EAP Affiliate Application

Be sure you meet requirements posted on the website prior to completing

PLEASE FILL OUT ALL FIELDS UNLESS OTHERWISE NOTED

BUSINESS INFORMATION

BUSINESS NAME: _____

PHYSICAL BUSINESS ADDRESS: _____

CITY: _____ STATE/PROVINCE: ____

ZIP/POSTAL CODE: _____ COUNTRY: United States

PHONE NUMBER FOR REFERRALS: (_____) _____-_____

FAX NUMBER FOR REFERRALS: (_____) _____-_____

IF MAILING/BILLING ADDRESS IS DIFFERENT FROM PHYSICAL, PLEASE SUBMIT DETAILS

IF ANY ADDITIONAL PRACTICE LOCATIONS, PLEASE SUBMIT DETAIL

THE FOLLOWING INFORMATION MAY BE USED FOR U.S. GOVERNMENT WORK & PROPOSALS

IS THIS BUSINESS OWNED BY A WOMAN? No

IS THIS BUSINESS OWNED BY A MEMBER OF A MINORITY GROUP? No

IS THIS BUSINESS OWNED BY A U.S. MILITARY VETERAN? No

IS THIS BUSINESS OWNED BY A SERVICE-DISABLED U.S. MILITARY VETERAN? No

IS THIS BUSINESS IDENTIFIED AS A SMALL DISADVANTAGED BUSINESS? No

IS THIS A HUBzone BUSINESS? No

IS THIS BUSINESS A MEMBER OF THE ALLIANCE FOR CHILDREN AND FAMILIES? No

IF NO, IS YOUR AGENCY A 501c3 HUMAN SERVICES NON PROFIT? No

EAP COORDINATOR/MAIN CONTACT PERSON INFORMATION

EAP COORDINATOR/MAIN CONTACT NAME: _____

EAP COORDINATOR DIRECT PHONE NUMBER: (_____) _____-_____

EMAIL ADDRESS FOR BUSINESS COMMUNICATION: _____

CELL PHONE: NOT GIVEN TO CLIENTS ONLY USED FOR EMERGENCIES (OFFICE PHONE OUTAGE, ETC): (_____) _____-_____

CLINICIAN INFORMATION

CLINICIAN FIRST NAME: _____

CLINICIAN LAST NAME: _____

GENDER: Female

RACE (OPTIONAL): _____

CAQH PROVIDER ID#: _____ (REQUIRED FOR PROVIDERS IN THE UNITED STATES)

CLINICIAN CELL PHONE NUMBER: (_____) _____-_____

EMAIL ADDRESS FOR BUSINESS COMMUNICATION: _____

IF YOU PRACTICE AT MULTIPLE LOCATIONS OF THIS CLINIC, PLEASE SUBMIT DETAILS.

DO YOU OFFER EVENING OR WEEKEND APPOINTMENTS? Both (REQUIRED)

IN WHICH OTHER LANGUAGE(S) CAN YOU CONDUCT SESSIONS? _____

DO YOU SEE CLIENTS IN YOUR HOME? No

**** PLEASE SUBMIT A CURRENT COPY OF YOUR RESUME HIGHLIGHTING YOUR EAP EXPERIENCE – YEARS OF EXPERIENCE AND NETWORKS THAT YOU'VE WORKED WITH. ****

PLEASE INDICATE ANY AREAS OF SPECIALTY YOU HAVE:

- ☐ AFRICAN AMERICAN
- ☐ ASIAN
- ☐ HISPANIC
- ☐ LGBT
- ☐ OTHER CULTURAL OR ETHNIC SPECIALTY (SPECIFY)
- ☐ VETERAN/MILITARY
- ☐ SUBSTANCE ABUSE

☐ GRIEF/LOSS

☐ CHILD/ADOLESCENT/PARENTING

☐ DOMESTIC ABUSE

☐ COUPLES

☐ CISD

☐ SEXUAL ABUSE

☐ EMDR

☐ GENERAL FAITH BASED COUNSELING

☐ RELIGION-SPECIFIC FAITH BASED COUNSELING (IDENTIFY) _____

☐ WORKING WITH EMPLOYER-MANDATED REFERRALS?

DO YOU HAVE EXPERIENCE

PROVIDING EAP ORIENTATIONS/TRAININGS? No

PROVIDING CRITICAL INCIDENT STRESS DEBRIEFINGS (ON-SITE)? No

TREATING CLIENTS WITH SUBSTANCE ABUSE/DEPENDENCE? No

TO RECEIVE REFERRALS FOR THE ABOVE SPECIAL SERVICES, PLEASE SUBMIT THE APPROPRIATE SPECIALTY APPLICATION FOUND ON OUR WEBSITE.

IF YOU BELONG TO ANY HEALTH INSURANCE PANELS, PLEASE SUBMIT A LIST.

AGREEMENT

MY SIGNATURE BELOW OR MY ELECTRONIC SUBMISSION CERTIFIES THE FOLLOWING:

- THAT I HAVE PROVIDED COMPLETE, TRUE AND CORRECT INFORMATION AND THAT I MEET AND WILL COMPLY WITH THE REQUIREMENTS OF THIS POSITION.
- I WILL NOT DISCLOSE ANY CLIENT-RELATED INFORMATION TO ANYONE OTHER THAN FEI.

ADDITIONAL INFORMATION IS AVAILABLE AT http://www.feinet.com/provider

SIGNATURE: _____

DATE: _____

Document Checklist

- ☐ Current resume with EAP experience (years and networks) highlighted
- ☐ List of Insurance Panels you belong to
- ☐ A current copy of your professional liability coverage if not posted on CAQH

Attach the following if applicable, on separate sheet(s)

- ☐ Mailing/Billing Address (if different from physical business address)
- ☐ Additional Office Locations – The Business in General (please include: physical address, phone and fax numbers (if different from referral numbers) – if applicable
- ☐ Clinician's Additional Office Locations – (please include: Physical address and clinician's direct phone number(s) if applicable)

If you practice in a country outside the United States, please include:

- ☐ A current copy of your professional license/certification

IMPORTANT!

Please be sure each document submitted clearly states provider and/or clinic name.

Required documents must be received within 7 days, or the application cannot be processed.

Email: network@feinet.com

Secure Fax: (414) 359-6519

Submit via email