NEW EMPLOYEE QUESTIONNAIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HUMAN SERVICE CENTERS
SFN 1515 (8-2024)

Clear Fields

This SFN 1515 New Employee Questionnaire is **required** to be completed before providing services to individuals with insurance coverage. It contains questions required by multiple insurance companies for credentialing.

Included are disclosure questions asking you about past legal actions, board actions, as well as questions about physical and mental disabilities, and substance use conditions. These questions may illicit responses you wish to keep private. We respect your right to privacy and will ensure only individuals directly processing your application will have access to the information provided.

This questionnaire along with the below items **must** be returned within **48 hours** of receiving to:

Name
Email Address

- A copy of your diploma (or an official transcript)
- A copy of your license to practice, if applicable
- A copy of your DEA license, if applicable

Upon return of the questionnaire, answers will be pre-filled into credentialing paperwork for the multiple insurance entities. Before submission to insurance entities, you will have the opportunity to review each application, sign and date them.

Your NPI number, username and password will be required at the time of signature. If you do not have an account assistance will be provided.

The copy of your diploma/transcript, copy of your license to practice, and the SFN 1515 New Employee Questionnaire will be stored in your staff file in the electronic health record to have access when re-credentialing is needed. These documents will be accessible only to staff completing the credentialling process.

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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? ☐ Yes ☐ No	Other Name Used (Last, First)		
Dates Other Name was Used Date Started: Date Ended:		Gender ☐ Male ☐ Female ☐ 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	Personal Email Address (for NPI purposes)	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	
☐ US Graduate ☐ Non-US/Canadian Graduate ☐ Fifth Pathway Graduate			

Name of Institution			
Address	City	State	ZIP Code
Degree Issued	Start Date	Graduation Date	
☐ US Graduate ☐ Non-US/Canadian Graduate ☐ Fifth Pathway Graduate			

Name of Institution			
Address	City	State	ZIP Code
Degree Issued	Start Date	Graduation Date	
☐ US Graduate ☐ Non-US/Canadian Graduate ☐ 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
☐ Fellowship ☐ Internship ☐ Residency	Start Date	Completion Date	

Institutional/Hospital Name	Telephone Number	Fax Number	
Address	City	State	ZIP Code
☐ Fellowship ☐ Internship ☐ Residency	Start Date	Completion Date	

Institutional/Hospital Name	Telephone Number	Fax Number	
Address	City	State	ZIP Code
☐ Fellowship ☐ Internship ☐ 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

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)

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)

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

☐ Adolescents	* Demonstration of adequate and relevant academic coursework or clinical training in adolescent treatment. * For non-MDs, at least 1500 hours supervised experience treating adolescents and families. * In general, at least 30 percent of current practice involves the treatment of adolescent and their families.
☐ Children	* Demonstration of adequate and relevant academic coursework or clinical training in the treatment of children. * 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.
☐ Psychological Testing	* Licensure as a psychologist. * Completion of doctorate level courses in test construction, statistics and measurement theories from a regionally accredited institution. * At least 1500 hours of supervised experience administering, scoring and interpreting psychological tests.
☐ 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?	ANCC Certifications	
☐ Yes ☐ No	☐ Nurse practitioner (NP), Psychiatric (MH NP)	☐ Specialty Certifications (Psychiatric, MH nursing)

ANCC Certificate Number	Expiration Date