



**NEW EMPLOYEE QUESTIONNAIRE**  
 DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 HUMAN SERVICE CENTERS  
 SFN 1515 (2-2024)

Filling out this form may notify current employers of a change in employment.

**A. PERSONAL INFORMATION**

In compliance with the Federal Privacy Act of 1974, the disclosure of the social security number on this form is voluntary and it is not disclosed to the public. The social security number is used to credential with third party payers. If you do not wish to disclose your social security number on this form, please contact the hiring manager to provide your social security number over the phone or in person.

Name (Last, Middle Initial, First, Suffix)			
Have you ever used another name? <input type="checkbox"/> Yes <input type="checkbox"/> No		Other Name Used (Last, First)	
Dates Other Name was Used Date Started: _____ Date Ended: _____		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other/Non-Binary	
Date of Birth	Social Security Number	National Provider Identification (NPI) Number	
Credential		Taxonomy	
Home Address		City	State   ZIP Code
ND.gov Email Address			Mobile Phone
License Number (if applicable)	License Issuing State	License Issue Date	License Expiration Date
DEA Number (if applicable)	State of DEA Registration	DEA Issue Date	DEA Expiration Date
Medicaid Number		Medicare Number	Medicaid State

**B. EDUCATION**

**List Education (Including High school)**

Name of Institution			
Address		City	State   ZIP Code
Degree Issued		Start Date	Graduation Date
<input type="checkbox"/> US Graduate <input type="checkbox"/> Non-US/Canadian Graduate <input type="checkbox"/> Fifth Pathway Graduate			

Name of Institution			
Address		City	State   ZIP Code
Degree Issued		Start Date	Graduation Date
<input type="checkbox"/> US Graduate <input type="checkbox"/> Non-US/Canadian Graduate <input type="checkbox"/> Fifth Pathway Graduate			

Name of Institution			
Address		City	State   ZIP Code
Degree Issued		Start Date	Graduation Date
<input type="checkbox"/> US Graduate <input type="checkbox"/> Non-US/Canadian Graduate <input type="checkbox"/> Fifth Pathway Graduate			

ECFMG Number (Non-U.S./Canadian Graduate Only)		Certificate Date
Non-US School Name	Degree Awarded	Date of Completion
Non-US Address		

**C. POST GRADUATE TRAINING**

Institutional/Hospital Name	Telephone Number	Fax Number	
Address	City	State	ZIP Code
<input type="checkbox"/> Fellowship <input type="checkbox"/> Internship <input type="checkbox"/> Residency	Start Date	Completion Date	

Institutional/Hospital Name	Telephone Number	Fax Number	
Address	City	State	ZIP Code
<input type="checkbox"/> Fellowship <input type="checkbox"/> Internship <input type="checkbox"/> Residency	Start Date	Completion Date	

Institutional/Hospital Name	Telephone Number	Fax Number	
Address	City	State	ZIP Code
<input type="checkbox"/> Fellowship <input type="checkbox"/> Internship <input type="checkbox"/> Residency	Start Date	Completion Date	

List any post graduate training gaps of 3 months of greater

**D. WORK HISTORY**

**Work History of the Last 5 Years**

Practice Employer Name	Telephone Number	Fax Number	
Address	City	State	ZIP Code
Employer Start Date	Employer End Date		

Practice Employer Name	Telephone Number	Fax Number	
Address	City	State	ZIP Code
Employer Start Date	Employer End Date		

Practice Employer Name	Telephone Number	Fax Number	
Address	City	State	ZIP Code
Employer Start Date	Employer End Date		

List any gaps in your work history and explain why

**E. MEDICAID QUESTIONS**

**Disclosure Questions**

Have you or any member of your immediate family ever been convicted, assessed, or excluded from the Medicare, Medicaid, State Health Insurance Program, or any other federal or state program due to fraud, obstruction of an investigation or controlled substance violation?

No  Yes

If Yes, Family Name (Last, First)	Relationship to You
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Do you under any name or business identity, have any overpayments with any federal or state programs?

No  Yes

If Yes, Name of Federal/State Program	Family Name (Last, First)
---------------------------------------	---------------------------

Have you ever been convicted of a felony under federal or state law?

No  Yes - Add appropriate document pertaining to the situation.

If Yes, Date of Occurrence (MM/DD/YYYY)
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If you have ever had any of the following adverse legal action imposed or are pending by any federal or state agency or program, check the appropriate box and indicate the date when the adverse legal action was imposed. Important: Attach a copy of legal action notifications.

Adverse Legal Action	Yes	No	Date of Occurrence (MM/DD/YYYY)
Administrative Sanction?			
Professional Board Disciplinary Action?			
Program Exclusion?			
Suspension of Payments?			
Civil Monetary Penalty?			
Assessment?			
Program Debarment?			
Criminal Fine?			
Restitution order?			
Pending Criminal Judgment?			
Judgment pending under the false claim act?			

**Disclosure Questions**

Have you ever had ownership in any organization that has billed or is currently billing Medicare or North Dakota Medicaid Services?

No  Yes

If Yes, Legal Business Name of Organization

Effective Date	End Date	EIN		
Address		City	State	ZIP Code
NPI	Medicaid Number	Medicare Number		

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Have you ever managed or directed any organization that has billed or is currently billing Medicare or North Dakota Medicaid?

No  Yes

If Yes, Legal Business Name of Organization

Effective Date	End Date	EIN		
Date of Birth		Social Security Number		
Address		City	State	ZIP Code
NPI	Medicaid Number	Medicare Number		

Do you have ownership interest in 5% or greater in a subcontractor for your business or practice?

No  Yes

If Yes, Name of Subcontractor

Effective Date	End Date	EIN		
Address		City	State	ZIP Code

Do any of the member of your immediate family have ownership of 5% or greater in a subcontractor to your business or practice?

No  Yes

If Yes, Family Name (Last, First, MI)		Relationship to You		
Address		City	State	ZIP Code
Name of Subcontractor				
Address		City	State	ZIP Code

## F. BLUE CROSS BLUE SHIELD QUESTIONS

### Disclosure Questions

Do you currently have any physical impairment or disability that could, without reasonable accommodation, impede your ability to provide care according to accepted standards of professional performance or poses a threat to the health or safety of your patients?

No  Yes Explain:

Do you currently have any mental impairment or disability that could, without reasonable accommodation, impede your ability to provide care according to accepted standards of professional performance or poses a threat to the health or safety of your patients?

No  Yes Explain:

Do you currently have any substance abuse problems that could, without reasonable accommodation, impede your ability to provide care according to accepted standards of professional performance or poses a threat to the health or safety of your patients?

No  Yes Explain:

Have you received treatment for substance abuse related conditions in the past five years?

No  Yes Explain:

Have you ever been convicted of a felony, fraud, narcotics offense, moral, or any other type of ethical crime?

No  Yes Explain:

Has your license or certification to practice in any jurisdiction ever been limited, restricted, revoked, suspended, voluntarily relinquished, terminated, subjected to disciplinary action, or otherwise acted upon in an adverse manner?

No  Yes Explain:

Have you ever been sanctioned or penalized by any hospital, licensing board, government entity or managed care organization?

No  Yes Explain:

Have you ever voluntarily or involuntarily refused or denied membership on a hospital medical staff?

No  Yes Explain:

**F. BLUE CROSS BLUE SHIELD QUESTIONS (continued)**

**Disclosure Questions**

Have your specific clinical privileges at a facility in any jurisdiction ever been denied, limited, suspended, diminished, revoked, withdrawn, or denied renewal?

No  Yes Explain:

Have you ever been subjected to disciplinary action by any medical organization?

No  Yes Explain:

Have you ever been subjected to any claim(s) or under investigation for unethical conduct?

No  Yes Explain:

Have you ever been the subject of a malpractice claim or are there currently pending malpractice claims, suits, settlements, arbitration proceedings, or complaints filed involving your professional practice? If yes, attach a copy of the claim(s).

No  Yes Explain:

Have any judgments been made against you or settlements by you in any malpractice claim?

No  Yes Explain:

Have you ever been denied liability insurance, in whole or in part, or has your policy ever been canceled, involuntarily restricted, denied renewal, or rated up because of the nature of volume of claims against you?

No  Yes Explain:

Has your DEA or state certificate controlled dangerous substance license ever been suspended or revoked?

No  Yes Explain:

**Behavioral Health Providers Capability/Services Capabilities**

**(Check those capabilities in which you are certified or have received specific or on-going training. These may or may not be a covered benefit)**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> ADD/ADHD                       | <input type="checkbox"/> Addictions                         | <input type="checkbox"/> Adoption Issues                 |
| <input type="checkbox"/> Anger Management               | <input type="checkbox"/> Anxiety Disorder                   | <input type="checkbox"/> Applied Behavior Analysis       |
| <input type="checkbox"/> Asperger's Syndrome            | <input type="checkbox"/> Autism Behavior Modification       | <input type="checkbox"/> Bi-Polar Disorder               |
| <input type="checkbox"/> Biofeedback                    | <input type="checkbox"/> Child Abuse                        | <input type="checkbox"/> Christian Counseling            |
| <input type="checkbox"/> Chronic Mental Illness         | <input type="checkbox"/> Chronic Physical Illness           | <input type="checkbox"/> Co-dependency                   |
| <input type="checkbox"/> Cognitive Behavioral Therapy   | <input type="checkbox"/> Compulsive Gambling                | <input type="checkbox"/> Conduct/Disruptive Disorders    |
| <input type="checkbox"/> Couples/Marriage Therapy       | <input type="checkbox"/> Crisis Diversionary Services       | <input type="checkbox"/> Crisis Intervention Services    |
| <input type="checkbox"/> Critical Incident Debriefing   | <input type="checkbox"/> Depressive Disorder                | <input type="checkbox"/> Developmental Disabilities      |
| <input type="checkbox"/> Dialectical Behavioral Therapy | <input type="checkbox"/> Disability Evaluation              | <input type="checkbox"/> Dissociative Disorder           |
| <input type="checkbox"/> Divorce                        | <input type="checkbox"/> Domestic Violence                  | <input type="checkbox"/> Dual Diagnosis                  |
| <input type="checkbox"/> Eating Disorders               | <input type="checkbox"/> Electro-Convulsive Therapy (ECT)   | <input type="checkbox"/> Faith Based Counseling          |
| <input type="checkbox"/> Family Therapy                 | <input type="checkbox"/> Forensic/Sex Offenders             | <input type="checkbox"/> Gay/Lesbian Identified Children |
| <input type="checkbox"/> Grief Counseling               | <input type="checkbox"/> Group Therapy                      | <input type="checkbox"/> Head Injury Patients            |
| <input type="checkbox"/> Hearing Impaired Issues        | <input type="checkbox"/> HIV Positive/AIDS Patients         | <input type="checkbox"/> Home Care/Home Visits           |
| <input type="checkbox"/> Hypnosis                       | <input type="checkbox"/> Independent Qualified/Medical Ex   | <input type="checkbox"/> Infertility                     |
| <input type="checkbox"/> Inpatient Therapy              | <input type="checkbox"/> Learning Disabilities              | <input type="checkbox"/> Medical Stress/Behavioral Med   |
| <input type="checkbox"/> Medication Management          | <input type="checkbox"/> Men's Issues                       | <input type="checkbox"/> Mood Disorders                  |
| <input type="checkbox"/> Multicultural Issues           | <input type="checkbox"/> Neuropsych Assessment              | <input type="checkbox"/> Nursing Home Visits             |
| <input type="checkbox"/> Obesity Assessment/Counseling  | <input type="checkbox"/> Obsessive Compulsive Disorder      | <input type="checkbox"/> Organic Brain Syndrome          |
| <input type="checkbox"/> Pain Management                | <input type="checkbox"/> Panic Disorder                     | <input type="checkbox"/> Parenting Skills                |
| <input type="checkbox"/> Pastoral Counseling            | <input type="checkbox"/> Personality Disorder               | <input type="checkbox"/> Pervasive Development Disorders |
| <input type="checkbox"/> Phobias                        | <input type="checkbox"/> Physical Abuse/Violence            | <input type="checkbox"/> Physically Impaired Patients    |
| <input type="checkbox"/> Play Therapy                   | <input type="checkbox"/> Police Personnel                   | <input type="checkbox"/> Post Partum Depression          |
| <input type="checkbox"/> Post Traumatic Stress Disorder | <input type="checkbox"/> Psychological Disability Eval/Mgmt | <input type="checkbox"/> Psychological Testing           |
| <input type="checkbox"/> Psychosomatic                  | <input type="checkbox"/> Psychotic Disorders                | <input type="checkbox"/> Rape Issues                     |
| <input type="checkbox"/> Rape Victims                   | <input type="checkbox"/> Schizophrenic Disorders            | <input type="checkbox"/> Sex Offender                    |
| <input type="checkbox"/> Sexual Abuse/Violence          | <input type="checkbox"/> Sexual Dysfunction                 | <input type="checkbox"/> Sexual Harassment               |
| <input type="checkbox"/> Sexual Identity Issues         | <input type="checkbox"/> Sleep Disorders                    | <input type="checkbox"/> Somatoform Disorders            |
| <input type="checkbox"/> Substance Abuse                | <input type="checkbox"/> Terminally Ill Patients            | <input type="checkbox"/> Visually Impaired Patients      |
| <input type="checkbox"/> Weapons Clearance              | <input type="checkbox"/> Women's Issues                     |  |

### G. SANFORD QUESTIONS

#### List 3 Professional references of the same license or higher:

Name	Email Address	Telephone Number	
Mailing Address	City	State	ZIP Code

Name	Email Address	Telephone Number	
Mailing Address	City	State	ZIP Code

Name	Email Address	Telephone Number	
Mailing Address	City	State	ZIP Code

#### Disclosure Questions

Have you practiced within your profession without professional liability insurance? (If yes, provide additional information below.)  
 No  Yes Explain:

Has any professional liability insurance carrier ever excluded any specific procedures from your coverage?  
 No  Yes Explain:

Have you had any judgments entered against you in a professional liability case?  
 No  Yes Explain:

Have you ever had any final judgments, settlements, or malpractice claims paid by you or on your behalf by another entity?  
 No  Yes Explain:

Have there been, or are there currently pending, any malpractice claims, suits, demands, settlements or arbitration proceedings involving your professional practice?  
 No  Yes Explain:

Have you ever been denied professional liability insurance, has your coverage ever been canceled or have you ever been rated at a higher rate than average risk class for your specialty?  
 No  Yes Explain:



### G. SANFORD QUESTIONS (continued)

#### Disclosure Questions

Has any insurance company ever imposed a surcharge or additional premium because of you?

No  Yes Explain:

Do you speak a language other than English, including American Sign Language, with sufficient fluency to speak to patients in that language without an interpreter?

No  Yes Additional Languages:

Do you plan to speak in that language with your patient population without an interpreter?

No  Yes

IF Yes, have you taken a medical language assessment exam for this language?

No  Yes If you have taken a medical language assessment exam, supply a copy.

### H. TRICARE QUESTIONS

Are you currently an active-duty service member or an employee appointed in the civil service of the United States Government?

No  Yes

HNFS Requires practitioners to meet specific criteria for the following specialty areas. If you meet the requirements and wish to receive referrals for these specialties, check the appropriate box(es) to attest you meet the minimum criteria

- |  |   |
|--|---|
| <input type="checkbox"/> Adolescents           | * Demonstration of adequate and relevant academic coursework or clinical training in adolescent treatment.<br>* For non-MDs, at least 1500 hours supervised experience treating adolescents and families.<br>* In general, at least 30 percent of current practice involves the treatment of adolescent and their families. |
| <input type="checkbox"/> Children              | * Demonstration of adequate and relevant academic coursework or clinical training in the treatment of children.<br>* For non-MDs, at least 1500 hours supervised experience treating children and families. In general, at least 30 percent of current practice involves the treatment of children and their families.      |
| <input type="checkbox"/> Psychological Testing | * Licensure as a psychologist.<br>* Completion of doctorate level courses in test construction, statistics and measurement theories from a regionally accredited institution.<br>* At least 1500 hours of supervised experience administering, scoring and interpreting psychological tests.                                |
| <input type="checkbox"/> Psychiatrist, Child   | * Proof of Board Certificate in child psychiatry or completion of a 2-year fellowship in child psychiatry approved by the American Council on Graduate Medical Education.   |

#### Psychiatric Nurses Only

Does your state license have a designation in a Psychiatric Specialty?

Yes  No If no, you must have an American Nurses Credentialing Center (ANCC) certificate.

Are you certified by the ANCC?

Yes  No

ANCC Certifications

Nurse practitioner (NP), Psychiatric (MH NP)  Specialty Certifications (Psychiatric, MH nursing)

ANCC Certificate Number

Expiration Date

#### Opioid Treatment Provider

Check all that apply:

- Holds an MD, DO, PA, or ARNP License.
- Possesses a DATA 2000 waiver from the substance abuse and mental health services administration (SAMHSA), allowing prescription of suboxone for opioid addiction.
- Holds a specific DEA number for buprenorphine prescriptions for opioid addiction therapy.
- Prescribes Buprenorphine/Suboxone.
- Prescribes Naltrexone/Vivitrol.