marital Counseling |
| <input type="checkbox"/> Elder Care Issues | <input type="checkbox"/> Spiritual Counseling |
| <input type="checkbox"/> Family Concerns | <input type="checkbox"/> Sports Performance |
| <input type="checkbox"/> Grief/Loss | <input type="checkbox"/> Workplace Conflict/Dynamics |
| <input type="checkbox"/> Health/Medical Issues | |

Past Experience Working with the Following Disorders

- | | |
|--|---|
| <input type="checkbox"/> Bipolar and Related Disorders | <input type="checkbox"/> Obsessive-compulsive and Related Disorders |
| <input type="checkbox"/> Depressive Disorders | <input type="checkbox"/> Schizophrenia Spectrum and Other Psychotic Disorders |
| <input type="checkbox"/> Disruptive, Impulse-Control and Conduct Disorders | <input type="checkbox"/> Sexual Dysfunctions |
| <input type="checkbox"/> Dissociative Disorders | <input type="checkbox"/> Sleep-wake Disorders |
| <input type="checkbox"/> Elimination Disorders | <input type="checkbox"/> Somatic Symptom and Related Disorders |
| <input type="checkbox"/> Feeding and Eating Disorders | <input type="checkbox"/> Trauma and Stressor-related Disorders |
| <input type="checkbox"/> Gender Dysphoria | <input type="checkbox"/> Substance-Related and Addictive Disorder |
| <input type="checkbox"/> Neurocognitive Disorders | <input type="checkbox"/> Personality Disorders |
| <input type="checkbox"/> Neurodevelopmental Disorders | <input type="checkbox"/> Paraphilic Disorders |

Statement

If any of the below statements apply to you, please provide: (1) a detailed explanation of your involvement, (2) the date the action was initiated, (3) the current status, including any final outcome, (4) amount of judgment/settlement or adverse decision, AND (5) a copy of any court order, consent order and findings, settlement agreement or other documentation regarding the current status or final resolution for each matter. If a matter is pending, include a letter from your attorney providing detailed information regarding current status of the matter and copies of any related documentation such as an indictment, statement of charges, Summons & Complaint, Answer, etc.

PLEASE CHECK THE BOX, IF ANY OF THE STATEMENTS APPLY TO YOU

- I have been charged or convicted of a misdemeanor related to my professional functions.
- I have been charged or convicted of a felony.
- I have been investigated by a professional or licensure board, professional association, private payer, state or federal regulatory agency, or other authority.
- My clinical license, certification, or ability to practice in any jurisdiction has been stipulated, denied, restricted, suspended, reduced, revoked, not renewed, placed on probation, or otherwise limited in any way by a licensing agency or any other regulatory bodies.
- I have voluntarily relinquished my professional license, certification or other authority to practice for any reason, as an alternative to disciplinary action.
- I am aware of formal disciplinary or criminal charges pending against me.
- I am aware of complaints against me that are filed with a licensing, certification, or other regulatory body.
- It has been determined that I have operated outside the recognized boundaries of my professional competencies.
- My employment, hospital privileges, managed care organization or EAP participation, or other privileges or participation status has been denied, restricted, suspended, reduced, revoked, not renewed, placed on probation or otherwise limited in any way.
- I have been involuntarily terminated from professional employment, or as a hospital staff member, terminated by a managed care organization, or an EAP or any other organization that granted me privileges or participation status.
- I have resigned with knowledge of an investigation about myself from my professional employer, or as a hospital staff member, managed care organization, EAP or any other organization that granted me privileges or participation status.
- I am aware of disciplinary actions that have been initiated against me by my professional employer, or as a hospital staff member, managed care organization, EAP or any other organization that granted me privileges or participation status.
- I am aware of complaints against me filed with by my professional employer, or as a hospital staff member, managed care organization, EAP or any other organization that granted me privileges or participation status.
- I am or have been sanctioned or excluded from federal, state or local government programs, including but not limited to Medicare and Medicaid.
- I have been expelled from or disciplined by a professional association or organization not included in any other statements.
- I have a physical or mental condition, treated or untreated, in which impairs my ability to practice to the fullest extent of my licensure and qualifications or in any way poses a risk of harm to my clients.
- I am currently engaged in the illegal use or abuse of drugs or controlled substances.
- I am aware of any malpractice suits, professional liability suits, arbitration or other proceedings that have been instituted against me.
- My professional liability carrier has denied, limited, not renewed, or canceled my coverage.
- I have had a non-professional relationship with a client or former client that was sexual in nature or otherwise in violation of any ethical rules of my profession.

Attestation Statement and Authorization

I acknowledge that I have completely read and fully understand this Application. All information submitted by me in this Application, as well as any attachments or supplemental information, is true, current, and complete to the best of my knowledge and belief as of the date of the signature below. I fully understand that any information provided during the application or re-credentialing process is subject to Sand Creek investigation and review. I understand that if any information contained in this Application is determined to be false or constitutes a material misstatement, my Application may be denied or my provider status may be terminated by Sand Creek immediately. I further understand that in that event, Sand Creek may be required to submit a report to state licensing authorities.

I understand Sand Creek will request information from relevant local, state and federal licensing boards as a part of the application review process.

I agree to notify Sand Creek in a timely manner (not to exceed 30-days) of any changes to the information requested on the initial application.

I hereby authorize Sand Creek to consult with any educational institution, board, other licensing or certification entities, former employer or any other professional organization, including past and present malpractice and/or professional liability carriers, who may have information bearing on my professional competence, character, or ethical qualifications. Upon request by Sand Creek, I will obtain and provide to Sand Creek documentation and materials pertaining to my qualifications and/or competence, including, but not limited to, any disciplinary action, suspension, or felony. I hereby consent to the inspection by Sand Creek or its representatives, of all documents that it determines to be material to this evaluation of my professional competence.

I hereby release from liability all individuals, institutions, and entities with which I have been or am associated, including but not limited to professional liability carriers, previous employers, clinics, hospitals, state licensing organizations, professional societies, and health plans to provide any relevant information requested by Sand Creek or its representatives. In the event that I am accepted for participation in Sand Creek Provider Network, I hereby consent to Sand Creek's inspection of my client records relating to Sand Creek participants as necessary for its utilization, clinical quality programs, and complaint resolution processes. I understand and agree that the authorizations and releases given by me are irrevocable as long as I am an applicant for participation status with Sand Creek or am participating in Sand Creek Group's Provider Network.

Signature of Provider and/or Applicant: _____

Name (Print): _____ Date: _____

Worker's Compensation Waiver Agreement as an Independent Contractor

Acting on my own behalf, as an Independent Contractor, I acknowledge that I do not participate in the Worker's Compensation and Employee's Liability Insurance Policy of The Sand Creek Group, Ltd.

Signature: _____

Print Name of Agency: _____ Date: _____

Completion Check List

Before submitting this application, please ensure you have read Sand Creek's Provider Network Guidelines and Eligibility and you are attaching the following information:

- ✓ Individual Applicant Information for Sand Creek Provider Network
- ✓ Copy of ALL current state licenses and/or certification that clearly illustrates license number and expiration date
- ✓ Copy of current professional liability insurance face sheet
- ✓ Resume/CSV

Thank you for your interest in joining Sand Creek's National Provider Network! Once your application is received, the Sand Creek Provider Coordinator will review your application. It takes up to two weeks to process an application.

Please submit this application via fax, e-mail or mail to:

Fax: 651.430.9753

E-mail: Reyna@sandcreekeap.com

Mail:

Attn: Reyna Rios-Starr
The Sand Creek Group, Ltd.
610 North Main Street, Suite 200
Stillwater, MN 55082