Thank you for your interest in applying to participate as an EAP Provider. Please return the application and supporting documents via email to:

Email address: WPORecruitment@workplaceoptions.com

Documents Checklist: PLEASE COMPLETE AND ENCLOSE THE FOLLOWING INFORMATION:

- Application with ALL sections completed (Application pages may be printed on front and back);
  - Please sign and date the Authorization, Attestation, and Release Page.
  - Work history must minimally cover the most recent five (5) years and include current employment.
  - Additionally, physical addresses and starting and ending month/year are required for each employment/practice entry. A current Resume/CV that includes the required information may be submitted. An explanation is needed for all employment gaps of 6 months or longer occurring within the last five (5) years.
  - If a section is not applicable, please mark N/A
- Copy of current certificate of Malpractice Insurance Coverage showing minimum limits of $1million per occurrence/$3million annual aggregate, policy number, legible expiration date and applicant's name
  - Please include a roster if coverage is under a group
- Copy of current, unrestricted state license(s) and certifications with legible expiration dates
- Completed W-9 form, signed and dated, for each Tax Identification Number used

The provider's rights during the credentialing process are:

- The right to review the information in support of his/her credentialing application
- The right to be notified of any information obtained during the organization's credentialing process that varies substantially from the information provided to the organization by the provider
- The right to correct erroneous information
- The right to confidentiality of all information obtained in the credentialing process except as otherwise provided by law
- The right, upon request, to be informed of the status of your credentialing or re-credentialing

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

SECTION 1 – PROVIDER INFORMATION		
First Name:	Middle Name:	Last Name:
Social Security #:	Birth Date:	Gender: ☐ M ☐ F
National Provider ID #--(NPI):	Years in Practice:	Years Post-Master's Clinical Exp:

SECTION 2 – LICENSURE (INDICATE LICENSES CURRENTLY OR PREVIOUSLY HELD AT PROFESSIONALLY INDEPENDENT LEVEL. ATTACH COPIES OF CURRENT				
Current License Class (License MUST be for Independent Practice): ❑ LMFT ❑ LPC ❑ LCSW ❑ APRN ❑ Psychologist ❑ Psychiatrist				
License Type:	License #:	Original Issue Date:	State:	Expiration Date:
License Type:	License #:	Original Issue Date:	State:	Expiration Date:
License Type:	License #:	Original Issue Date:	State:	Expiration Date:

SECTION 3 - CERTIFICATIONS (INCLUDING, BUT NOT LIMITED TO CISM, COACHING, TRAINING, ETC. ATTACH COPIES OF CURRENT CERTIFICATES.)			
Certification Type:	Certification #:	Date of Issue:	Expiration Date:
Certification Type:	Certification #:	Date of Issue:	Expiration Date:
DOT Substance Abuse Professional (SAP)? ☐Y ☐N		Date of Issue:	Expiration Date:
CEAP Certified? ☐Y ☐N	Certification #:	Date of Issue:	Expiration Date:

SECTION 4 - OFFICE INFORMATION (ATTACH ADDITIONAL COPIES OF THIS PAGE FOR EACH PRACTICE ADDRESS)					
Practice Type: ☐Individual ☐Group		Practice Name (if applicable):			
Practice Address STREET (include suite # if applicable):					
City:	State:	Zip Code:	County:	24/7 Access #:	
Primary Phone #:	Cell Phone #:		Secure Primary Fax #:	Secure Email Address:	
I will accept referrals by secure email: ☐Yes ☐No			I will accept referrals by SMS Text to the above Cell Phone Number: ☐Yes ☐No		
Tax Identification # (Must be supported by an attached FORM W9):					
Billing/Mailing Address (if different from practice address) as supported on FORM W9:					
City:	State:	Zip Code:	County:		
Application Follow up Person if Other than Applicant:			Application Follow up Phone and Email Address:		
Evening Availability: ☐Yes ☐No			Weekend Availability: ☐Yes ☐No		

SECTION 5 - ADDITIONAL OFFICE ATTRIBUTES	
1. This office complies with federal, state/provincial, and local legal requirements governing public accessibility, health and safety.	☐Yes ☐No
2. This office is close to public transportation.	☐Yes ☐No
3. Procedures require that all visitors present identification and sign in at this office.	☐Yes ☐No
4. This office is located in a home.	☐Yes ☐No

SECTION 6 - PROFESSIONAL LIABILITY INSURANCE INFORMATION (Previous 5 years needed)			
Name of Current Liability Carrier:	Policy Number:	Effective Date:	Expiration Date:
$ Limit per Occurrence:	$ Limit Aggregate:	Length of time with Carrier:	
Name of Previous Liability Carrier:	Policy Number:	Original Effective Date:	Expiration Date:
Carrier Address:	City:	State:	Zip Code:
Carrier Phone Number:	$ Limit per Occurrence:	$ Limit Aggregate:	
Name of Previous Liability Carrier:	Policy Number:	Original Effective Date:	Expiration Date:
Carrier Address:	City:	State:	Zip Code:
Carrier Phone Number:	$ Limit per Occurrence:	$ Limit Aggregate:	

SECTION 7 - INSURANCE PLAN INFORMATION (PLEASE PROVIDE ALL INSURANCE PLANS YOU CURRENTLY ACCEPT)
Accepted Insurance Plans:

SECTION 8 - EDUCATION AND TRAINING	
Highest Degree Attained:	Graduate School or Medical School:
Month and Year Degree Awarded:	Address (include City/State/ZIP/Country):

SECTION 9 - PRACTICE OVERVIEW	
Do you work in a clinical practice for a minimum of ten hours per week?	☐Yes ☐No
Number of supervision/consultation hours received per month:	
Do you keep records of all training/education you receive that can be made available to us and/or external reviewers upon request?	☐Yes ☐No
Are you able to return client phone calls within 1 business day?	☐Yes ☐No
Are you able to offer a routine appointment within 3 business days?	☐Yes ☐No
Are you able to offer an urgent appointment within 1 business day?	☐Yes ☐No
How would you rate your overall familiarity with local community resources?	☐Excellent ☐Good ☐Fair

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SECTION 10 - LANGUAGES ABLE TO PROVIDE COUNSELLING SERVICES IN: (OTHER THAN ENGLISH)				
☐American Sign Language	☐Spanish	☐French	☐ Mandarin	☐ Cantonese
Tagalog	☐ Vietnamese	☐Hindi	☐ Arabic	☐Other:

SECTION 11 - TREATMENT SPECIALTIES (CHECK ALL THAT APPLY)

Counseling/Psychotherapy Specialties:

☐Abuse Victim
☐Abuse Perpetrator
☐Addiction—Substance
☐Addiction--Behavioral
☐Adolescent Issues (12yr to 18yr)
☐Adoption
☐Anger Management
☐Child Custody
☐Child Issues (less than 12yr)
☐Religion/Faith-based Issues
☐Co-Dependency
☐Conflict Management
☐Couples/ Marital
☐Domestic Violence
☐Eating Disorders
☐Family Counseling
☐Fertility
☐Financial
☐First Responder
☐Geriatric Issues
☐Grief/ Loss
☐LBGT Counseling
☐Medical Issues
☐Men's Issues
☐OCD
☐Pain Management
☐Personal Growth
☐Physical Disabilities/Special Needs
☐ Self Esteem
☐ Sexual Dysfunction
☐ Smoking Cessation
☐ Stress Management
☐ Trauma/ PTSD
☐ Veteran Issues
☐ Women's Issues
☐ Work Issues

Testing and Evaluation Specialties:

☐ DOT SAP
☐ Substance Abuse Evaluation
☐ Substance Abuse Evaluation and Monitoring
☐ Psychological Testing (Adult)
☐ Psychological Testing (Child/Adolescent)
☐ Psychological Assessment

Coaching Specialties:

☐ Life Coaching
☐ Career Coaching
☐ Wellness Coaching
☐ Financial Coaching

Other Specialties:

☐CISM/ CISD
☐Trainings/Workshops/Seminars
☐Fitness for Duty Exam

Modalities:

☐**Face to Face Counseling:**
☐ Individual
☐ Couples
☐ Family
☐ Group

☐**Structured Telephonic Counseling:**
☐ Individual

☐**Video Conferencing:**
☐ Individual
☐ Couples
☐ Family
☐ Group

SMS (Texting):
Individual

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SECTION 11 (CONTINUED)	
Are you a psychologist or psychiatrist who wishes to be identified to perform Fitness for Duty Exams to employers?	Yes No
Are you a certified Geriatric Care Assist Manager?	Yes No
Are you willing to provide training and/or facilitating services for Workplace Options?	Yes No
Are you willing to complete short-term disability paperwork?	Yes No

SECTION 12 - TREATMENT APPROACH (CHECK ALL THAT APPLY)

Biofeedback/Neurofeedback Brief Therapy CBT EMDR Mindfulness
Family Systems Group Hypnosis Psychodynamic

SECTION 13 - CLIENT DEMOGRAPHICS (CHECK ALL THAT APPLY)

Child 8 – 12 Adolescent (13 -17) Adult Geriatric Military International Assignee
LGBTQ Other:

SECTION 14 - REFERENCES (OUTSIDE CURRENT PRACTICE/AT LEAST ONE REFERENCE FROM AN EAP PROVIDER/PROFESSIONAL IS PREFERRED)	
Name & Title:	Name & Title:
Address:	Address:
Phone:	Phone:
Relationship to Applicant:	Relationship to Applicant:

SECTION 15 - OPTIONAL, VOLUNTARY AND NOT REQUIRED	
Are you willing to identify your military experience?	Yes No
If so, are you a Veteran?	Yes No
Are you a US citizen?	Yes No

Business Status (Check any that apply – *Must be 51% owned, operated and controlled to qualify):

Minority-Owned Business* Women-Owned Business* 8(a) certified (as defined by SBA)

SECTION 16 - EAP EXPERIENCE	
I am a member of the Employee Assistance Professionals Association (EAPA) or Employee Assistance Society of North America (EASNA)? EAPA or EASNA Membership #: Expiration:	☐Yes ☐No
Total number of years of EAP experience:	
I am professionally qualified to provide general assessments, short-term problem-resolution counseling, and/or referrals for:	
Mental Health	☐Yes ☐No
Relationships, Family & Children Within Family	☐Yes ☐No
Alcohol/Drug Addiction	☐Yes ☐No
I am experienced in identifying and resolving workplace issues that may be caused or exacerbated by an employee's personal or work life.	☐Yes ☐No
I am experienced in workplace mediation and resolving conflict at work.	☐Yes ☐No
I am experienced working in dual client relationships and am able to professionally and simultaneously serve the client who is the individual recipient of services and the client company who is the service payer.	☐Yes ☐No
I have knowledge and experience with assessing and managing high-risk situations (e.g., suicidal, homicidal, or self-injury).	☐Yes ☐No
I am experienced in providing services for work-mandated cases.	☐Yes ☐No
I am experienced in providing drug-free workplace services.	☐Yes ☐No
Describe your experience in providing training services: ☐Employee Orientation ☐Supervisor Training ☐Sexual Harassment ☐ Violence in the Workplace ☐Stress Management ☐Other	
After providing an EAP assessment, you may need to make a referral for a client. Are you comfortable facilitating a referral for the client by: 1) Contacting the insurance carrier to determine in-network provider options, 2) Reviewing referral options as needed, 3) Referring the client to a specific provider, and 4) Contacting that provider to pass on your assessment information (with a client release)?	☐Yes ☐No

SECTION 17 – WORK HISTORY

Beginning with current employment, provide a chronological work history for **the past 5 years (minimally).** Starting and ending months, as well as years, are **REQUIRED for all entries.** Physical addresses are REQUIRED for all entries. This page may be reproduced or appended if additional space is needed.

A RESUME/CV MEETING THE ABOVE REQUIREMENTS MAY BE SUBSTITUTED FOR THIS SECTION

1. Current Employer/Practice Name:					
Tile:			Practice Address:		
City:	State:	Zip:	Phone:	Start Date: (MM/DD/YYYY)	**CURRENT**
2. Employer/Practice Name:					
Tile:			Practice Address:		
City:	State:	Zip:	Phone:	Start Date: (MM/DD/YYYY)	End Date:
3. Employer/Practice Name:					
Tile:			Practice Address:		
City:	State:	Zip:	Phone:	Start Date: (MM/DD/YYYY)	End Date:
4. Employer/Practice Name:					
Tile:			Practice Address:		
City:	State:	Zip:	Phone:	Start Date: (MM/DD/YYYY)	End Date:
Reason for departure if applicable:					
Gaps in Work History: Please explain all employment gaps of 6 months or greater occurring within the last five (5) years					
City:	State:	Zip:	Phone:	Start Date: (MM/DD/YYYY)	End Date:
Gap Start Date (MM/YYYY):			Gap End Date (MM/YYYY):		
Reason for gap:					
Gap Start Date (MM/YYYY):			Gap End Date (MM/YYYY):		
Reason for gap:					

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SECTION 18 – DATA ACCESS PROTECTION	
1. Do you agree to satisfactorily complete online training to be provided by WPO as a pre-condition to accessing WPO's computer systems, programs or applications and will you provide data security protection acceptable to WPO for the duration of the time such access is permitted?	☐Yes ☐No
2. Do you have physical safeguards (i.e., locked rooms, locked file cabinets, alarms, etc.) in place to prevent inappropriate use or disclosure of personal/medical information across all applicable media?	☐Yes ☐No
3. Do you have administrative safeguards (i.e., restricted, limited, monitored access) in place to prevent inappropriate use or disclosure of personal/medical information across all applicable media?	☐Yes ☐No
4a. Do you backup all professionally relevant information and data across all applicable media?	☐Yes ☐No
4b. If so, which systems do you use to backup this information?	

SECTION 19 – DISCLOSURE

Please answer the following questions relative to your professional history within the **last five years.** For all **"Yes"** responses please complete and follow the additional instructions: You are **REQUIRED** to provide: (1) a detailed explanation of your involvement, (2) the date the action was initiated, (3) the current status, including any final outcome, (4) amount of judgment/settlement or adverse decision, **AND** (5) a copy of any court order, consent order and findings, settlement agreement or other documentation regarding the current status or final resolution for each matter. If a matter is pending, include a letter from your attorney providing detailed information regarding current status of the matter and copies of any related documentation such as an indictment, statement of charges, summons, complaints, answers, etc.

Question	Response
1. Have you ever been convicted of a misdemeanor related to your professional functions?	☐Yes ☐No
2. Have you ever been charged or convicted of a felony in any state?	☐Yes ☐No
3. Have you ever been investigated by any professional or licensure board, professional association, private payor, state or federal regulatory agency, or other authority?	☐Yes ☐No
4. Has your clinical license, certification, DEA, CDS, or ability to practice in any jurisdiction ever been stipulated, denied, restricted, suspended, reduced, revoked, not renewed, placed on probation, or otherwise limited in any way by a licensing agency or other regulatory bodies?	☐Yes ☐No
5. Have you ever voluntarily relinquished your professional license, certification or other authority to practice for any reason, including as an alternative to disciplinary action?	☐Yes ☐No
6. Are you aware of any formal disciplinary or criminal charges pending against you?	☐Yes ☐No
7. Are there any current complaints against you filed with any licensing, certification, or other regulatory body?	☐Yes ☐No
8. Has it ever been determined that you have operated outside the recognized boundaries of your professional competencies?	☐Yes ☐No
9. Has your employment, hospital privileges, managed care organization or EAP participation, or other privileges or participation status ever been denied, restricted, suspended, reduced, revoked, not renewed, placed on probation, or otherwise limited in any way?	☐Yes ☐No
10. Have you ever been involuntarily terminated from professional employment or a hospital staff, or, terminated by a managed care organization, EAP or any other organization that granted you privileges or participation status?	☐Yes ☐No
11. Have you ever resigned with knowledge of an investigation about you by a professional employer, hospital staff, managed care organization, EAP or any other organization that granted you privileges or participation status?	☐Yes ☐No
12. Are you aware of any disciplinary actions that have been initiated against you by a professional employer, hospital staff, managed care organization, EAP or any other organization that granted you privileges or participation status?	☐Yes ☐No
13. Are you aware of any complaints against you filed with a professional employer, hospital staff, managed care organization, EAP or any other organization that granted you privileges or participation status?	☐Yes ☐No
14. Has a professional liability carrier ever denied, limited, not renewed, or canceled your coverage?	☐Yes ☐No

NETWORKSERVICES

15. Are you now or have you ever been sanctioned or excluded from federal, state or local government programs?	☐Yes ☐No
16. Have any malpractice suits, professional liability suits, arbitration or other proceedings ever been instituted against you?	☐Yes ☐No
SECTION 20 - ABILITY TO PERFORM ESSENTIAL FUNCTIONS	
1. Are you unable to perform the essential functions of a provider in your area of practice?	☐Yes ☐No
2. Do you require accommodations in order to perform the essential functions of a provider in your area of practice?	☐Yes ☐No
3. Are you currently engaged in the illegal use or abuse of drugs or controlled substances?	☐Yes ☐No
4. Do you have any reason to believe that you would pose a risk to the safety or wellbeing of your patients?	☐Yes ☐No

PLEASE USE THE SPACE BELOW TO EXPLAIN 'YES' ANSWERS TO ANY QUESTIONS IN SECTIONS 23, 24 OR 25: (ATTACH ADDENDUM IF NEEDED)

Question Number:	Explanation:	Documentation attached?
		☐Yes ☐No
		☐Yes ☐No
		☐Yes ☐No
		☐Yes ☐No

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<u>**AUTHORIZATION, ATTESTATION AND RELEASE**</u>

I hereby give permission to Network Advantage Services including its affiliates and the employees, contracted entities, agents, representatives or its authorized designee thereof to obtain information about my professional education, training, licensing, competence, ethics, character and other qualifications. I consent to the release of such information, whether in the form of transcripts, records, tapes, letters, photocopies/duplications of any of the forgoing, or verbal statements by hospital administrators, chiefs of clinical departments of hospitals in which I have served on staff, state licensing boards or regulatory bodies (by whatever name known in their respective jurisdictions), physicians clinics or other individuals or organizations who or which possess information about me. Such information may be released to the above named entity and its affiliates or to representatives of such entity and its affiliates.

I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation in, or with, the Entity.

I authorize my current and past professional liability carrier(s) to release the past five years of my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

I hereby release from liability and agree to hold harmless any person or entity who or which provides the above described information as authorized herein.

I hereby release from liability and agree to hold harmless all employees, agents, representatives and authorized designee of the above named entity and its affiliates for their acts performed and statements made in connection with obtaining, reviewing, and evaluating my credentials and qualifications. I further acknowledge my cooperation by consenting to the production of such information about me as a provider of services to their insurers and enrollees. The determination of whether I am qualified to serve as a provider of services is the reason such information is needed for the review and evaluation by the above-named organization and their representatives.

This application shall not be considered complete until query is made to and received from the contracted Sanction agent by Network Advantage Services.

In the event I am accepted for participation by Network Advantage Services, I hereby consent to the inspection of my patient records by Network Advantage Services relating to Network Advantage Services covered members as necessary for its peer review, utilization review, quality management and quality improvement processes and agree to be bound by the Network Advantage Services Agreement and Provider manual.

I attest that all information provided in this application and disclosure is true, correct and complete to the best of my knowledge and belief. I will notify Network Advantage within 10 days of any material changes to the application. I understand and agree that any material misstatement or omission in this application may constitute grounds for denial or revocation of participation. I acknowledge that I have read the foregoing Authorization, Attestation and Release.

I further agree that a photocopy of this document will serve as a duplicate original.

Print Name:_______________________________ Date: ______________________
(MM/DD/YYYY)

Applicant Signature:

Last 4 digits of SSN#:

Created: May 2010
Revised: September 2019