Ascension WI EAP Affiliate Application

Practice Information- Clinic/ Office

Clinic Name: _____

Clinic Address: _____

Billing Address: _____

Primary Phone Number: _____

Fax Number: _____

Email address of Clinic or Office Contact person _____

Clinic Tax ID: _____ Is office handicap accessible? Y or N

Does our Clinic/Counselor(s) have Liability Insurance? Y or N

Name of Liability Carrier _____ Policy Number _____

Effective date _____ Expires _____

$Limit per occurrence $Limit aggregate Session reimbursement rate $0.00

Please fill out below for each provider that will be seeing clients for us

Background information- Practitioner

First Name	Middle Name	Last Name
If different from clinic's, Tax ID / EIN/ SSN	Years in Practice	Gender M/F
Provider Credentials		
If different from clinic's, Phone	If different from clinic's, Fax	
Email		

Background information- Practitioner

First Name	Middle Name	Last Name
If different from clinic's, Tax ID / EIN/ SSN	Years in Practice	Gender M/F
Provider Credentials		
If different from clinic's, Phone	If different from clinic's, Fax	
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Email		

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Please copy these next 2 pages and have each provider answer, sign and return.

Disclosure Yes/ No

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 payer, state or federal regulatory agency or other authority? Yes No

4. Has your clinical license , certification or ability to practice in any jurisdiction ever been stipulated, denied, restricted, suspended, reduced, revoked, not renewed, placed on probation or limited in any way by a licensing agency or other regulatory body? Yes No

5. Have you ever voluntarily relinquished your license, certification or 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 you aware of any 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, 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 by an 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 that granted you privileges or participation status? Yes No

12. Are you aware of any disciplinary actions against you by a professional employer that granted you privileges or participation status? Yes No

13. Are you aware of any complaints against you filed with a professional employers who granted you privileges or participation status? Yes No

14. Are you now or have you ever been sanctioned or excluded from federal state or local government programs including but not limited to Medicare and Medicaid? Yes No

15. Have you ever been expelled from or disciplined by any professional organization or association not included in any other question? Yes No

16. Have any malpractice suits, professional liability suits or arbitration or other proceedings ever been instituted against you? Yes No

17. Has a professional liability carrier ever denied, limited, not renewed or cancelled your coverage? Yes No

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Professional Experience

Are you trained/ experienced in providing Critical Incident and Trauma Response Services? Yes No

If so, describe the training model._____

Do you meet the qualifications of a (SAP) Substance Abuse Professional under the Department of

Transportation regulations? Yes No

If so, explain your experience and include documentation of training and test completed._____

_____

Areas of counseling interest/expertise_____ _____

EAP Experience

I have experience providing Employee Assistance Counseling. Yes No

Total years of EAP experience _____

I am qualified to provide general assessments, short term solution focused counseling, and referrals. Yes No

I am experienced in identifying and resolving workplace problems that may be caused or exacerbated by an employee's personal or work life. Yes No

I am experienced in helping employees resolve conflict at work. Yes No

I have experience and understanding of dual client relationships. (Employee/ Employer) Yes No

I have knowledge and experience in providing assessments to employees who have tested positive for substance abuse. Yes No

Availability

Are you able to return phone calls within 24 hours? Yes No

Are you able to offer an appointment within 2 business days? Yes No

Are you able to offer an urgent appointment within the same day? Yes No

I certify that all information provided in this application is true and correct to the best of my knowledge and belief. I authorize Ascension WI EAP to verify my license, malpractice coverage, highest degree, as well as additional information included in this application, with all appropriate issuing organizations. I understand that filling out this application does not mean that I will be accepted in the Ascension WI EAP affiliate network.

Applicant Name_____

Applicant Signature_____ Date_____

Please return this printed application along with the following information

- Certificate of insurance and copy of license
- Completed W-9 form
- Clinic brochure and business card

To: Ascension WI EAP
1550 Midway Place
Menasha, WI 54952
Fax: 920-720-1091
eap@ascension.org