Sand Creek
WORKPLACE WELLNESS

SAND CREEK NATIONAL PROVIDER NETWORK GUIDELINES

The primary goal of Sand Creek Workplace Wellness is to deliver healing. We want to work closely with you, the national providers, to make delivery of services to employees and family members a smooth and mutually rewarding operation. We welcome your comments, concerns, and suggestions. We look forward to working with your organization.

All employees and their family members must contact the office of Sand Creek to initiate access to the National Provider Network. All employees have been provided with the telephone numbers of their EAP.

Sand Creek will perform an initial, brief intake and then refer the employee to provider (s) in their area. Should an employee erroneously contact the provider before contacting Sand Creek, they need to be referred back to Sand Creek so they can begin the intake process. It is a contractual obligation that all employees and family members be offered an appointment within two working days of their initial call for routine appointments. Emergency appointments will be offered within 24-hours of initial contact. Any deviations from these standards need to be reported to Sand Creek.

Providers are authorized to provide two to eight EAP counseling sessions (depending upon contract) for each client referred to them. In accordance with standardized EAP protocol, the two to eight sessions are for assessment and referral to long-term counseling as required. Clients should be referred earlier when clinically justified.

Payment for all sessions beyond the EAP assessment/referral are the responsibility of the client; therefore, caution must be used when making the referral so services are covered, to whatever extent possible, by the client's health insurance plan. To receive payment for EAP sessions, a fully completed Sand Creek billing form must be completed and submitted within 30-days of each session the client was seen for reimbursement. The billing forms are used for utilization reporting, and therefore it is imperative that they be completed and returned in a timely manner.

When clients are given referrals, the provider is required to identify at least two other referral resources besides the provider's own clinic or agency. To underscore the point, payment for all sessions beyond the EAP are the responsibility of the client, and every attempt must be made to make a referral that is covered under the employee's benefit plan. If that is not possible, the client should be given a referral to social services / sliding fee scale resources.

Providers must be aware when scheduling EAP clients from the same organization that they need to allow for a minimum of 30-minutes between EAP clients. This is to protect their confidentiality and privacy by precluding meeting other employees at the provider site.

At any point in the EAP process, if questions arise regarding the client's welfare, the treatment plan you are following with the client, or if you have concerns with the disposition of the case at the end of the EAP benefit, please contact Sand Creek and consult with a member of our clinical staff as soon as possible.

PROVIDER ELIGIBILITY FOR NETWORK PARTICIPATION

Before completing the participating practitioner application, please review the following summary of minimum criteria for consideration as a network provider:

Qualifications

- Master's Degree in a Behavioral Health field from an accredited college or University or certification for chemical dependency counseling or as a Substance Abuse Professional as defined by the United States Department of Transportation.**
- At least 3 years clinical experience in a mental health setting treating alcoholism, drug addiction, and/or providing individual and family counseling.
- At least 30 hours post-master's training in the identification and treatment of mental health and/or substance abuse issues. Possess and maintain current state license or state certification (if required by the state services are rendered in).
- Sand Creek requires copies of any applicable license or certification.

*** The United States Department of Transportation (USDOT) rules define the Substance Abuse Professional (SAP) to be a licensed physician (Medical Doctor or Doctor of Osteopathy), a licensed or certified psychologist, a licensed or certified social worker, or licensed or certified employee assistance professional. In addition, alcohol and drug abuse counselors certified by the National Association of Alcoholism and Drug Abuse Counselors (NAADAC) Certification Commission, a national organization that imposes qualification standards for treatment of alcohol and drug related disorders, are included in the SAP definition. ALL must have knowledge of and clinical experience in the diagnosis and treatment of substance abuse-related disorders, the degrees and certificates alone do not confer this knowledge.*

General Office Liability Insurance and Professional Liability Insurance

- Insurance policies of general liability and professional liability for a minimum of $1-3 million. Must submit a face sheet that indicates effective policy dates, coverage amounts, and personal injury liability.
- Signed Worker's Compensation Waiver Form as an Independent Contractor.

Availability

- All providers must be in practice at least 20-hours per week. All providers must be accessible 24-hours a day, seven (7) days a week or make other appropriate arrangements. Providers must agree to make his/her best effort to be available for appointments within the following guidelines:
    - Emergency appointments on the day of the request if possible or within 24-hours of request.
    - Routine appointments within two (2) working days.

You May Not Be a Good Fit for Our Network If:

- You are unable to provide short-term counseling, solution focused counseling.
- You or your agency requires a diagnosis as part of your process.
- You are unable to offer a same day appointment to a client in crisis.
- You are unable to process billing information within 30-days after a client session.

Please proceed to the next section of the application to provide us with information about yourself. This portion takes about five minutes to complete. Please refer to the checklist at the end of this document to submit necessary supportive documentation.

Office Information

Tax ID Number: _____ **Practice/Agency Name**:_____

Office Information

Physical Office Address _____City _____State _____Zip_____

Mailing Address (*if different*) _____City _____State _____Zip_____

Billing Address (*if different*) _____City _____State _____Zip_____

Contact Information

Office Number: _____ EAP Contact Name: _____

Office Fax: _____ Credentialing Contact *(if different):* _____

Office Email: _____ Credentialing E-mail: _____

Website: _____ Preferred Method of Receiving Authorization Form?

☐Email _____ ☐Fax _____

Availability

☐Business Hours (9:00 am to 5:00 pm) ☐Evening Hours ☐Weekend Hours

_____

If you have additional office locations, please fax or e-mail an extended list of the offices

Liability Insurance ***(Must include your current liability insurance face-sheet)***

Liability Carrier:_____ Policy Number: _____

Limit of Coverage Single Occurrence:_____ Expiration Date: _____

Limit of Coverage for Aggregate: _____

Accessibility (Attach explanations for unchecked responses to the following questions)

☐ Ability to return client phone calls within 1 business day?
☐ Ability to offer a routine appointment within 3 business days?
☐ Ability to offer an urgent appointment within 1 business day?

☐ Do you comply with federal, state and/or provincial, and local legal requirements governing public accessibility, health and safety?
☐ Do you maintain a service environment in all primary and affiliate offices that is: Safe, clean, free of fire hazards, smoke free, and professional?

Insurance Panels Accepted

Please list insurance panels that your practice/agency is in network with.

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)

☐Certified Substance Abuse Professional (SAP) Assessment to comply with DOT Regulations
☐Chemical Health Assessment
☐CISM/Critical Incident Response
☐EMDR
☐Trainings

Able to Provide Counseling in the Following Modalities

HIPAA Compliant Telehealth Counseling
☐ via telephone counseling ☐via video/web counseling
☐Face-to-Face Counseling

Client Focus

☐Adult
☐Adolescent
☐Children 1-3 years old
☐Children 3-6 years old
☐Children 6-10 years old
☐Couples
☐Family
☐GLBTQ/LGBTQ
☐Group

Client Specific Population Specialist

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

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

Areas of Competencies

☐Anger Management
☐Career Related Concerns
☐Christian Counseling
☐Elder Care Issues
☐Family Concerns
☐Grief/Loss
☐Health/Medical Issues
☐Interpersonal Violence
☐Physical/Sexual Abuse
☐Relationship/Marital Counseling
☐Spiritual Counseling
☐Sports Performance
☐Workplace Conflict/Dynamics

Past Experience Working with the Following Disorders

☐Bipolar and Related Disorders
☐Depressive Disorders
☐Disruptive, Impulse-Control and Conduct Disorders
☐Dissociative Disorders
☐Elimination Disorders
☐Feeding and Eating Disorders
☐Gender Dysphoria
☐Neurocognitive Disorders
☐Neurodevelopmental Disorders
☐Obsessive-compulsive and Related Disorders
☐Schizophrenia Spectrum and Other Psychotic Disorders
☐Sexual Dysfunctions
☐Sleep-wake Disorders
☐Somatic Symptom and Related Disorders
☐Trauma and Stressor-related Disorders
☐Substance-Related and Addictive Disorder
☐Personality Disorders
☐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 are attaching the following information:

- ✓ Provider Office Information
- ✓ Individual Applicant Information for Sand Creek Provider Network
- ✓ Completed W-9
- ✓ 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. If accepted into the Network, you will receive a Provider Agreement via fax or e-mail to be carefully read, signed and returned back. 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