PROVIDER APPLICATION

Please complete all sections of this application. If a section is not applicable, please mark it N/A

OFFICE INFORMATION (Attach additional copies of this page for each practice location)			
Practice Type: Individual ☐ Group ☐	Practice Name		
Practice Address (include suite # if applicable)			
City		State	Zip Code
Secure Primary Phone #:		Cell Phone #:	
Secure Email Address:	Secure Primary Fax #	Secure Alternate Phone #:	
Tax Identification Number or Number Appearing on W9 Form (for billing purposes):			
Billing/Mailing address (if different from practice address)	City	State	Zip Code

ADDITIONAL OFFICE INFORMATION	
1. This office complies with federal, state, and local legal requirements governing public accessibility, health and safety.	☐ Yes ☐ No
2. This office is wheelchair accessible.	☐ Yes ☐ No
3. This office is close to public transportation.	☐ Yes ☐ No
4. This office is located in a home.	☐ Yes ☐ No
5. Appointments available: ☐ Morning ☐ Afternoon ☐ Evening ☐ Weekends	
6. Are you able to return client phone calls within 1 business day?	☐ Yes ☐ No
7. Are you able to offer a routine appointment with 3 business days?	☐ Yes ☐ No
8. Are you able to offer an urgent appointment within 1 business day?	☐ Yes ☐ No

PROVIDER INFORMATION		
First Name:	Middle Name:	Last Name:
Gender: ☐ Male ☐ Female	Date of Birth:	Email:
National Provider ID #:	Years Post-Master's Clinical Exp.:	

LICENSE/CERTIFICATIONS HELD				
Current License Class:				
License type:	License #:	Original Date of Issue:	State:	Expiration Date:
License type:	License #:	Original Date of Issue:	State:	Expiration Date:
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CERTIFICATIONS			
Alcohol & Drug Certification ☐ National ☐ State	Certification #:	Date of Issue:	Expiration Date:

Certified Employee Assistance Program (CEAP) ☐ Yes ☐ No	Certification #:	Date of Issue:	Expiration Date:
ADDITIONAL CERTIFICATIONS (CISD, Coaching, Training, Etc.)			
Certification Type:	Certification #:	Date of Issue:	Expiration Date:
Certification Type:	Certification #:	Date of Issue:	Expiration Date:
Certification Type:	Certification #:	Date of Issue:	Expiration Date:

INSURANCE PLAN INFORMATION	
Please list the insurance plans you currently accept:	
Are you a participating Medicare provider?	☐ Yes ☐ No
Are you a participant Medicaid provider?	☐ Yes ☐ No

SESSION FORMAT (CHECK ALL THAT APPLY)

☐ Individual	☐ Couples	☐ Family	☐ Group
☐ Online e-counseling	☐ Telephonic	☐ Video - Virtual Visits	☐ Other

TREATMENT APPROACH (CHECK ALL THAT APPLY)

☐ Bio-Neurofeedback	☐ Brief Therapy	☐ COG Behavior Therapy	☐ Family Systems
☐ Psychodynamic	☐ Psychoeducational	☐ EMDR	☐ Group
☐ Rational Emotive Therapy	☐ Hypnosis	☐ Solution-Focused	☐ Other __________

TREATMENT SPECIALTIES

☐ Abuse	☐ Executive Coaching	☐ Parenting
☐ ACOA/Codependency	☐ Family	☐ Personality Disorders
☐ ADD/ADHD	☐ Fertility	☐ Post-Traumatic Stress Disorder
☐ Adjustment Disorders	☐ Financial	☐ Psychological Testing
☐ Adoption	☐ Gambling	☐ Relationship Issues
☐ Anger Management	☐ GBLT	☐ Sexual abuse
☐ Anxiety	☐ Grief/Loss	☐ Sexual Compulsivity
☐ Career/Prof. Development	☐ Legal	☐ Sleep disorders
☐ Chronic Illness	☐ Marital /Couples	☐ Smoking Cessation
☐ Disability	☐ Mediation, including Divorce	☐ Spiritual/Pastoral Counseling
☐ Depression	☐ Medical Issues	☐ Stress Management
☐ Domestic Violence	☐ Mood disorders	☐ Trauma
☐ Eating Disorders	☐ OCD	

CLIENT DEMOGRAPHIC (CHECK ALL THAT YOU ARE EXPERIENCED IN SERVING)

☐ Child below 6 ☐ Child 6 to 12 ☐ Adolescent ☐ Adults ☐ Geriatric

LANGUAGES SPOKEN OTHER THAN ENGLISH			
☐ American Sign Language	☐ Cantonese	☐ French	☐ Japanese
☐ Mandarin	☐ Russian	☐ Spanish	☐ Other ___________

EAP EXPERIENCE	
Are you a member of The Employee Assistance Professionals Association (EAPA) or Employee Assistance Society of North America EASNA)? EAPA or EASNA Membership # Expiration	☐ Yes ☐ No
Do you have experience providing Employee Assistance Counseling?	☐ Yes ☐ No
Total of years of EAP experience	
Are you qualified and experienced in providing brief solution-focused counseling?	☐ Yes ☐ No
Are you qualified to provide general assessment, short-term problem resolution counseling, and o referrals for:	
Mental Health	☐ Yes ☐ No
Substance Abuse	☐ Yes ☐ No
Family Relationships	☐ Yes ☐ No
Are you experienced in helping employees understand and resolve conflict at work?	☐ Yes ☐ No
Do you have knowledge and experience with assessing and managing high-risk situations (e.g. suicidal, homicidal, self-injury)?	☐ Yes ☐ No
Are you skilled in providing assessments to employees who have tested positive for substance abuse?	☐ Yes ☐ No
After providing EAP assessment, are you comfortable facilitating a referral for the client by (1) Contacting insurance provider to determine in-network options, (2) Interviewing options as needed, (3) Making the referral for the client, and (4) Contacting that provider to pass on assessment information IF NEEDED.	☐ Yes ☐ No

CRISIS RESPONSE - TRAINING QUALIFICATIONS, SUPERVISORY REFERRALS SAP - VIRTUAL VISTS			
CRISIS RESPONSE: Do you have formal training and/or certification in Trauma Response Services? If yes, attach latest proof or trainings/certificates			☐ Yes ☐ No
If you have not received formal training or certification, are you able to provide other onsite crises response services, for example providing onsite availability for clients in need of support during a crisis?			☐ Yes ☐ No
Number of years of Trauma Response Service Experience:		Number of onsite Trauma Responses within the past two years:	
Types of Trauma Response Services you have performed: ☐ Robbery ☐ Death of Employee ☐ Downsizing ☐ Natural Disaster ☐ Suicide ☐ Terrorism ☐ Other ____________			
Are you able to provide onsite services within 24-72 hours' notice? ☐ Yes ☐ No		If yes, please provide after-hours contact number:	
TRAINING: Do you have experience providing EAP training? ☐ Yes ☐ No	Are you able to provide EAP training? ☐ Yes ☐ No	Years of training experience:	Hours of training you provide per month (average):
Types of trainings delivered: ☐ Coaching ☐ Stress Management ☐ Wellness ☐ Work-Life Balance ☐ Other ___________________________________			

SUPERVISORY REFERRALS:

Do you have experience and understanding of dual client relationships where one is simultaneously serving both the client, (recipient of the sessions) and the company (payer of the service)? ☐ Yes ☐ No

Are you experienced in providing services for work-mandated cases (Supervisory Referrals)? ☐ Yes ☐ No

Are you able to offer an appointment for a mandatory referral within 2 business days? ☐ Yes ☐ No

SAP:

Are you a qualified Substance Abuse Professional (SAP) under Department of Transportation (DOT) regulations of 1/1/04? ☐ Yes ☐ No

If yes, please include documentation of training.

FITNESS FOR DUTY:

Do you belong to a practice that has a doctor who can provide fitness for duty evaluations? ☐ Yes ☐ No

VIRTUAL VISITS: Do you have experience providing Virtual Visits? ☐ Yes ☐ No	Length of experience providing virtual visits:	Number of virtual visits you provide per month (average):

If you haven't provided virtual visits before, would you be interested in receiving information about providing that service? ☐ Yes ☐ No

VOLUNTARY – NOT REQUIRED

The following information regarding religious affiliation, sexual orientation, and race/ethnic group is not used for purposes of denying an application for participation. Often clients ask for a counselor who meets specific preference within one of the following categories. If your application is approved, and you provided this information, your response will be entered into our database so that you can be identified if a client requests a counselor who meets a specific category. Any responses you provide or your decision to not provide this information will not be basis for denying your application for participation.

Are you willing to identify your religious background for clients requesting an EAP counselor with your specific background? ☐ Yes ☐ No

☐ Catholicism ☐ Christianity ☐ Eastern religion ☐ Jewish ☐ Islam

☐ Other ____________________

Are you willing to identify your sexual orientation for clients requesting an EAP counselor with your specific orientation? ☐ Yes ☐ No

☐ Bisexual ☐ Gay ☐ Transgender ☐ Heterosexual

Are you willing to identify your ethnicity or nationality for clients requesting an EAP counselor with your specific background? ☐ Yes ☐ No

☐ African American ☐ Arab American ☐ Hispanic ☐ Native American
☐ Asian, Pacific Islander ☐ Israel ☐ Caucasian

☐ Other ___________

Business Status: ☐ Minority-Owned Business ☐ Women-Owned Business ☐ 8(a) certified (as defined by SBA)

(Check any that apply - *Must be 51% owned, operated and controlled to qualify)

DISCLOSURE	
READ EACH STATEMENT, if you answered **YES** to any of the following questions, you are **REQUIRED** to provide a detailed explanation of your involvement, the date the action was initiated, and current status including any final outcome.	
Has your license, registration or certification to practice in your profession ever been voluntarily or involuntarily relinquished, denied, suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation or any conditions or limitations by any state or professional licensing, registration or certification board?	☐ Yes ☐ No
Has there been any challenge to your licensure, registration or certification?	☐ Yes ☐ No
Are you currently the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program or a defendant in any civil action that is reasonably related to your qualifications, competence, functions or duties as a medical professional for alleged fraud, an act of violence, child abuse or a sexual offenses or sexual misconduct?	☐ Yes ☐ No
Are you currently being investigated or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation by a hospital or healthcare facility of any military agency?	☐ Yes ☐ No
Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history?	☐ Yes ☐ No
Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony?	☐ Yes ☐ No
In the past 10 years, have you ever been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor (excluding minor traffic offenses) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, functions or duties as a medical professional, or for fraud, an act of violence, child abuse or a sexual offence or sexual misconduct?	☐ Yes ☐ No
Are you able to perform all the services required by the applicable participating practitioner agreement, with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to the safety of patients?	☐ Yes ☐ No

CERTIFICATION

The undersigned hereby certifies that the above information requested by REACH EAP & Workplace Solutions for participation in its Provider Network is truthful, correct and complete in all respects.

_______________________________ _______________________

Signature *Date*

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Name (Please Print)