SONDER
COUNSELING & CONSULTING

Treatment Provider Application Checklist

Email completed forms to SCC@SonderCC.com

This checklist provides a quick reference to the information that should accompany your application.

- ❑ Treatment Provider Application – please complete in full, and sign and date the Certification and Authorization (last page)
- ❑ Treatment Provider Affiliation Agreement and Attachment A – please sign, date, and return the original agreement and attachment
- ❑ Form SS-4, Assignment of Employer Identification Number, or a completed Form W-9
- ❑ Curriculum Vitae or Resume – must be month/year specific, beginning with your current practice
- ❑ Current State License(s)/Certification(s) – please submit a photocopy showing expiration date
- ❑ Professional Liability Insurance – please submit a photocopy of current policy declaration page indicating limits of at least $1 million per occurrence/$3 million aggregate, and expiration date
- ❑ Specialty Board Certificate(s) – please submit photocopy, if applicable
- ❑ Continuing Education Certificates, if applicable
  - If you specialize in child/adolescent or substance abuse, 4 – 6 hours of CEUs per licensure period must be directly related to the specialty
  - If you are applying for the CISM specialty, please submit a copy of CISM training certificate

PLEASE NOTE: Failure to complete the application in full will delay your network affiliation. Please return the Treatment Provider Application and Affiliation Agreement with original signatures to SCC.

Email completed forms to SCC@SonderCC.com

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Treatment Provider Application

Identifying Information (Please type or print.)

Provider's Name

Degree/Title or Licensure
❑ MD ❑ DO ❑ PhD ❑ PsyD ❑ LPC ❑ LCSW ❑ LMHC ❑ MFT ❑ CNP ❑ Other _____

Gender (Optional) ❑ Male ❑ Female

Race/Ethnic Group (Optional) ❑ American Indian ❑ Asian ❑ Black ❑ Hispanic ❑ White ❑ Other _____

Date of Birth | Social Security Number | NPIN

Address Information (Please list all locations and group affiliations.)

Primary Office

Practice Type
❑ Solo ❑ Group ❑ Employee ❑ Independent Contractor ❑ Other _____

Practice/Business Name

Street Address | Suite #

City | State | Zip | County

Phone | Fax | Emergency | Email

Federal Tax ID Number | Normal Business Hours | Schedule (Check all that apply to this location.) ❑ S ❑ M ❑ T ❑ W ❑ T ❑ F ❑ S

Office Contact Person | Is this location a home office? ❑ Yes ❑ No | If yes, does it have a separate entry? ❑ Yes ❑ No | Is this office completely separate from the living quarters? ❑ Yes ❑ No

Office Accommodations (Please check all that apply.) ❑ Private Waiting Area ❑ Handicapped Accessible ❑ Smoke-Free ❑ Fire Exits ❑ Fire Extinguisher ❑ Fire Plan ❑ Free Parking ❑ Lighted Parking ❑ Off-Street Parking ❑ Public Transportation ❑ Sign Language ❑ Hearing Impaired w/Translator ❑ TTY ❑ Locked Medication Storage ❑ Locked Records Storage

Mailing Address (if different)

Street Address or PO Box | Suite #

City | State | Zip

Phone | Fax

Claims Payment Address (if different)

Street Address or PO Box | Suite #

City | State | Zip

Phone | Fax

Additional Address Information

Practice Type
❑ Solo ❑ Group ❑ Employee ❑ Independent Contractor ❑ Other _____

Practice/Business Name

Street Address | Suite #

City | State | Zip | County

Phone | Fax | Emergency | Email

Federal Tax ID Number | Normal Business Hours | Schedule (Check all that apply to this location.) ❑ S ❑ M ❑ T ❑ W ❑ T ❑ F ❑ S

Office Contact Person | Is this location a home office? ❑ Yes ❑ No | If yes, does it have a separate entry? ❑ Yes ❑ No | Is this office completely separate from the living quarters? ❑ Yes ❑ No

Office Accommodations (Please check all that apply.) ❑ Private Waiting Area ❑ Handicapped Accessible ❑ Smoke-Free ❑ Fire Exits ❑ Fire Extinguisher ❑ Fire Plan ❑ Free Parking ❑ Lighted Parking ❑ Off-Street Parking ❑ Public Transportation ❑ Sign Language ❑ Hearing Impaired w/Translator ❑ TTY ❑ Locked Medication Storage ❑ Locked Records Storage

Mailing Address (if different)

Street Address or PO Box | Suite #

City | State | Zip

Phone | Fax

Claims Payment Address (if different)

Street Address or PO Box | Suite #

City | State | Zip

Phone | Fax

Please make a copy of this page and attach to the application if you have additional locations.

Medical Education/Professional Degree/Other Training

Type	Degree/Specialty	Name of School/University	City/State	Completion Date
Graduate/Medical School				
Internship				
Residency				
Fellowship				
Other Training				

Work History (Please attach a CV reflecting work history including month/year dates (required). Include a written explanation for any employment gaps greater than 6 months.)

References (List the names, complete addresses (including zip codes), and phone numbers of three professional references not in practice or affiliated with you.)

Name	Address, City, State & Zip Code	Telephone #

License History (Please list licensure information for the past 10 years.)

Type	State	License Type (i.e., MD, LPC, etc.)	Number	Issue/Renewal Date	Expiration Date
State License					
Other State License					
Other State License					
Other State License					
Federal license	US				

Specialty Certifications

Are you board certified or do you hold specialized credentials? ❑ Yes ❑ No ❑ N/A

If yes, please list below and attach copy of certificate(s).

Certification Board	Specialty	Certification Number	Issue/Renewal Date	Expiration Date

Insurance Information (Please attach a copy of your current insurance certificates or declaration pages showing the dates and amounts of coverage.)

Professional Liability Insurance

Current Insurance Carrier			Policy #
Amounts of Coverage $ Occurrence / $ Aggregate	Effective Date	Expiration Date	Years with Carrier

Patient Compensation Fund Carrier (if applicable)

Effective Date	Expiration Date	Coverage Amount $

General Liability Insurance

Current Insurance Carrier			Policy #
Amounts of Coverage $ Occurrence / $ Aggregate	Effective Date	Expiration Date	Years with Carrier

Hospital Privileges

Do you have hospital staff privileges? ❑ Yes (Indicate below.) ❑ No If no, how do you handle admissions? _____

Facility Name	Address, City, State & Zip Code	Affiliation Type

Languages

Do you speak a language other than English? ❑ Yes (If yes, please list below.) ❑ No

Specialty Services (You must meet criteria for treatment providers as detailed on page 6 for those checked.)

❑ General ❑ Child/Adolescent ❑ Substance Abuse

❑ Critical Incident Stress Debriefing ❑ Disability Management/Workers Compensation ❑ Applied Behavior Analysis

Practice Information (Please indicate the percent of your current caseload which falls into each of the following categories.)

Client Groups

Child _____**%** Adolescent _____**%** Adult _____**%** Geriatric/Elderly_____**%**

Client age range: Minimum age: _____ Maximum age: _____ What percent of total caseload, if any, is substance abuse? _____**%**

Number of years at current practice _____ Number of years clinical experience _____

Percent of referrals from EAP _____% Managed care _____%

Treatment Modalities ❑ Individual ❑ Family/Marital ❑ Group (Types: _____)

Number of hours per week in direct care activities: _____

Do you currently receive professional supervision? ❑ Yes ❑ No Ratio supervised/direct care hours= _____ : _____

To which area professionals do you refer? _____

Briefly describe your therapeutic orientation. _____

_____

_____

_____

Please describe the treatment approach you *typically* employ when seeing a new client, including reliance on psychological testing. _____

_____

_____

_____

_____

How do you handle cases that require hospitalization or detoxification? _____

_____

_____

Clinical Support Information (Select plans and certain services require SCC precertification. This information is required to process application.)

Are you willing to submit brief client progress notes to SCC as required by the plan? Yes No	
Are you willing to provide DSM 5 diagnosis codes to SCC staff as requested? Yes No	
Are you willing to participate in periodic clinical reviews with SCC regarding the clinical status and progress of SCC clients? Yes No	
If you receive a client referral after an assessment and initial treatment plan have been prepared are you willing to coordinate treatment with SCC? Yes No	

Length of Treatment

Please indicate the percent of your cases in the past two years which were treated and terminated within:

_____% 1 – 12 sessions or 3 months

_____% 13 – 24 sessions or 6 months

_____% 25 – 36 sessions or 9 months

_____% 37 – 48 sessions or 12 months

Facility Referrals (Please indicate to which area facilities you refer.)

Patient Type	Outpatient Facilities	Inpatient Facilities
General Adult		
Child/Adolescent		
Substance Abuse		
Other Specialties		

Specialty/Treatment Categories (Please check all that apply.)

	Abortion Issues		ECT (MD only)		Parenting Issues
	Acculturation Problem		Emergency Assessment		Phase of Life Problem
	Acute Signs/Symptoms of Abuse Victim		Family Systems Therapy		Psychological Factors Affecting Physical Conditions
	ACOA/Codependency		Forensics		
	AIDS Issues		Grief Issues		Psychological Testing
	Assertiveness		Habit Control		Psychopharmacology
	Autism		Hispanic Issues		Reality Therapy
	Black Issues		Identity Problem		Relocation Counseling/Out-Placement
	CEAP		Insight Therapy		Return to Work Evaluations/Disability
	Cognitive–Behavioral Therapy		Intervention, Non-Crisis		Rogerian (client/person centered) Therapy
	Conflict Resolution		Men's Issues		Solution-Oriented Therapy
	Consultation Liaison		Mental Retardation		Stress Management
	Couples /Relational Problem		Neuropsychology		Substance Abuse Solutions/Treatment
	Crisis Intervention		Occupational Problem		Suicide Prevention
	Critical Incidents		On-Site Testing		Travel Ability
	Domestic Violence		Other Addictions		Women's Issues
	DOT-Approved SAP		Pain Management		Worker's Compensation

Presenting Problems (Please check the disorders you treat most frequently.)

- ❑ Adjustment Disorder
- ❑ Anxiety Disorder
- ❑ Child & Adolescent Disorder
- ❑ Disorders due to General Medical Conditions
- ❑ Delirium
- ❑ Dissociative Disorder
- ❑ Eating Disorder
- ❑ Impulse Control Disorder
- ❑ Mood Disorder
- ❑ Personality Disorder
- ❑ Schizophrenia/Psychotic Disorder
- ❑ Sexual/Gender Identity Disorder
- ❑ Somatoform Disorder (Pain Management)
- ❑ Substance Abuse Disorder
- ❑ Other _____
- ❑ Other _____

What disorders/clinical areas do you not treat?

Availability

❑ Immediately (crises) ❑ 48 hours ❑ More than three days for appointment

❑ 24 hours ❑ 72 hours

Describe your back-up coverage: _____

_____

Mandatory Questionnaire

IMPORTANT: If any of the following questions is answered "Yes", please provide a summary below or attach an explanation for each answer. If any questions do not apply to you, please answer "No". **Failure to respond or provide explanations for "Yes" responses may result in delay of application processing.**

Licensure Information

In the last ten (10) years:

1. Have you been censured, reprimanded, or had disciplinary action taken by an ethical standards committee, licensing board, or other board of inquiry, or is any such action currently pending or under investigation?
2. Have you voluntarily surrendered your professional license, had your professional license revoked, suspended, or limited, or worked under a probationary license or consent agreement?
3. Have you been the subject of any investigation by any private, federal, or state health program or is any such action pending?
4. Has your Federal DEA and/or State Controlled Dangerous Substance (CDS) Certificate(s) been voluntarily or involuntarily limited, suspended, revoked, surrendered, or not renewed, or is any such action currently pending?

Hospital and Other Affiliations

In the last ten (10) years:

1. Have you been denied hospital privileges?
2. If you were granted hospital privileges, were they voluntarily or involuntarily limited, suspended, revoked, or denied renewal, or is any such action currently pending, or has any such action been recommended?
3. Have you resigned from, or withdrawn an application for privileges or membership with, the staff of any hospital or medical organization because of problems regarding privileges or credentials, or is any such action currently pending?
4. Has your membership in any professional organization been revoked, suspended, or terminated involuntarily for any reason other than failure to pay membership fees, or is any such action currently pending?

Criminal History

In the last ten (10) years:

1. Have you been indicted for, convicted of, or pleaded guilty to a crime, or are you presently under investigation for a crime?
2. Have you entered into a consent agreement, entered a plea of guilty, or been found guilty of, fraud or abuse involving payment of health care claims by any health care payor or been sanctioned by any third party payor or health care claims or professional review organization, governmental entity or agency, or is any such action pending?

Insurance Information

In the last ten (10) years:

1. Has your professional liability insurance coverage been involuntarily terminated, or modified by action of any insurance company?
2. Have you been denied or refused renewal of professional liability coverage, rated in a higher-than-average risk class for your specialty, or had a surcharge relative to claims?
3. Have you filed a claim under your professional liability insurance, have any suits, actions, or claims alleging malpractice been filed, or are there any pending against you?
4. Have you filed a claim under your general liability insurance, have any suits, actions, or claims been filed, or are there any pending against you?
5. Have any judgments been made against you in professional liability cases or claims, or have you entered into any settlements?
6. To your knowledge, has information pertaining to you been reported to the National Practitioner Data Bank or the Healthcare Integrity and Protection Data Bank?

Health Status

In the last ten (10) years:

1. Are you currently using any illegal drugs?
2. Have you been under the influence of alcohol during working hours, or have you used drugs illegally?
3. Do you suffer from any medical or mental health condition which impairs your ability to practice to the fullest extent of your license, qualifications, and privileges with or without reasonable accommodations?
4. In the last five (5) years, have you received any mental health treatment for a diagnosis identified in DSM-IV-TR which was ordered by an ethical standards committee, licensing board, or other board of inquiry?
5. In the last four (4) years, have you voluntarily participated in a rehabilitation program or other treatment for substance abuse?

Comments (Please provide an explanation to any "Yes" answer given above. Attach a separate sheet if you need additional space.)

SCC CRITERIA FOR PROFESSIONAL PROVIDER NETWORK AFFILIATION

Part One

I. Providers must have at least one of the following:
- A. Masters degree in behavioral sciences/human services (i.e., psychology, counseling, social work, psychiatric nursing); or
- B. Doctoral degree in behavioral sciences/human services; or
- C. Medical degree with completion of ABMS-approved residency program in psychiatry or addictionology.

II. Providers must meet the following qualifications:

A. State licensure in related discipline

Masters-prepared individuals currently licensed may satisfy this requirement with: (1) three years post-masters supervised clinical(direct care) experience and current employment in a community mental health center; or (2) certification as an employee assistance professional (CEAP) by the Employer Assistance Certification Commission

B. Continuing education at no less than the minimum level required by the state of licensure.

C. Support a least restrictive treatment philosophy and a managed care approach.

D. In practice at least 20 hours per week.

III. Providers with a **Child/Adolescent** specialty must meet the following qualifications in addition to those in I. and II. above:
- A. Current active child/adolescent caseload averaging 33% or more.
- B. Experience in court hearing process desirable.
- C. A minimum of 4 – 6 hours continuing education specific to treatment of children/adolescents per licensure period.

IV. Providers with a **Substance Abuse** specialty must meet the following qualifications in addition to those in I. and II. above:
- A. Certification as an Addictions Specialist, or two years post-degree clinical (direct care) experience in the field of substance abuse, as defined by association with a formal, structured substance abuse program or carrying a caseload of at least 33% substance abuse cases.
- B. Current active substance abuse caseload averaging 33% or more.
- C. A minimum of 4 – 6 hours continuing education specific to substance abuse per licensure period.

V. Providers with a **Critical Incident Stress Debriefing** specialty must meet the following qualification in addition to those in I. and II. above:

A. Documented completion of a group debriefing course, or experience Critical Incident Stress Debriefing cases done within the past four years.

VI. Providers with a **Disability Management/Workers Compensation** specialty must meet the following qualification in addition to those in I. and II. above:
- A. Two years post-degree clinical (direct care) experience in the field of disability management/workers compensation.

VII. Providers with an **Applied Behavior Analysis** specialty must meet the following qualifications in addition to those in I. above:
- A. Certification through the Behavior Analysis Certification Board as a Behavior Analyst (BCBA or BCBA-D), and comparable state licensure, if applicable. Board Certified Assistant Behavior Analysts (BCaBA) and Registered Behavior Technicians (RBT) who do not meet the qualifications in I. above may satisfy this requirement through the supervision of a SCC-approved BCBA or BCBA-D.
- B. Current active ABA caseload pertinent to Autism Spectrum Disorders averaging 50% or more.
- C. In practice at least 20 hours per week.
- D. Continuing education specific to ABA.

Part Two

Sonder Counseling & Consulting (SCC) is commtitted to providing excellent standard of care at all times to the patient, and the patient's perception of that quality of care, and because SCC operates as a preferred provider organization rather than as a health maintenance organization, SCC will ensure the following criteria for its provider network. These criteria apply to all SCC providers, current and future. These criteria are subject to be changed by SCC as appropriate.

I. Licensure

A. The provider may not have had a revoked, suspended, limited, or probationary license, or worked under a consent agreement, within the past ten years, regardless of the state of issuance of such revocation, etc. SCC reserves the right to reduce this period to five years for revocations, suspensions, limitations, probations, or consent agreements based on administrative infractions not directly impacting patient care.

B. An unlicensed practitioner working under the supervision of a licensed or certified mental health professional, may not have had any disciplinary action taken against him/her by the supervisory individual, employing organization, ethical standards committee, or licensing board.

C. The provider may not have received any form of mental health treatment for a diagnosis identified in DSM-IV-TR which was ordered by an ethical standards committee, licensing board, or other board of inquiry within the past five years.

D. The provider may not have any actions or formal complaints pending or currently under investigation by any ethical standards committee, licensing board, or other board of inquiry or authority. (Provider status shall be suspended until the outcome is known.)

E. Physicians must be authorized under current state and federal certificates to prescribe class 4 pharmaceuticals, and may not be prohibited from prescribing class 2, 2N, 3, or 3N pharmaceuticals as a result of any disciplinary action by a state or federal agency.

II. Insurance

A. The provider, either as an individual practitioner or as an owner of a corporation, may not have had any substantive* liability claims, settlements, or judgments within the last ten years. However, lawsuits against a provider who is named *solely* due to his/her status as an owner/principal of a corporation shall be reviewed on a case by case basis for applicability under this section. *Substantive shall be defined as either: 1) a combined dollar amount paid for compensatory damages within the ten year period in excess of $250,000.00, or 2) any determination of sexual misconduct, patient injury/negligence/unwarranted confinement, or administrative/professional misconduct.

B. The provider may not have any pending liability claims, settlements, or judgments of the substantive nature described in paragraph A above. (Provider status shall be suspended until the outcome is known.)

C. The provider may not have been denied or refused renewal of liability insurance, or had liability insurance involuntarily terminated, within the last ten years.

III. Miscellaneous

A. The provider may not, concurrent with his/her active practice, be in a rehabilitation program or other treatment for substance abuse. Any provider who has participated in such a program or treatment must have successfully done so at least four years prior to applying for network affiliation, and must have completed four subsequent continuous years of non-substance abuse status and be able to demonstrate continued aftercare compliance (including random drug tests) for at least two years post-treatment. (Also refer to I.C. above.)

B. The provider may not suffer from any medical or mental condition which impairs his/her ability to practice.

C. The provider may not have any criminal record within the last ten years, nor have any criminal actions pending.

D. The provider may not have had membership in any professional organization revoked, suspended, or terminated involuntarily for any reason other than failure to pay membership fees, within the last ten years.

E. The provider may not have resigned from the staff of any hospital because of problems regarding privileges or credentials, nor had hospital privileges limited, suspended, revoked, or been denied renewal within the last ten years.

F. SCC reserves the right to terminate or refuse/reject any application for provider status after reasonable investigation by SCC in the event: 1) more than five patients complain to SCC regarding the provider, and/or any allegation of sexual misconduct is made by a SCC patient with respect to such provider; or 2) SCC receives such direction by one or more of its business clients; or 3) SCC learns of inappropriate or unprofessional conduct on the part of that provider.

G. The provider must have completed: 1) a SCC Treatment Provider Application and Certification, Authorization and Attestation. The information contained in said application(s) must be true and complete, and any material misstatement, error, or omission in, said application(s) shall constitute cause for: 1) denial of said application(s); or 2) immediate termination of provider's participation in the network.

Certification, Authorization and Attestation

I acknowledge and agree that Sonder Counseling & Consulting, LLC. (SCC) has a valid interest in obtaining and verifying information concerning my professional competence, in determining whether to enter into an agreement with me for the provision of services to its members.

I represent and certify to SCC that the information contained in this Application is true and complete to the best of my knowledge and belief, that I meet the SCC Criteria set forth above and, if applicable, the Assessment/Case Manager Criteria, for those specialties I have indicated on the Application, and I agree to inform SCC promptly if any material change in such information occurs, whether before or after acceptance by SCC of my Application for affiliation with SCC's provider network.

I understand and agree that I have the burden of producing adequate information for proper evaluation of my professional qualifications, credentials, clinical and mental competence, clinical performance, ethics, or any other matter that might directly or indirectly have an effect on my competence, performance, or patient care and for resolving any reasonable questions regarding such qualifications, and that SCC has no responsibility to consider this Application until all necessary information is received by SCC.

I authorize SCC to consult with state licensing boards, hospital administrators, members of staffs of hospitals, malpractice carriers and other persons to obtain and verify information concerning my professional competence, character and moral and ethical qualifications, and I release SCC and its employees and agents from any and all liability for their acts performed in good faith and without malice in obtaining and verifying such information and in evaluating my Application.

I consent to the release by any persons to SCC of all information that may reasonably be relevant to an evaluation of my professional competence, character and moral and ethical qualifications, including any information relating to any disciplinary action, suspension or curtailment of privileges, and hereby release any such person providing such information from any and all liability for doing so.

I warrant that I have the authority to sign this Application. I agree that submission of this Application does not constitute approval or acceptance as a participating provider.

I understand that any material misstatement, error, or omission in this Application shall constitute cause for denial of this Application and of my participation in the network. I further understand that if my Application is rejected for reasons relating to my professional conduct or competence, SCC may report the rejection to the appropriate state licensing board, National Practitioner Data Bank, Healthcare Integrity and Protection Data Bank, or other professional data bank(s).

Your signature is required to complete this Application. Stamped signatures are not acceptable.

Name (Please Print or Type)	**Signature**	**Date**