APPLICATION FOR EAP PROVIDER NETWORK

Questions about this application should be directed to (800) 865-1044.

Please return application to:
EAP Provider Relations
7600 E. Eastman Ave., Suite 500
Denver, Colorado 80231
Fax:(303) 695-1371

Applying group organizations should complete an individual application and provide documents for each individual group member.

Before sending back to us please include:

- o Copy of current license/certificate
- o Face sheet of malpractice insurance in the amounts of $1M/$3M
- o Resume/Professional Vita
- o Copy of current CEAP Certificate, if applying to deliver EAP *Employer* Services

Group Name (if applicable)____

Applicant (Group Officer Name, if applicable)___________________________________ Degree________________________

Type of License(s)/Certification, Number/State(s) - *A minimum of a Master's Degree in a mental health discipline is required*

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Federal Tax I.D.#____________________Social Security #__________________________ Date of Birth___________________

Graduate School ____ Date Graduated___________________

Primary Office Address____

Secondary Office Address____
(Attach separate sheet with zip codes if more than two offices)

Mailing Address____

Telephone _______________________Fax Number______________________ Email Address__________________________
(Please do not list fax or email numbers unless confidential documents can be sent to this location on a routine basis.)

Behavioral Health Plan Provider Network Participation *(Please mark all that you participate in)*

o BC/BS *(indicate State and Plan type)* ________________________________ o Aetna o Cigna o Great West
o Health Net o Humana oPacifiCare oPreferred Health o Sloans Lake o United Healthcare
Other____

Office use only: **Date received__________________ Date entered into database________Date Sent to Credentialing Committee_____________________Date Agreement sent ___________________**

EAP Employee Services *(Please answer the following questions regarding your experience and training)*

1. Applicant has had professional training in short term problem resolution techniques? o Yes o No

2. Applicant is typically able to offer non-emergency appointments within five business days and appointments for urgent matters within 24 hours of accepting a referral? o Yes o No

3. During the first face-to-face meeting, applicant advises clients how to access him/her, or a designated mental health professional, in a crisis situation or when unavailable. o Yes o No

4. Applicant sees clients in a private, professional office setting. o Yes o No

EAP Employer Services

5. Applicant has a minimum of two years employment in an employee assistance program, or equivalent experience, personally delivering direct service to work organizations including management training, supervisor consultations, formal management referrals, critical incident debriefings, on-site employee group support, policy development related to EAP services such as alcohol and drug policies and drug testing protocols, ***OR*** applicant has a CEAP certification. o Yes o No

6. Applicant has a minimum of 30 hours experience delivering workplace training. o Yes o No

7. Applicant has completed structured training in critical incident debriefing management and delivered a minimum of three debriefings in at least two different industries. o Yes o No

Please indicate your areas of expertise/specialization below:

Populations

- o Adults
- o Children
- o Couples
- o Developmentally Delayed
- o Gay / Lesbian
- o Hearing Impaired
- o Minority / Cultural
- o Physically Impaired
- o Religious Preference_____
- o Geriatric
- o Other _________________
- o Languages_____________

EAP Services

(The numbers in parentheses reference the respective questions above.)

- o CEAP Certified / EAP Acct Services (5)
- o Corporate Training (5)
- o Critical Incident Debriefing CISD (7)
- o EAP Counseling (1 - 4)
- o Employee Orientations (5&6)
- o Formal Referrals (5)
- o Management Consultations (5)
- o Organizational Development (5&6)
- o Return to Work Assessments (5)
- o Supervisor Training (5&6)
- o Workshops / Seminars (5&6)

Specialties

- o ADHD
- o Anger Management
- o Brain Injury
- o Chemical Dependency
- o Chronic Pain/Medical Stress
- o Dementia / Alzheimer's
- o Disability
- o Domestic Violence
- o Grief
- o HIV / AIDS
- o Infertility
- o Job Stress
- o Marital Issues
- o Anxiety/Depression/Bi-polar
- o Postpartum Depression
- o Sexual Addiction
- o Sexual Dysfunction
- o Sexual / Physical Abuse
- o Trauma
- o Other _________________

EAP Professional Questionnaire/Attestation

NOTE: If any of your answers to the following questions is YES, please explain on a separate sheet. Your signed statement regarding the alleged incident will suffice for pending cases.

1. □ Yes □ No Have you ever had any disciplinary action taken by any professional organization (state licensing board, state or national professional society, hospital or clinical staff) you have been/are licensed by (including reprimands, censures, probation, limitations, and suspension, or revocations, etc?)

2. □ Yes □ No Have you ever had any judgments and/or settlements made against you in a professional malpractice case? (Documentation is required; if you have malpractice claims pending or settled in the past five years. Include any settlements/adjudication's, original complaint and final disposition).

3. □ Yes □ No Have you ever been convicted of a felony or involved in charges relating to moral turpitude?

4. □ Yes □ No Do you currently have any physical or mental conditions that may impair your ability to render the professional services that are the subject of this application?

5. □ Yes □ No Do you currently use illegal drugs or abuse drugs and alcohol?

6. □ Yes □ No Has any professional insurance coverage ever been revoked, suspended, denied or canceled for you?

I certify that all the information submitted by me is this application is true and accurate to the best of my knowledge.

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Applicant's Signature

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Print Name

____

Date