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 one other referral resource 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 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

- Must indicate effective policy dates, coverage amounts, and personal injury liability.
    - Sand Creek requires copies of the general liability insurance face sheet and professional liability insurance face sheet. In addition, please read and fill out the 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.

Individual Applicant Information for Sand Creek Provider Network to Add to Group Practice

Group Practice Name _____**Office Location to Add to** _____

Personal Demographics

First Name _____ Last Name _____

Date of Birth _____Gender _____

Languages Spoken _____

Optional Demographics

The following information regarding sexual orientation, race/ethnic group, and religious affiliation is not used for purposes of denying an application for participation. Often clients will ask for a counselor who meets specific criteria within one of the following categories. If your application is approved, and you provide this information, your response will be entered into our database so that you can be identified if a client requests a counselor who meets a specific category. Any responses you provide or your decision to not provide this information will not, in any way, be the basis for denying your application for participation.

Sexual Orientation

☐Bisexual ☐Gay/Lesbian ☐Heterosexual ☐Transgender
☐Other _____

Ethnic Background

☐African American ☐Asian, Pacific Islander ☐Caucasian ☐Arab/Arabian ☐Native American ☐Hispanic
☐Other _____

Religious Background

☐Christian ☐Eastern Religion ☐Islam ☐Jewish
☐Other _____

Military Experience

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

Required Demographics

Total number of years of post-Master degree clinical experience _____

Total number of years Employee Assistance experience _____

Professional Experience

Type of Degree*	Name of Institution	Degree	Graduation Date

* **Type of Degree**: **U**= Undergraduate **P**= Professional/Graduate **I**= Internship **O**=Other

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)

☐CISM/Critical Incident Response
☐Trainings, Employee Orientations, Presentations
☐Chemical Health Assessment
☐Certified Substance Abuse Professional (SAP) Assessment to comply to DOT Regulations

Able to Provide Counseling in the Following Modalities

☐Face-to-Face Counseling
☐Telephonic Counseling (Local and Long Distance)
☐Web Counseling

Clientele Served

☐Adult
☐Adolescent
☐Children 1-3 years old
☐Children 3-6 years old
☐Children 6-10 years old
☐Couples
☐Family
☐Gay Lesbian Bisexual Transgender Queer/Questioning (GLBTQ)
☐Group

Individual Specialties

☐ADD/ADHD
☐Addiction, Non Chemical
☐Alzheimer's
☐Anger Management
☐Anxiety
☐Autism
☐Christian Counseling
☐Depression
☐Domestic Violence
☐Health/Medical Issues
☐Intimacy Concerns
☐Infertility/Conception Complications
☐Law Enforcement or Working with Law Enforcement Population
☐Marital/Couples Counseling
☐Military Experience or Working with Military Population
☐Personality Disorders
☐Pregnancy, Prenatal, Postpartum
☐Trauma or Post Traumatic Stress Disorder (PTSD)
☐Eating Disorder
☐Elder Care Issues
☐Gambling
☐Grief/Loss
☐Retirement
☐Sexual Abuse
☐Spiritual Counseling
☐Substance Abuse/Alcohol and Drug Counseling
☐Workplace/Career Concerns

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:

☐Individual Applicant Information for Sand Creek Provider Network to Add to Group
☐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

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 Letter of 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