

THE SAND CREEK NATIONAL PROVIDER NETWORK GUIDELINES

The primary goal of The Sand Creek Group, Ltd. 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 The Sand Creek Group Ltd. to initiate access to the National Provider Network. All employees have been provided with the telephone numbers of their EAP.

The Sand Creek Group 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 The Sand Creek Group.

Providers are authorized to provide three to six EAP counseling sessions (depending upon contract) for each client referred to them. In accordance with standardized EAP protocol, the three to six 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 Group billing form must be completed and submitted within 30 days of the session 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 The Sand Creek Group 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 (See Note).
- At least 5 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.
- At least 12 hours per year of continuing education in the 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).

The Sand Creek Group requires copies of any applicable license or certification.

NOTE: 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.

The Sand Creek Group requires copies of the general liability insurance face sheet and professional liability insurance face sheet.

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.
- Urgent appointments within 24 hours of a request for emergency appointments.
- Routine appointments within two (2) working days.

HOW THE EAP WORKS

By Gretchen M. Stein, PhD, CEAP

President and CEO

The Sand Creek Group, Ltd.

The Employee Assistance Program (EAP) is a counseling resource for employees and their dependents. Employers make the EAP available to their employees as a way to keep employee productivity high. Over the years, the EAP has been a proven resource in reducing stress and frustration and helps employees find meaningful solutions to their problems.

The Sand Creek Group has been providing EAP to employers since 1994. The Sand Creek Group is a women-owned, small business that specializes in EAP services to government and serves many corporate customers as well.

There is still some confusion over what the EAP is and how it works and what it is not. The purpose of this article is to clarify the EAP's function.

First Place to Turn

For employees who are experiencing problems at work or at home, the EAP is often the first place to turn for professional help. Our phones are answered 24 hours a day, everyday, by counselors who can help a caller in crisis. Employees simply need to call 1-888-243-5744 or 1-800-632-7643 or 651-4340-3383 to reach a master's level counselor.

Our model allows for employees or their dependents to come in to the office of a professional counselor in the employee's community for assessment of their problem and brief counseling. We have over 10,000 clinical offices in the United States.

Access to a counselor is very quick, often within two days of the initial call. Clients in immediate crisis are seen on the same day of their call.

Short Term and Brief Counseling

The EAP was never meant to replace an employee's mental health coverage through his or her health plan. Our work is at the front end of a problem where employees need quick access to professional help night or day.

Our goal is to provide effective short term counseling services to help address our clients' concerns whenever possible. As we identify their specific stressors and gain a broader understanding of the history behind their concerns, the EAP is then able to provide short term counseling services for those situations. The EAP also assists our clients in finding longer term or specialty-focused programs such as chemical dependency treatment, domestic violence/anger management programs or other community support groups. It is important to refer the client to his or her health benefits plan whenever possible to help defray the expense of accessing other resources outside the EAP. In most cases, the EAP clinician will be able to make a determination of the most suitable plan of action for the client after the first few sessions.

Eligibility

Employees who work for participating employers are covered under the EAP. Employees' dependents living within an employee's household are also covered.

The employee and their family members are eligible for up to the contracted allotted number of counseling sessions for each distinctively different problem. How many sessions they receive is a clinical decision that will be made between the client and his or her counselor. For example, in situations where the problem assessment is completed in two sessions and the client needs treatment beyond the EAP for chemical dependency or psychiatric treatment, referral will be made immediately outside the EAP to a treatment program for needed further assistance.

Not a Treatment Program for Chronic Problems

The vast majority of employees and dependents who use the EAP use it appropriately to address problems that impact their lives and their work. Unfortunately, with the rising costs of insurance co-pays and other economic pressures on families, some clients are trying to use the EAP as a substitute for long term care under their health plan. The EAP is a brief short term resource. If clients need more than the contracted allotted sessions to address their problem, they will be referred to other resources for this help.

The request for any additional sessions, after the initial sessions have been provided to address this or a similar problem, is not the appropriate use of this program.

EAP is a benefit that attempts to reach as many people that need it as possible. We have to limit our services to the number of sessions we have been contracted to provide in order to insure that this resource is available to all who need it, when they need it.

The EAP is a Counseling Resource—Not Medical

If employees or their family members are in need of psychiatric services, they require the help of a psychiatrist who is a medical doctor. These services are not available through the EAP, but rather, through their medical health plan. We do not do school testing, psychiatric testing or any other form of psychological testing. Testing is beyond the scope of work for any employee assistance program.

We Specialize In Addressing Workplace Problems

What makes EAP unique is that we are an easily accessed, quick service to help people immediately with their problems over a brief period of time. We are specialists in addressing work related problems and concerns. We offer brief counseling to help employees immediately begin to address problems that may impact their concentration or productivity at work. We offer coaching and consultation to supervisors and managers to provide innovative ideas on ways to address employee problems. We provide optional on site training and consultation for work teams who need assistance as well.

The EAP is professional, confidential, easily accessible and at no cost to the employee.

SECTION I: Group/Office Information

This application is ready for mailing if the following are completed:

- Individual and Group Data information is complete.
- Copies of any documents requested are included.
- W-9 is complete and attached.
- Individual applicant information is completed, signed, dated, and attached for each agency staff member or individual applicant.

Attach current copies of the following for each staff member or individual applicant:

- Current resume or vitae (corresponding months and years required).
- Copy of all current licenses and certifications.
- Copy of current malpractice/professional liability insurance face sheet that lists liability limits and all covered individual names on certificate (minimum requirement: \$1,000,000 occurrence/\$3,000,000 aggregate).

The following are preferred but not required:

- Certified Employee Assistance Professional (CEAP).
- Office hours at least 4 days per week.
- Office hours at least one evening and/or weekend per week.
- Internet access in office setting with Internet Explorer browser 6.0 or higher.

For consideration as providers for SA, SAP, & CISM complete Optional Sections

- Individual applicant information for inclusion in the mandated substance abuse network.
- Individual applicant information for inclusion in the SAP network – Section VI.
- Individual applicant information for inclusion in the critical incident stress management network and copy of training certificate.

Primary Office Information

_____ Type of Practice: Solo Group Other: _____
Agency or Office Name

_____ *Address (Physical Office)* _____ *City* _____ *County* _____ *State*

_____ *Zip/Postal Code* _____ *Country*

_____ *Landmark or Identifying Description (i.e. Borough, Quarter, Mid-Town, etc.)*

_____ and _____
Cross Streets

Handicap and wheelchair accessible? Yes No

Location accessible by affordable public transportation? Yes No

Preferred, but not required:

Ability to access the Internet on a full-time basis to review and respond to referral intakes, complete necessary forms, document all case activity, and submit invoices? Yes No

Ability to access the Internet via Internet Explorer 6.0 or higher? Yes No

Office E-Mail Address: _____ Office Web Site: _____

Office Contact /EAP Coordinator: _____

Telephone, Main, **(confidential)** : _____

Telephone, 24 hour/7 day **(confidential)**: _____

referral authorization voice mailbox or answering service number: _____

Describe what arrangements you provide for 24/7 emergency coverage:

Fax Number **(confidential and secure)**: _____

TTY/TTD, telecommunication typewriter, phone number: _____

Payee Tax Number: (Must match W-9 name)

When submitting invoices, what tax ID number/business name do you use? (Choose one: Employer ID# and name **OR** Social Security number and name)

1. Employer Identification Number: _____ Employer Identification Name: _____

2. Social Security Number: _____ Social Security Name: _____

Payee Tax Information: (Must match W-9 address)

Address (Billing Office): _____ Suite: _____

City: _____ County: _____

State/Province: _____ Zip/Postal Code: _____ Country: _____

Office Hours:

What hours can clients be seen for in-person appointments (main location):

Mon _____ Tues _____ Wed _____

Thurs _____ Fri _____ Sat _____

Sun _____

SATELLITE/OTHER OFFICE LOCATIONS

(If different than main office location)

Satellite Office 1	Satellite Office 2
Street: _____	Street: _____
City: _____ County: _____	City: _____ County: _____
State/Province: _____ Zip/Postal Code: _____	State/Province: _____ Zip/Postal Code: _____
Phone: _____	Phone: _____
Handicap and wheelchair accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No	Handicap and wheelchair accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No
Location accessible by affordable public transportation? <input type="checkbox"/> Yes <input type="checkbox"/> No	Location accessible by affordable public transportation? <input type="checkbox"/> Yes <input type="checkbox"/> No
EAP Contact: _____	EAP Contact: _____
Satellite Office 3	Satellite Office 4
Street: _____	Street: _____
City: _____ County: _____	City: _____ County: _____
State/Province: _____ Zip/Postal Code: _____	State/Province: _____ Zip/Postal Code: _____
Phone: _____	Phone: _____
Handicap and wheelchair accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No	Handicap and wheelchair accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No
Location accessible by affordable public transportation? <input type="checkbox"/> Yes <input type="checkbox"/> No	Location accessible by affordable public transportation? <input type="checkbox"/> Yes <input type="checkbox"/> No
EAP Contact: _____	EAP Contact: _____

(Attach supplemental pages for additional office locations.)

What hours can clients be seen for in-person appointments at Satellite Office 1

Mon _____ Tues _____ Wed _____ Thurs _____ Fri _____ Sat _____ Sun _____

What hours can clients be seen for in-person appointments at Satellite Office 2

Mon _____ Tues _____ Wed _____ Thurs _____ Fri _____ Sat _____ Sun _____

What hours can clients be seen for in-person appointments at Satellite Office 3

Mon _____ Tues _____ Wed _____ Thurs _____ Fri _____ Sat _____ Sun _____

What hours can clients be seen for in-person appointments at Satellite Office 4

Mon _____ Tues _____ Wed _____ Thurs _____ Fri _____ Sat _____ Sun _____

Accessibility (Attach explanations for “no” responses to the following questions.)

- Ability to return client phone calls within 1 business day? Yes No
- Ability to offer a routine appointment within 3 business days? Yes No
- Ability to offer an urgent appointment within 1 business day? Yes No
- Do you comply with federal, state and/or provincial, and local legal requirements governing public accessibility, health, and safety? Yes No
- Do you maintain a service environment in all primary and affiliate offices that is:
 - safe Yes No
 - clean Yes No
 - free of fire hazards Yes No
 - smoke free Yes No
 - child friendly Yes No
 - professional Yes No

Which classification best describes your agency as defined by the Small Business Administration? (Please select all that apply; for example, you may be small women owned and located in a HUBZONE)

- Large Business Small Disadvantaged Business Non-Profit
 Small Business Women-Owned Small Business Veteran-Owned Small Business
 HUBZone Small Business Service-Disabled Veteran-Owned Small Business

The following information is used for the VETS-100 annual report. Because The Sand Creek Group, Ltd. contracts with federal government agencies, our group is required to submit an annual report that includes the following information about our sub-contractors.

Please report the total maximum and minimum number of permanent employees in the past year:

Maximum Number _____ Minimum Number _____

Please report number of permanent full-time or part-time employees and new hires who are targeted veterans:

Job Categories	Special Disabled Veterans	Vietnam Era Veterans	Newly Separated Veterans	Other Protected Veterans
Officials and Managers				
Professionals				
Technicians				
Sales Workers				
Office and Clerical				
Craft Workers (Skilled)				
Operative (Semi-Skilled)				
Laborers (Unskilled)				
Service Workers				
Total				

SECTION II: Individual Applicant Information

Personal demographics

Legal Name: _____ Birth Date (mm/dd/yyyy): _____

Gender: Male Female

Total number of years post-Masters degree clinical experience:.....

Total number of years Employee Assistance experience:.....

Do you work in a clinical practice for a minimum of 10 hours/ week? (total hours in all practices) Yes No

Do you receive supervision or consultation?..... Yes No
If yes, indicate number of supervision or consultation hours you receive per month:.....

Do you keep records of all training/education you receive and are you able to make these available to us and/or external reviewers upon request?..... Yes No

The following information regarding sexual orientation, religious affiliation, and race/ethnic group 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.

Would you be willing to identify your sexual orientation in our database for clients that request an EAP counselor with your specific orientation?..... Yes No

If yes, check all that apply:

Heterosexual Bisexual Gay/ Lesbian Transgender

Would you be willing to identify your religious background in our database for clients that request an EAP counselor with your specific religious background?.... Yes No

If yes, check all that apply:

Catholicism Christianity Eastern Religion Islam Judaism Other: _____

Would you be willing to identify your ethnic background in our database for clients that request an EAP counselor with your specific background?..... Yes No

If yes, check all that apply:

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

Would you be willing to identify your military experience in our database for clients that request an EAP counselor with your specific background?..... Yes No

If yes, are you a Veteran?..... Yes No

Special Disabled Vet. Vietnam Era Vet. Newly Separated Vet. Other Protected Vet.

Employment History (Attach current resume or vitae)

(Work history must include at least the most current 5-year period, including present employment. Attach supplemental pages for additional employer information and explanations for any gaps in employment over last 5 years.)

Name of Employer Organization Office Practice	City, State	Phone Number	Position	Dates	Manager's Name

License/Certification Information (Attach copy(s) of all current licenses and/or certifications.)

Type of license/certification	State	Date of License/Certification	License Number	Status A=Active I=Inactive S=Suspended	Expiration Date

Professional Education

Type U =Undergraduate P =Prof./Graduate I =Internship O = Other	Name of Institution	Mailing Address	Degree	Dates (From-To)	Graduation Date

Liability Information

Complete all the information below and attach a copy of current malpractice/ professional liability insurance face sheet that lists liability limits and individual name(s). **\$1 Million/\$3 Million required.**

Name of Agent/Carrier for Professional liability / malpractice insurance

Address City State Zip

Policy Number: _____ Expiration Date: _____

Coverage limits: _____ Amount Per Occurrence: _____

Aggregate: _____

Individual office locations and hours

What hours and offices are clients seen for in-person appointments with you individually:

Day	Hours	Location	Hours	Location
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
Sunday				

EAP Experience

1. I have experience providing Employee Assistance counseling..... Yes No
2. I am qualified and experienced in providing solution-focused counseling..... Yes No
3. I am qualified to provide general assessments, short-term problem-resolution counseling, and/or referrals for:
 - a. Mental Health..... Yes No
 - b. Family, Children Within Family Context, & Relationship..... Yes No
 - c. Alcohol/ Drug Addiction..... Yes No
4. I am experienced in identifying and resolving workplace problems that may be caused and/or exacerbated by an employee’s personal or work life..... Yes No
5. I am experienced in helping employees understand and resolve conflict at work..... Yes No
6. I have experience and understanding of dual-client relationships*..... Yes No
7. I have knowledge of community resources and local treatment providers..... Yes No
8. I have knowledge and experience with assessing and managing high-risk situations (e.g. suicidal, homicidal, self-injury)..... Yes No
9. I am experienced in providing services for work-mandated cases..... Yes No

* Dual-client relationships: You are simultaneously serving both the client, recipient of sessions, and the client company, payer of the service.

CLINICAL PREFERENCES/EXPERTISE (Check all that apply.)

Clientele served

- Adolescent/Teen
- Adult
- Children
- Family
- Group

Languages

List any that you are able to provide counseling in: _____

Individual Specialties

- ADD/ADHD
- Addictions, Non-Chemical
- Anger Management
- Anxiety
- Career Concerns
- Christian Counseling
- Depression
- Domestic Violence
- Eating Disorders
- Elder Care Issues
- Financial
- Gambling
- GLBT
- Grief Loss
- Health/Medical Issues
- Mandatory Workplace Referrals
- Marital/Couples Counseling
- Military Experience or Working with Military Population
- Personality Disorders
- PTSD, Post Traumatic Stress Disorder
- Retirement
- Sexual Abuse
- Spiritual Counseling
- Substance Abuse/Alcohol and Drug Counseling
- Training, employee orientation, presentation experience

EAP Provider Relationships

Please list those EAP Organizations you are approved to provide services for:

Insurance Provider Relationships

Please list those insurance providers you are approved to provide third party billing services for:

Statement

If you answer “YES” to any of the following questions, 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.

Have you ever been charged or convicted of a misdemeanor related to your professional functions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been charged or convicted of a felony in any state?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been investigated by any professional or licensure board, professional association, private payer, state or federal regulatory agency, or other authority?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has your clinical license, certification, or ability to practice in any jurisdiction ever 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever voluntarily relinquished your professional license, certification or other authority to practice for any reason, including as an alternative to disciplinary action?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you aware of any formal disciplinary or criminal charges pending against you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you aware of any complaints against you filed with any licensing, certification, or other regulatory body?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has it ever been determined that you have operated outside the recognized boundaries of your professional competencies?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has your employment, hospital privileges, managed care organization or EAP participation, or other privileges or participation status every been denied, restricted, suspended, reduced, revoked, not renewed, placed on probation or otherwise limited in any way?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been involuntarily terminated from professional employment or a hospital staff, or, terminated by a managed care organization, an EAP or any other organization that granted you privileges or participation status?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever resigned with knowledge of an investigation about you by a professional employer, hospital staff, managed care organization, EAP or any other organization that granted you privileges or participation status?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you aware of any disciplinary actions that have been initiated against you by a professional employer, hospital staff, managed care organization, EAP or any other organization that granted you privileges or participation status?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you aware of any complaints against you filed with a professional employer, hospital staff, managed care organization, EAP or any other organization that granted you privileges or participation status?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you now or have you ever been sanctioned or excluded from federal, state or local government programs, including but not limited to Medicare and Medicaid?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been expelled from or disciplined by any professional association or organization not included in any other question?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any physical or mental condition, treated or untreated, which in any way impairs your ability to practice to the fullest extent of your licensure and qualifications or in anyway poses a risk of harm to your clients?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you currently engaged in the illegal use or abuse of drugs or controlled substances?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have any malpractice suits, professional liability suits, arbitration or other proceedings ever been instituted against you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has a professional liability carrier ever denied, limited, not renewed, or canceled your coverage?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever 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 your profession?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Attestation Statement and Authorization

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 recredentialing process is subject to The Sand Creek Group 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 affiliate status may be terminated by The Sand Creek Group immediately. I further understand that in that event, The Sand Creek Group may be required to submit a report to state licensing authorities.

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

I acknowledge that I have completely read and fully understand this Application. I certify that all of the information contained in this Application and all of its attachments are complete, true and correct.

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

Signature of Affiliate and/or Applicant: _____

Name (print): _____ Date: _____

I hereby authorize Sand Creek Group EAP 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 The Sand Creek Group, I will obtain and provide to The Sand Creek Group 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 The Sand Creek Group, 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 The Sand Creek Group or its representatives. In the event that I am accepted for participation in Sand Creek Group’s EAP Provider Network, I hereby consent to The Sand Creek Group’s inspection of my client records relating to The Sand Creek Group 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 The Sand Creek Group or am participating in The Sand Creek Group’s EAP Provider Network.

I acknowledge that I have completely read and fully understand this Authorization and Release.

Signature of Affiliate and/or Applicant: _____

Name (print): _____ Date: _____

OPTIONAL SECTION: MANDATED SUBSTANCE ABUSE

To be completed by those applying for inclusion in our Mandated Substance Abuse Network

EAP Mandated Substance Abuse, Network Criteria

- Bachelor’s, Master’s degree, or higher in counseling, social work, psychology, or a related mental health profession.
- Alcohol and Drug Counselor Certification or Licensure (or have proof of applicable specialized training).
- Confidential and secure fax.
- Malpractice/professional liability insurance: \$1,000,000 occurrence / \$3,000,000 aggregate.
- Professional office setting that ensures confidentiality.
- Minimum of 2 years of clinical experience working in outpatient or inpatient substance abuse treatment setting.

Other Considerations: (Preferred, but not required)

- Certified Employee Assistance Professional.
- Office hours at least 4 days per week.
- Office hours at least one evening and/or weekend per week.
- Internet access in office setting with Internet Explorer browser 6.0 or higher.
- Ability to meet accessibility guarantees.

Substance Abuse Experience:

1. I am qualified to conduct a chemical dependency assessment..... Yes No
2. I am qualified to provide substance abuse education and information services..... Yes No
3. I am qualified and willing to make treatment recommendations on all mandated referrals..... Yes No

Total number of years working in an outpatient/private practice or inpatient substance abuse treatment setting:.....

Substance Abuse Outpatient or Inpatient Treatment Positions	Company Name	Company Address	Dates	% of practice in Substance abuse
<input type="checkbox"/> Inpatient Outpatient Position:				
<input type="checkbox"/> Inpatient Outpatient Position:				
<input type="checkbox"/> Inpatient Outpatient Position:				

**Substance Abuse
(SA) Services**

- Detox
- Drinking/Drug Impaired Driver Programs
- Drug Testing
- In Patient SA Treatment
- Intake/Assessment
- Outpatient SA Treatment
- Perinatal Drug Treatment
- Public Inebriate Transportation
- Residential SA Treatment
- SA Crisis Intervention
- SA Education/Prevention
- SA Intervention Programs
- Transitional SA Services

**Substance Abuse
Target Groups**

- Adolescents
- Adults
- Aided Person
- Developmental Disability
- Educational Status
- Frail Elderly
- Functionally Disabled
- Health Conditions
- Homebound People
- Learning Disabilities
- Long Term Care Recipients
- Men
- Mental/Emotional Disturbance
- Physical Disabilities
- Senior Citizens
- Sexual Orientation / Gender Identity
- Terminal Illness
- Transients
- Victims/Survivors
- Visual Impairments
- Women

**Target Substance
Abuse Groups**

- Alcohol
- Cross Addiction
- Drugs
- Nicotine

**Twelve Step Mutual
Support Groups**

- Adult Children of Alcoholics (ACOA)
- Alcoholics Anonymous (AA)
- Al-Anon
- Alateen
- Gamblers Anonymous (GA)
- Co-dependency (CODA)
- Cocaine Anonymous (CA)
- Narcotics Anonymous (NA)

OPTIONAL SECTION: SAP (SUBSTANCE ABUSE PROFESSIONAL)

To be completed by those applying for inclusion in our SAP Network

Criteria: Substance Abuse Professional

- Licensed Physician (Doctor of Medicine or Osteopathy); or
 - Licensed or certified Psychologist; or
 - Licensed or Certified Employee Assistance Professional (LEAP, CEAP), or
 - Alcohol and Drug Counselor Certification Commission (NAACAC), or by the International Certification Reciprocity Consortium/Alcohol and Other Drug Abuse (ICRC), by the National Board for Certified Counselors, Inc., and Affiliates/Mater Addictions Counselor (NBCC),
- You must have knowledge of and clinical experience in the diagnosis and treatment of substance abuse related disorders.
 - You must understand how the SAP role relates to the special responsibilities employers have for ensuring the safety of the traveling public.
 - You must be well informed about Park 40, pertinent DOT agency regulations, these SAP guidelines, and any significant changes to them.
 - Add Malpractice Insurance information.
 - Ability to immediately return emergency phone requests.

Training

Received qualification training:

- Training must include the nine required components laid out in Section 28 (c) of Part 40.
- You must have completed this training requirement by December 31, 2003, if you became a SAP on or before December 31, 2003, and submit proof of this
- If you became a SAP after December 31, 2003, you must meet the about training requirements before performing any SAP functions.
- You must have satisfactorily completed an examination, which was given by a nationally recognized professional or training organization (i.e., any training or professional organization giving this exam must have their SAP examination validated by a test evaluation organization.)
- During each three-year period following satisfactory completion of your training and examination, you must complete at least 12 professional development hours (e.g., Continuing Education Units) relevant to performing SAP duties.

Other Considerations:

Forward to The Sand creek Group copies of the SAP forms you currently use. If they do not meet The Sand Creek Group's expectations of SAP documentation, The Sand Creek Group will supply its SAP pack with expectations that these forms will be used on the SAP's own letterhead.

SAP Experience:

SAP evaluations you have experience with (Check all that apply)

- Federal Motor Carrier Safety Administration (FMSCA). Regulation 49 Part ____ (Fill in the correct number)
- Federal Railroad Administration (FRA) Regulation 49 Part ____ (Fill in the correct number)
- Federal Aviation Administration (FAA) Regulation 49 Part ____ (Fill in the correct number)
- Federal Transit Administration (FTA) Regulation 49 Part ____ (Fill in the correct number)
- United States Coast Guard (USCG) Regulation 49 Part ____ (Fill in the correct number)
- Research and Special Programs Administration (RSPA) Regulation 49 Part ____ (Fill in the correct number)

OPTIONAL SECTION: CRITICAL INCIDENT STRESS MANAGEMENT

To be completed by those applying for inclusion in our CISM network Criteria: Critical Incident

Stress Management

- Master's degree or higher in counseling, social work, psychology, or a related mental health profession
- State license/certification in area(s) of specialty, unrestricted
- Minimum of 2 years of onsite CISM related experience
- Minimum of 5 critical incident interventions within the last 2-year period
- Minimum of 2 critical incident interventions where applicant was the primary facilitator within the last 2-year period
- Malpractice/professional liability insurance: \$1,000,000 occurrence/\$3,000,000 aggregate
- Ability to immediately return emergency phone requests
- Specialized training in post-trauma intervention, preferably one of the following:
 - ICISF-Approved, Basic Critical Incident Stress Management Course
 - Board Certified Expert in Traumatic Stress through the American Academy of Experts in Traumatic Stress
 - Red Cross Certification
 - National Organization of Victim Assistance (NOVA) Certification
 - Federal Aviation Administration (FAA) Certification
 - Human Resource Management (AHR) Critical Incident Stress Debriefing Program
 - Other CISM models that are verifiable (subject to approval by Ceridian EAP & Life-Works Services)

Other Considerations: (Preferred, but not required)

- Ability to meet accessibility requirements for CISM response within 24-72 hours
- Ability to meet accessibility requirements for CISM response within 2 hours
- Internet access in office setting with Internet Explorer browser 6.0 or higher

Accessibility

Ability to be onsite to conduct critical incident interventions within 24-72 hours Yes No

Ability to be onsite to conduct critical incident interventions within 2 hours Yes No

Please provide cell phone or pager number: _____

Critical Incident Stress Management Experience:

Types of critical incident interventions you have performed (Check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Robbery | <input type="checkbox"/> One to One Counseling After Critical Incident at Work-Site |
| <input type="checkbox"/> Death of Employee | <input type="checkbox"/> Suicide |
| <input type="checkbox"/> Downsizing | <input type="checkbox"/> Terrorism |
| <input type="checkbox"/> Natural Disaster | <input type="checkbox"/> Other: _____ |

Total number years of CISM experience: _____

Total number of onsite critical incident interventions within the last 2 year period: _____

Total number of onsite critical incident interventions as the primary facilitator in the last 2 year period: _____

CISM Training Information:

TYPE OF CISM TRAINING	NAME OF TRAINING INSTITUTION	CITY/STATE	PHONE	HOURS OF TRAINING	TRAINING COMPLETION DATE (M/DD/YY)