ESI EMPLOYEE ASSISTANCE GROUP

TotalCare EAP
Public Safety EAP
Educators' EAP
Higher Ed EAP
HealthCare EAP
Union AP

SERVICE PROVIDER APPLICATION FORM

55 Chamberlain Street Wellsville, NY 14895

☐Dr. ☐Mr. ☐Ms. ☐Mrs.	Date:
Name Organization/PC	Office Phone:
Practice Address:	Secondary:
Handicap Accessible ☐ No ☐ Yes	Mobile:
Second Location:	Fax No:
Handicap Accessible ☐ No ☐ Yes	Email:
Mailing Address:	Tax ID.
	NPI No.
License/Certifications Held	License No.

Optional, Voluntary and Not Required

The following information regarding sexual orientation, religious beliefs, and race/ethnic group is not used for purposes of denying an application for participation. Often clients will ask for a counselor who meets a specific preference within one of the following categories. If your application is approved, and you provide this information, your response will be entered into our database so that you can be identified for our use only 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 the basis for denying your application for participation.

☐ Female ☐ Male

☐ Christian ☐ Jewish ☐ Islam ☐ Non-Secular ☐ Other:_____

☐ Hispanic ☐ Caucasian ☐ Asian ☐ African American ☐ Native American

Are you willing to identify your military experience? ☐ Yes ☐ No, if so, are you a veteran? ☐ Yes ☐ No

Any other information that would help us place Members in your practice (e.g. experience with elderly, medical social work etc.…)? _____

☐ I do not wish to provide this information

Do you speak a second language? ☐ No ☐ Yes, please specify_____

Can you use sign language? ☐ No ☐ Yes

Type of Practice: ☐Corporation ☐Partnership ☐Sole Proprietorship ☐Telehealth/Video Only

Office setting: ☐Group Practice ☐Private Practice ☐Home Office ☐ Other_____

Major Health Insurance Panels (Please list all accepted i.e. BCBS, Aetna, Cigna Etc.)

Have you ever had a malpractice claim brought against you? ☐ **No** ☐ **Yes**

Has your professional license ever been limited, revoked or suspended? ☐ **No** ☐ **Yes**

Have you ever been disciplined by any professional association, organization, or professional society? ☐ **No** ☐ **Yes**

(If yes to any of the three previous questions, please attach documentation of final resolution.)

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Professional Clinical Concentration

☐ Individual Therapy ☐ Group Therapy ☐ Family Therapy ☐ Brief Therapy ☐ Telehealth/Video Only

Areas of Specialization

☐ Affective Disorders
☐ Marriage/Couples
☐ Family
☐ Children Less than 8
☐ Children Ages 8-13
☐ Children Ages 14-18
☐ Grief
☐ Phobias
☐ Christian Counseling
☐ Eating Disorders
☐ Anger Management
☐ LGBTQ
☐ Drug/Alcohol Evaluation
☐ Drug/Alcohol Treatment
☐ DOT Assessment/ SAP
☐ Fit for Duty
☐ Administrative Referrals
☐ CISD/CISM
☐ Trauma/PTSD
☐ Public Safety
☐ Military/Veteran
☐ EMDR

Other: _____

Days and Hours of availability: _____

Workplace Services

Are you interested in providing on-site services indicated below? (**Attach experience and/or training**) ☐ No ☐ Yes

Hours Available: _____ Preferred form of contact: ☐ Email ☐ Mobile ☐ Office

☐ Critical Incident Stress Debriefing ☐ Grief ☐ Public Safety ☐ Bank Robbery ☐ Trainings ☐ Health Fairs

Do you or your organization provide direct services to employers? ☐ No ☐ Yes, please specify_____

I authorize Employee Services to verify any and all information provided in this application for the purpose of determining my professional competence, character, ethical qualifications and consideration for acceptance.

I also authorize any person or organization named in this application to release relevant information to Employee Services for the purposes stated above.

I hereby certify that the information contained in the foregoing application is true and complete to the best of my knowledge and belief.

_____ _____

Applicant Signature Date

Any questions comments or concerns please reach us at 800-821-5040 Opt 7