SANDHILLS CENTER

Managing Mental Health, Intellectual/Developmental Disabilities and Substance Abuse Services
910-673-9111 (FAX) 910-673-6202 www.sandhillscenter.org Victoria Whitt, CEO

Provider Agency/Facility Re-Credentialing Application

For IPRS (State Funds) and Medicaid Services

Please email application to:
Recredentialing@sandhillscenter.org

P.O. Box 9, West End, NC 27376
24-Hour Access to Care Line: 800-256-2452
TTY: 1-866-518-6778 or 711
Serving Anson, Guilford, Harnett, Hoke, Lee, Montgomery, Moore, Randolph, & Richmond Counties

Instructions for SHC Provider Re-Credentialing Application

A provider agency/facility must apply for and be re-credentialed with Sandhills Center to qualify for reimbursement of services provided to Sandhills Center Members. The re-credentialing process includes: submission of an application, verification of credentials, review of any adverse actions or sanction activity, and review of qualifications and current competency. Sandhills Center will schedule an on-site service visit, if applicable. Additionally, agencies must have a signed contract with Sandhills Center to qualify for reimbursement of services provided to Sandhills Center members.	
A.	This application must be **completed in its entirety**, with **all questions addressed** and **required information submitted**. **An application is considered to be invalid and will be returned to the provider for correction and/or for additional information if:**
	The version date on any of the documents that comprise the provider application packet is prior to March 2020. Older versions are not accepted.
	Any spaces in the application are **not completed.** (Please indicate "N/A" or "None" if the question is not applicable.)
	The "Attestation Statement" Signature is not original/scanned and dated
	The text has been altered, highlighted, struck through, or obstructed through the use of correction fluids.
	The responses are illegible.
	Any of the documents or pages that comprise the "Provider Agency/Facility Re-Credentialing Application" are missing.
	Any of the requested information in any of the documents that comprise the "Provider Agency/Facility Re-Credentialing Application" are missing, with the exception of the fax number and e-mail address.
B.	Sandhills Center shall notify the provider within ten (10) business days of receipt of the completed application **or** if materials are missing. **An application and materials will be returned if incomplete.**
NOTE: A contract must be renewed between the Agency/Facility and Sandhills Center prior to service delivery. **If the Agency/Facility has Licensed Practitioners (LP's) or Provisional Licensed Practitioners (PLP's) it is the responsibility of the Agency/Facility to ensure that each Practitioner completes and submits the "Uniform Application to Participate as a Health Care Practitioner" (if a new employee with the Agency/Facility) or the "Uniform Re-Credentialing Application to Participate as a Health Care Practitioner".** Upon approval of the Practitioner's Re-Credentialing status by the Sandhills Clinical Advisory Committee the Agency/Facility can submit claims for services provided by the LIP or PLP back to the Board Approval Date.	
Before submitting the Re-Credentialing Application, make sure you have completed the following:	
	Include an answer in all spaces. Indicate "N/A" or "None", if the question is not applicable.
	The Authorized agent for the group or entity has signed and dated the Re-Credentialing Application
	Any requested information in any of the documents that comprise the Re-Credentialing Application is not missing, with the exception of the fax number and email address.
	Copy of National Provider Identifier (NPI) Certification Letter for Agency and Each Site.
	Explanation & Supporting documentation regarding background checks.
	Any of the required accreditation documentation is missing
	Explanations for confirmation of adverse actions indicated in Section 1
	Authority for Release of Information (SBI – Background Check) – Ownership of 5% or more.
	For individuals with 5% or greater ownership in the Organization, original signed and dated Acknowledgement and Authorization for Social Security Number Check form; must be completed with all personal information (included in this application).
	Copy of facility license for each site (if applicable)
	Each provider facility must be accommodating for members with physical disabilities. If facility is not accommodating, please provide an explanation of how those members with physical disabilities would be accommodated.
	Sandhills Center will schedule an on-site service visit, (if applicable)
	Copy of Disaster Plan
	Completed Attestation Letter signed and dated (included in this application)
	Cultural, Gender, and Linguistic Data Form – Cultural Competency Training is required.

	Copy of the Certificate of Insurance for your current commercial general, professional liability, and worker's compensation ***(if there is more than three employees)*** indicating by name, provider(s) covered, coverage amounts, effective date, expiration date, policy numbers and Sandhills Center should **be listed as additional insured & certificate holder**. (Sandhills Center cannot accept Notice of Intent as proof of insurance), stating liability amounts equal or greater than $1,000,000 / $3,000,0000 aggregate
	Submit Proof of automobile insurance for company vehicles, and employee vehicles that are used to transport members, include contracted employees.
	Completed Insurance Attestations form regarding all liability insurance coverages.
	Completed original signed and dated W-9 Tax Payer Request for Tax ID # and Certification
	Current Valid NC Tracks enrollment, active status in Medicaid Health Plan, and appropriate affiliation to employment agencies.
	Signed and dated Trading Partner Agreement
	Copy of Conflict of Interest Policy and Procedure
Important Points to Remember:	
a)	If services are being provided at multiple sites, **you are required to list each site** in this application. Each site **must** also **specify** the services and specialties that will be rendered at that location.
b)	Copies of the applicable accreditation documentation **must** accompany the application. If these **documents are missing**, the application will be **returned** to the provider.
c)	**Retain a copy of your completed Re-Credentialing Application and all documentation submitted with the Re-Credentialing application for your records.** Providers will be notified via email from Sandhills Center upon receipt of their application. Please do not submit claims for dates of services prior to the effective date.
d)	Billing information and clinical coverage policies are available on Sandhills Center website at: http://www.sandhillscenter.org
e)	Providers are requested to include on their application the name, e-mail address, and fax number of the individual contact person at their site who is responsible for receiving Sandhills Center Health Plan information.
f)	Please review your Re-Credentialing Application packet BEFORE submitting to Sandhills Center for completeness, accuracy, and sign and date all pages requiring signature within the application. Any illegible or missing items will cause a delay in Re-Credentialing your application.
We want to thank you in advance for your efforts in completing your Re-Credentialing Application process in the manner stated above. Submitting an organized application will expedite the review process and increase efficiency and accuracy. Please ensure that all applicable information requested is submitted to avoid delays with processing.	

Section 1: Agency Information

Date of Application:	For Office Use Only
	Prior MD Approval Date:
	SHC ID#:

1. Legal Name of Organization: (as used for tax reporting purposes)

2. Federal Tax ID #:	**3. NPI #:**

4. Taxonomy #(s): List all applicable to the agency.

5. NC Tracks Requirements:

a. Are you enrolled in NC Tracks? Yes No
If "No", provide Enrollment Registration # and submission date and/or provide the Managed Change Request (MCR) # and submission date.
Registration #/MCR#:
Submission Date:

b. Do you have an active status in the Medicaid Health Plan? Yes No

c. Are all applicable service locations activated in NC Tracks? Yes No

d. Do you have a valid taxonomy for each service locations? Yes No

6. Please specify the Federal Tax Status:
Not for Profit For Profit 501 C 3

7. Organization Legal Entity Type:
C-Corporation Sole Proprietorship
General Partnership Limited Liability Corporation Limited Liability Partnership

8. Organization Address:
Street ***City*** ***State*** ***Zip+4*** *(Required)*
(Must be the physical address – no P.O. Box)

9. Check (√) County of Address :

Anson	Guilford	Harnett
Hoke	Lee	Montgomery
Moore	Randolph	Richmond
Other:		

10. Accepting new patients? Yes No

11. Website Address:

12. Number of years doing business under this name:

13. Has this Organization ever been in business under a different name? Yes No
If yes, what name?

14. Primary Contact:	**15. Title:**
16. Email Address:	**17. Phone #:**

18. Executive Director:

19. Clinical/Medical Director:

20. Email Address:	**21. Phone #:**

22. Have background checks been completed on the owners, directors, officers, administrators and staff? Yes No
(If yes, please attach the policy/procedure and supporting documentation. If no, please provide an explanation.)

23. Is this Organization accredited? (If yes, attach verification of accreditation) **Yes No**

JCAHO: Yes No
Most recent date accredited: Expiration date:

CARF: Yes No
Most recent date accredited: Expiration date:

COA: Yes No
Most recent date accredited: Expiration date:

CQL: Yes No
Most recent date accredited: Expiration date:

OTHER: Yes No
Most recent date accredited: Expiration date:

Section 1: Agency Information

If no, please identify, if applicable, the Accrediting body your agency/facility has selected and your current status in the accreditation process as required by the NC Division of MH/IDD/SAS.
Note: Refer to SECTION 10.15A. (c) Article 3A of Chapter 122C of the General Statutes. Sandhills Center "General Credentialing & Re-Credentialing Criteria" stipulates the specific services that require accreditation.

24. Liability Insurance:		
a) Since last credentialing have you had a claim against your organization? (If yes, please list the name & amounts of the Insurance & disposition.)	**Yes**	**No**
b) Are there any current unsettled claims? (If yes, please attach explanation.)	**Yes**	**No**
c) Are you aware of any circumstances that may result in a claim or suit? (If yes, please attach explanation.)	**Yes**	**No**
d) Since last credentialing has your organization ever had a policy cancelled? (If yes, please attach explanation.)	**Yes**	**No**

25. Since last credentialing has there been any action or investigation against you, your organization, any owner or qualified professional in your Organization relating to:
(If yes, please attach explanation.)

License	**Registration**	**Billing Organization**
Yes **No**	**Yes** **No**	**Yes** **No**
Certification	**Privileges**	**Sanctions**
Yes **No**	**Yes** **No**	**Yes** **No**

26. Since last credentialing have any adverse actions been filed against your agency, any owner, or qualified professional by:

Medicaid **Yes** **No**	**Medicare** **Yes** **No**	**Other Insurance** **Yes** **No**

27. Since last credentialing has your organization or anyone within your organization who has an ownership, managerial or clinical role been sanctioned by any professional organization or government organization for violation of ethics, professional misconduct, unprofessional conduct, incompetence, negligence, lost accreditation or certification status in any state or country?
Yes No (If yes, please attach explanation of the circumstances and how it was resolved.)

28. Are you aware of any circumstances that may result in such an action? Yes No
(If yes, please attach explanation.)

29. Has your organization ever had a contract cancelled by another LME-MCO, Area Authority, County Program in North Carolina or similar entity in another state? Yes No
(If yes, please attach explanation.)

30. Has anyone in your company who has an ownership, managerial or clinical role ever been convicted of a felony or misdemeanor, or is under investigation with respect to such conduct.
Yes No (If yes, please attach explanation.)

31. If you are enrolling as a group provider, list all shareholder/partners (including self) who have 5% or more ownership (or whose spouse, parent, child or sibling as such an interest) and all individual officers, directors, managers, and electronic funds transfer (EFT) authorized individuals and information requested on each. (this page may be duplicated if necessary.)

Name:		**Date of Birth:**	
Address:			
Street	***City***	***State***	***Zip+4*** *(required)*
Title:		**SSN:**	
License #:		**% Owner:**	

Check business relationship that applies:		
Owner	Shareholder	Partner
Officer/Director	Manager	EFT Authorized Employee

Check relationship to enrolling provider (if applicable):			
Spouse	Parent	Child	Sibling

Section 1: Agency Information

Name:				**Date of Birth:**		
Address:						
Street				***City***	***State***	***Zip+4*** *(required)*
Title:				**SSN:**		
License #:				**% Owner:**		
Check business relationship that applies:						
Owner		Shareholder			Partner	
Officer/Director		Manager			EFT Authorized Employee	
Check relationship to enrolling provider: (if applicable)						
Spouse	Parent			Child	Sibling	

Name:				**Date of Birth:**		
Address:						
Street				***City***	***State***	***Zip+4*** *(required)*
Title:				**SSN:**		
License #:				**% Owner:**		
Check business relationship that applies:						
Owner		Shareholder			Partner	
Officer/Director		Manager			EFT Authorized Employee	
Check relationship to enrolling provider: (if applicable)						
Spouse	Parent			Child	Sibling	

Name:				**Date of Birth:**		
Address:						
Street				***City***	***State***	***Zip+4*** *(required)*
Title:				**SSN:**		
License #:				**% Owner:**		
Check business relationship that applies:						
Owner		Shareholder			Partner	
Officer/Director		Manager			EFT Authorized Employee	
Check relationship to enrolling provider: (if applicable)						
Spouse	Parent			Child	Sibling	

32. Identify other providers, if any, which are owned or operated by the applicant under the same owner name.			
Provider Name:			
Address:			
Street	***City***	***State***	***Zip+4*** *(required)*
Relationship type:			
Nursing Home	Home Health Agency		
Community Based Residential Facility	Hospital		

33. Is the applicant a subsidiary company, either wholly or partially owned by another organization or Business: Yes No (if yes, please provide the following information)
Legal Business Name: (parent company)
Type of Ownership:

Section 2: Site Specific Credentialing

FACILITY/SITE SPECIFIC INFORMATION – A facility/site is a physical location where supervision and/or management of services occur. Please attach the facility site license if applicable.

If your Organization operates more than one facility/site, copy and complete SECTION 2 for each facility/site.

1. Facility/Site Name:

2. Facility/Site Address:

Street	***City***	***State***	***Zip+4*** *(Required)*

3. Check (√) County of Address:

Anson	Guilford	Harnett
Hoke	Lee	Montgomery
Moore	Randolph	Richmond
Other:		

4. Facility/Site Days/Hours of Operation:

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

5. Phone #:	**6. Fax #:**

7. Email:

8. Please List all National Provider Identifier (NPI) and Taxonomy Numbers that pertain to this site:

NPI Numbers	Taxonomy Numbers

9. Please list services to be provided at this site

Service Code(s)	Service Description

Section 2: Site Specific Credentialing *(continued)*

10. Information about the Facility/Site Director/Supervisor
Facility/Site Director's Name & Credentials:
Facility/Site Director's Education:
(If necessary add additional page(s)
Facility/Site Director's Credentials:
Facility/Site Director's Phone #:
Facility/Site Director's Email:

11. Is this facility/site staffed and equipped to serve: *(If no, please explain how you plan to accommodate below.)*

Physically Disabled:	Yes	No	Deaf & Hearing Impaired:	Yes	No
Blind/Visually Impaired:	Yes	No	Behaviorally Disruptive:	Yes	No
Sexually Aggressive:	Yes	No	Foreign Languages:	Yes	No

Foreign Languages please specify:

Plan to accommodate those members with physical disabilities:

12. Is this facility/site licensed by: (if yes, attach a copy of the license)

DHSR:	Yes	No	License #:	State:
DSS:	Yes	No	License #:	State:
Other:	Yes	No	Type:	

13. Coverage: Indicate what arrangements you have made to cover member emergency situations during nights, weekends, and holidays:

14. Physician Coverage: Indicate what arrangements you have made to cover your Organization for members who need psychiatric evaluation or psychiatric medication.

List psychiatrist/physician who will see your members:

Name:	**Phone:**
Name:	**Phone:**
Name:	**Phone:**

15. Do you have a manmade, natural disaster, or act of God crisis/disaster plan?
Yes No (if yes, please attach)

NOTE: SHC will schedule Health and Safety Review to review personnel, training, medication, facility and medical records, if applicable.

SANDHILLS CENTER

Site Specific

Cultural, Gender, and Linguistic Data Form

By providing the information below, you will be assisting Sandhills Center with member/provider matching as well as providing information necessary for analyzing the Network and its ability to meet our Members cultural, racial, ethnic and linguistic needs. This information will reside within Sandhills Center Provider Directory and the online Provider Search.

Name of Agency Site:

Focus of Treatments the Agency Provides:

Chemical Dependency/Substance Abuse	Co-Occurring/Dual DX – MI, MH, SA
Eating Disorder	Intellectual Developmental Disabilities
Mental Health	

Agency Expertise/Certified Specialties: (please check (√) ONLY those that apply)

Co-Location with/Primary Care Physician	Community Based Services	Crisis Services
Detoxification Services	Faith Based Services	Inpatient Services
Intensive In-Home Therapy	Marriage & Family Counseling	MST – (Multi-systemic Therapy)
Outpatient Therapy	Psychiatry	Psychological Testing
Residential Services	Self-Direction	Telemedicine
Therapeutic Foster Care		Trauma Focused Services

Language(s) the Agency are able to communicate in fluently: (please check (√) ONLY those that apply)

The agency must explain or attach their organizational plan for sustaining their ability for the interpretation services checked below – direct language services through hiring staff or other translation entities.

NOTE: Do not consider licensed practitioners as part of your agency languages. Sandhills Center has already collected the clinicians' languages spoken that will be credited toward your Agency.

American Sign Language	Chinese/Korean	English
French	German	Hmong
Portuguese	Spanish	Telugu
Other:	Translator on site? Yes No	

Population(s) that you serve: (please check (√) ONLY those that apply)

All Populations	Gay & Lesbian
Gender Identity Issues	Geriatric
Hearing Impaired	HIV/Aids
Men	Sexually Reactive/Aggressive Youth
Visually Impaired	Women

	MH		SA		IDD	
Adult	18-21 22-54 55 & Up		18-21 22-54 55 & Up		18-21 22-54 55 & Up	
Child	3-11	12-17	12-17	18-21	3-11	12-17

Culturally diverse populations the Agency feels competent to treat: (please check (√) ONLY those that apply)

All Races/Ethnicities	American Indian & Alaska Native
Asian, Pacific Islander	Black or African American
Hispanic or Latino	White
Other:	

Completed Cultural Competency Training? Yes No

Section 3: SIGNATURE AUTHORIZATION PAGE

Authorization to File Credentialing Application

To the best of my knowledge, my Agency is able to meet all requirements necessary to apply for Sandhills Center Credentialing. I am submitting the attached Sandhills Center Provider Credentialing Application, which, to my knowledge, is a true and complete representation of the requested materials.

Printed Name

Authorized Signature ***Date***

Title

Thank you for taking the time to submit this form. If this form is not completed and returned, your agency will not appear within the Sandhills Center online Provider Directory.

Please List Practitioners:

If the Agency/Facility has Licensed Practitioners (LP's) or Provisional Licensed Practitioners (PLP's) it is the responsibility of the Agency/Facility to ensure that each Practitioner completes and submits the "Uniform Application to Participate as a Health Care Practitioner" (if new with the Agency/Facility) or the "Uniform Credentialing Application to Participate as a Health Care Practitioner".

Please list all Licensed Practitioners (LP)/ Provisional Licensed Practitioner, their Taxonomy #, NPI #, and License Type who are currently seeing Sandhills Center members.

(You may make copies of this page if more space is needed/ please print)

	LP Name	License Type	NPI	Taxonomy
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SANDHILLS CENTER

Managing Mental Health, Intellectual/Developmental Disabilities and Substance Abuse Services
910-673-9111 (FAX) 910-673-6202 www.sandhillscenter.org Victoria Whitt, CEO

Attestation Statement

No Stamps or Copies Please (Original Only)

This Application is to be signed by the individual who has authorization to submit an application on behalf of this agency/facility.

All information submitted by me in this application, as well as any attachments or supplemental information, is true, current, and complete to my best knowledge and belief as of the date of signature below. I fully understand that any significant misstatement in this application may constitute cause for denial of may application or termination of a resulting participation agreement.

By application for membership in Sandhills Center Network, I signify my willingness to appear for an interview in regards to my application. I authorize Sandhills Center to consult with administrators and members of the medical staffs of hospitals or institutions with which I have been associated and with other, including past and present malpractice carriers, who may have information bearing on the questions in this application. Upon request, I will obtain and provide to Sandhills Center materials pertaining to my qualifications and competence, including, materials relating to complaints filed, any disciplinary actions, suspensions, or actions to curtail my medical, surgical privileges. I further consent to the inspection by representatives of Sandhills Center of all documents that may be material to an evaluation of my professional qualifications and competence.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any doubt about such qualifications. I release from liability all representative of Sandhills Center for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I release from any liability, all individuals and organizations that provide information to Sandhills Center in good faith and without malice concerning this application and I hereby consent to the release and verification of information relating to any disciplinary actions, suspensions, or curtailment of medical – surgical privileges to Sandhills Center.

I understand that if my application is rejected for reasons relating to my professional conduct or competence, Sandhills Center may report the rejection to the appropriate state licensing board and/or National Practitioner Data Bank. In the event I am accepted for participation in Sandhills Center Network, I hereby consent to Sandhills Center for inspection of my patient records relating to Sandhills Center members as necessary for its peer and utilization review purposes as permitted by state or federal laws and regulations. I further agree to notify Sandhills Center in a timely manner (not to exceed 30 days) of any changes to the information requested on the application.

Print Name of Agency / Facility above	
Print Name of Authorized Agent to sign the application on behalf of the Agency / Facility above	
Signature of Authorized Agent above	Date
Please sign and date this Attestation	

P.O. Box 9, West End, NC 27376
24-Hour Access to Care Line: 800-256-2452
TTY: 1-866-518-6778 or 711
Serving Anson, Guilford, Harnett, Hoke, Lee, Montgomery, Moore, Randolph & Richmond Counties

Trading Partner Agreement

TRADING PARTNER AGREEMENT– Electronic Data Interchange (EDI)

This document constitutes an agreement to the following provisions for exchanging Electronic Data Interchange (EDI) between the Trading Partner and Sandhills Center (SHC).

The Trading Partner agrees:

1. To conform to the requirements for *Administrative Simplifications* as defined in the provisions of the *Health Insurance Portability and Accountability Act (HIPAA) of 1996 (P.L. 104-91)*, and regulations promulgated there under and to take no action which adversely affects SHC's HIPAA compliance.

2. That it will promptly notify SHC of any and all unlawful or unauthorized disclosures of confidential information or protected health information (PHI) that comes to its attention and will cooperate with SHC in the event any litigation arises concerning the unauthorized use, transfer, or disclosure of either confidential or protected health information.

3. That it will use sufficient security procedures to ensure that all transmissions of documents are authorized and protect all participant-specific data from improper access.

4. That it will ensure that all files transmitted comply with the appropriate national *Electronic Data Interchange (EDI) Transaction Set Implementation Guide, in effect on the date of transmission, as provided by the Health Insurance Portability and Accountability Act (HIPAA) of 1996.*

5. That it will establish and maintain procedures and controls so that information concerning SHC health plan participants or any information obtained from SHC, shall not be used by agents, officers, or employees of the trading partner other than for its sole intended purpose.

6. That the information stated in any EDI Trading Partner Profile(s) submitted with this Agreement, or subsequently is correct and complete.

7. That it will allow SHC 30 days after receipt of written notice from the Trading Partner if there is any change in the trading partner representative or location where electronic transactions are sent.

8. That it is bound by this written agreement to comply with state and federal law, if the trading partner is an intermediary for the billing provider.

SHC agrees:

1. To conform to the requirements for *Administrative Simplifications* as defined in the provisions of the *Health Insurance Portability and Accountability Act (HIPAA) of 1996 (P.L. 104-91)*, and regulations promulgated there under and to take no action which adversely affects the trading partner's HIPAA compliance.

2. That it will use sufficient security procedures to ensure that all transmissions of documents are authorized and protect all participant-specific data from improper access.

3. That it will ensure that all files transmitted comply with the appropriate national *Electronic Data Interchange (EDI) Transaction Set Implementation Guide, in effect on the date of transmission, as provided by the Health Insurance Portability and Accountability Act (HIPAA) of 1996.*

Both parties agree:

1. That documents will not be considered as received and no responsibility assigned until accessible at the receiving party's computer.

2. That upon receiving any documents, to prepare and transmit a timely response or an acknowledgement of transaction receipt. If acceptance of a document is required, a document is not considered received until an acceptance acknowledgement is returned.

3. To notify the other party within a reasonable time frame if any transmitted data are received in an unintelligible or garbled form.

4. That each party will provide and maintain the equipment, software, services, and testing necessary to transmit and receive documents.

5. To conduct business and perform as required by this agreement and any applicable rules or regulations.

6. That this agreement will remain in effect until terminated by either party with at least 30 days prior written notice. The notice will specify the effective date of termination, but will not affect the obligations or rights of either party prior to the effective date of termination. This agreement is automatically terminated in the event the trading partner is disqualified through a federal administrative action or state action. That any document transmitted according to this agreement will be considered an original and signed when received.

Effect of Termination

1. Except as provided in paragraph (2) of this section or in the contract or by other applicable law or agreements, upon termination of this agreement and services provided by the Trading Partner, for any reason, the Trading Partner shall return or destroy all Protected Health Information received from SHC, or created or received by Trading Partner on behalf of SHC. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of the Trading Partner. Trading Partner shall retain no copies of the Protected Health Information.

2. In the event that Trading Partner determines that returning or destroying the electronic protected health information is not feasible, Trading Partner shall provide to SHC notification of the conditions that make return or destruction not feasible. Trading Partner shall extend the protections of this agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Trading Partner maintains such Protected Health Information.

____

Trading Partner Name

____

Street Address Line 1 (Site/Physical Address, not a P.O. Box)

____

Street Address Line 2

____

City, State, Zip Code

Contact Information (Phone Number, email address)

Signature of Applicant or Authorized Individual Date

Printed Name and Title

For Sandhills Center for MH, DD & SAS use only

Trading Partner's EDI Submitter ID: ______________________

Sandhills Center for MH, DD & SAS Receiver ID: SHC303

Please return completed form to:
Sandhills Center for MH, DD & SAS
P.O. Box 9
West End, NC 27376
Attn: EDI Coordinator, Information Technology Department

AUTHORITY FOR RELEASE OF INFORMATION
State Access Only
Name Check Access

I authorize the North Carolina Department of Justice through the State Bureau of Investigation to perform a North Carolina name-based criminal history record information check in connection with my application for employment, my employment or volunteer services with SANDHILLS CENTER FOR MENTAL HEALTH pursuant to DHHS-LONG TERM – STATE AND FED – NCGS 122C-80B/131 D-40A A1/131D-40A A1.

(type or print clearly)

Last Name	First	Middle	Maiden
Social Security #	Date of Birth	Sex	Race

I understand that the North Carolina State Bureau of Investigation, officials and employees shall not be held legally accountable in any way for providing this information to the above named agency, and I hereby release said agency and persons from any and all liability which may be incurred as a result of furnishing such information. I further understand that the above named agency cannot provide a HARD COPY of the results of this criminal history record check to me.

*Disclosure of social security number is entirely voluntary and not required. If disclosed, the social security number will be utilized to assist with accurate identification/exclusion of possible criminal history records.

Applicant's/Employee's/Volunteer's Signature

____

Date

____

This form must be maintained on file with the above named agency for one year. UPON COMPLETION OF THIS FORM, MAIL A PHOTOCOPY TO THE ADDRESS INDICATED BELOW:

State Bureau of Investigation
Criminal Information and Identification Section Attn: Applicant Unit
Post Office Box 29500
Raleigh, North Carolina 27626-0500

ORI # HCP000008 – SANDHILLS CENTER FOR MENTAL HEALTH HCP000008

SANDHILLS CENTER

Managing Mental Health, Intellectual/Developmental Disabilities and Substance Abuse Services
910-673-9111 (FAX) 910-673-6202 www.sandhillscenter.org Victoria Whitt, CEO

Provider Insurance Coverage – Attestations

Directions: These attestations are required as proof that the **signatory agency/practice (CONTRACTOR)** (1) does not transport Sandhills Center's members and therefore does not maintain Automobile Liability Insurance; and/or (2) is not required by law to acquire and maintain Workers' Compensation/Employer Liability Insurance; and (3) holds coverage under its Comprehensive General Liability, Professional Liability and Automobile insurance, if applicable, for the CONTRACTOR's employees and agents. The third and fourth attestations, regarding the scope of the CONTRACTOR's insurance coverage, and notice of changes to CONTRACTOR's insurance coverages, are required by the State of North Carolina and cannot be waived.

Provider (CONTRACTOR) Name:

Attestation No. 1 -- Automobile Liability Insurance
Select one (1) of the following in this section:

	(Initials)	CONTRACTOR uses and maintains insurance coverage for all vehicles owned, non-owned, and hired that are used by CONTRACTOR "for the provision of services under the Contract." If not already submitted, CONTRACTOR will provide Sandhills Center with a Certificate of Insurance reflecting the requirements of the contract.
	(Initials)	CONTRACTOR attests that it does not use any automobile or other vehicle for the provision of services under its Contract with Sandhills Center.

Attestation No. 2 – Workers' Compensation and Employer Liability Insurance
Select one (1) of the following in this section:

	(Initials)	CONTRACTOR maintains Worker's Compensation and Employer Liability Insurance to the extent required by North Carolina Law." If not already submitted, CONTRACTOR will provide Sandhills Center with a Certificate of Insurance reflecting the requirements of the contract.
	(Initials)	CONTRACTOR attests that it is not required under North Carolina law to secure and maintain Workers' Compensation and Employer Liability Insurance.

Attestation No. 3 – Scope of CGL and PL coverage, and Automobile coverage (if applicable)

	(Initials)	The scope of the CONTRACTOR's CGL and PL insurance, as well as its Automobile insurance (if applicable), must cover all of the CONTRACTOR's employees and agents.

Attestation No. 4 – Notice of Change in Insurance Policy Status

	(Initials)	CONTRACTOR attests that CONTRACTOR's insurance coverages cannot be suspended, voided, canceled or reduced unless the agency/practice gives thirty (30) calendar days prior written notice to Sandhills Center.

By signature and date below, CONTRACTOR attests that each of the initialed statements accurately reflect the agency/practice's insurance coverages and requirements as set out by the contract with Sandhills Center.

Printed Name	Signature
Printed Title	Date

Indemnification Agreement: By signing this waiver, I hereby agree to indemnify and hold harmless Sandhills Center from all losses, costs, damages, claims, liabilities and expenses (including attorneys' fees and court costs) whatsoever, which may arise or be claimed against Sandhills Center, for any loss, injuries or damages, consequent upon or arising from any acts, omissions, neglect or fault in connection with Sandhills Center's reliance upon this waiver.

P.O. Box 9, West End, NC 27376
24-Hour Access to Care Line: 800-256-2452
TTY: 1-866-518-6778 or 711
Serving Anson, Guilford, Harnett, Hoke, Lee, Montgomery, Moore, Randolph, & Richmond Counties

ACKNOWLEDGEMENT AND AUTHORIZATION FOR SOCIAL SECURITY NUMBER CHECK

I,______________________________________, hereby authorize Sandhills Center to verify my
(Print Name)

Social Security Number through a third party consumer reporting agency for credentialing/re-credentialing purposes. This verification will be conducted by American DataBank, 110 Sixteenth St., 8th Fl., Denver, CO 80202, 1-800-200-0853, www.americandatabank.com. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.

All of the information requested below is mandatory and must be provided. Please type or print clearly.

Last Name:	First Name:	Middle:
Social Security Number*:	Date of Birth*:	
Present Address:		
City/State/Zip:		
Email Address:		

Signature:____Date:____________________

*This information is limited to verification of the individual's Social Security Number and will not be used for employment/hiring purposes. American DataBank's privacy policy can be found at http://www.americandatabank.com/consumer-information/privacy-policy/.