Substance Use Initiative - Healthcare Provider Scope of Work

Onondaga County Substance Use Initiatives is seeking a Healthcare Provider to provide wound care, point of care Hepatitis C and HIV testing, patient education, and other care as needed. Providers must be a licensed independent practitioner with advanced education and certification with experience in providing evidence-based care for a population of patients. Interested applicants must have at least two years of experience serving unsheltered patients.

Responsibilities Include:

- Independently manage a panel of patients with acute and chronic health conditions with an emphasis on wound care, health promotion and disease prevention using evidence-based practice
- Determines needed supplies and monitors inventory to ensure uninterrupted care.
- Develops individual care plans for patients
- Demonstrates leadership and works collaboratively with the Health Department Team and community stakeholders
- Orders and interprets labs, tests, and diagnostic studies
- Prescribes pharmacologic and non-pharmacologic interventions
- Initiates referrals and consults to specialty services
- Links patients to other SUI services
- Provides education to patients and their families
- Assesses and adjusts the plan of care as needed to achieve optimal patient outcomes
- Exemplifies the values of-Integrity, Commitment, Advocacy, Respect, and Excellence
- Provides reporting to Substance Use Initiatives.

Additional Details:

Flexible work schedule, Monday-Friday, with priority focus on working with Syringe Services Program during these hours:

Monday: 1pm-3pm
Tuesday: 10am-12pm, 2pm-4pm
Wednesday: 1pm-3pm
Thursday: 6:30am-8:30am, 1pm-3pm
Friday: 7:30am-12pm

Weekend schedule is not anticipated.

Requirements:

Licensed Nurse Practitioner, Doctor of Medicine, or Doctor of Osteopathy

Nurse Practitioners must possess an advanced education including Master of Science in Nursing or Doctor of Nursing Practice

Active license to practice in the State of New York

Minimum of 2 years' experience providing healthcare services to unsheltered populations

Dual certification in medicine and psychology preferred

Possess the following minimum insurance requirements with a licensed carrier with Best Rating A- XV or better:

Auto Liability: $1,000,000 Occurrence

General: $1,000,000 Occurrence
$1,000,000 Personal & Advertising Injury
$2,000,000 General Aggregate
$2,000,000 Products & Completed Operations

Professional: $2,000,000 / Claim

$4,000,000 Aggregate

Umbrella: $1,000,000 Occurrence

Worker's Compensation Insurance or W/C exemption (CE-200)

Rate of pay: $85-90/hour, based on years of experience

Responses: Please provide the information listed below and requested rate of pay to JessicaLopez@ongov.net. Please put in the subject line SUI Healthcare Provider Application. If you do not receive an email within 1 business day, acknowledging receipt, please call 315-435-3155 and ask for Jessica.

Document or Proof	**Checklist**
Completed Medical Staff Application (*attached*)	
Resume / CV	
Copy of diplomas	
Copy of current licenses and/or registrations	
Proof of Board Certification(s)	
Copy of your photo id	
Completed W-9	
Proof of insurance (Acord Certificate of Liability Insurance)	
Notarized Conflict of Interest Affidavit (*attached*)	

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MEDICAL STAFF APPLICATION

_____

Name in FULL | Social Security Number | Date of Birth

_____(____)_____

Office Address | Telephone Number

_____(____)_____

Home Address | Telephone Number

_____

Citizenship | Medical Specialty

_____

Medical/Dental School | Date of Graduation | *Degree

_____

Address | City | State | Zip Code

(___) YES (___) NO_____

Program Completed | Dates Attended

_____

Residency Hospital | Chairman/Director of Program

_____

Address | City | State | Zip Code

(___) YES (___) NO_____

Program Completed | Dates of Residency

Fellowships/Preceptorships:
List in chronological order with dates and location, program completed, degree granted, and names of preceptors responsible for evaluating your performance. (MUST include current address and phone number!)

*Please provide supporting documents. ractice sites in chronological order with dates (include assistantships, appointments and military service experience). (MUST include current address and phone number!)

Are you Board Certified: _____ YES _____ NO

Name of Board: _____

If not, are you Admissible[1] for the Boards? _____ YES _____ NO

If you are neither certified nor admissible, what is your status? _____

[1]Admissible means you have applied to take the Board examination and your application has been approved.

_____

*Medical/Dental/Professional Licensures License Number Date of Licensure

_____

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_____

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If you are a Foreign Medical School Graduate, have you passed the *ECFMG Examination? ___ YES ___ NO

*Drug Enforcement Administration (DEA) _____

Number State Date

Unique Physician ID Number (UPIN): _____ Medicaid Provider Number: _____

List at least three (3) peers who have direct knowledge of your clinical abilities. (Include name, address & telephone number of each. (Must include current address and phone number!)

List names and locations of any other hospital, clinical or health care facility or organization where you provided s *Please provide supporting documents. .

Name of Facility	Location	Dates of Affiliation
Name of Facility	Location	Dates of Affiliation
Name of Facility	Location	Dates of Affiliation
Name of Facility	Location	Dates of Affiliation
Name of Facility	Location	Dates of Affiliation

If your answer to any of the following questions is "yes", please give full details on a separate sheet of paper.

Has your license to practice medicine in any jurisdiction ever been limited, suspended or revoked? ___ YES ___ NO

Has your DEA number to prescribe controlled substances ever been limited, suspended or revoked? ___ YES ___ NO

Have your privileges at any hospital ever been suspended, diminished, revoked or not renewed? ___ YES ___ NO

Has your Specialty Board status ever been suspended, diminished, revoked or not renewed? ___ YES ___ NO

Have you ever been denied appointment or renewal thereof or been subject to disciplinary action by any medical or hospital organization? ___ YES ___ NO

Have you been named in a malpractice action within the last five (5) years? ___ YES ___ NO

Has your faculty membership in any medical or other professional school ever not been renewed or subject to disciplinary action? ___ YES ___ NO

Are you aware of any health impairments which would affect your ability to perform professional and staff duties fully? ___ YES ___ NO

If yes, please provide written explanation on a separate sheet of paper.

I hereby apply for appointment to the medical staff of the Onondaga County Health Department.

The information provided on this application will be used to query the National Practitioner Data Bank.

_____

Signature Date

Contractor further provides the sworn **Conflict Interest Affidavit**, below, consistent with the terms of this Agreement.

State of)
County of) ss.:

Contractor, being duly sworn, deposes and says:

_____ (Contractor) agrees that Contractor has no interest and will not acquire any interest, direct or indirect that would conflict in any manner or degree with the performance of the services to be rendered to the County of Onondaga (County).

Contractor further agrees that, in the rendering of services to County, no person having any such interest shall knowingly be employed by Contractor.

CONTRACTOR

By: _____
Name:
Title:

Sworn to before me on this day of _____, 20____.

_____