WellSpan EAP
P.O. Box 1827
York, PA 17405-1827
Phone: 866-227-6527
Fax: 717-851-4493

Affiliate Provider Application

Instructions and Check Sheet

Enclosed is an Affiliate Provider Application for your consideration as an Employee Assistance Program Affiliate Provider for *WellSpan Employee Assistance Program*.

The following documents are required to complete your application:

- ☐ 1. A completed application.
- ☐ 2. A signed Release of Information form. (Bottom of page 6)
- ☐ 3. Copy of current licenses and certifications.
- ☐ 4. Copy of a current Certificate of Malpractice Insurance.
- ☐ 5. Curriculum Vitae *(Please explain any gaps in work history).*
- ☐ 6. Diploma *(highest academic degree).*
- ☐ 7. A list of insurances with whom you are currently credentialed.
- ☐ 8. Completion of payment preference process (Virtual Credit Card, Electronic Funds Transfer, or Paper Check)

If you have any questions or need further clarification regarding this application, please call Mike Diller, Psy.D., Director, WellSpan EAP at 717-812-5542.

Mail the completed packet of information to:

WellSpan Employee Assistance Program
Attn: Client Services Department
P.O. Box 1827
York, PA 17405-1827

WELLSPAN EAP
AFFILIATE PROVIDER APPLICATION

A. General Information

☐ Dr. ☐ Mr.
☐ Mrs. ☐ Ms. ____
Last *First* *Middle Initial*

____/____/____ Date of Birth

Male / Female (Circle One)

____________________ NPI Number

____________________ Group NPI Number

B. Office Information

Primary Location:

Group Name ____

Address ____

____
City *State* *County* *Zip Code*

Phone Number __________________ Fax Number __________________

Emergency Contact Number ____

E-mail Address ____

Tax ID # & Name listed with the IRS: ____

Primary Contact (Name/Title) ____

Phone Number __________________ E-mail Address__________________

Secondary Location:

Group Name ____

Address ____

____
City *State* *County* *Zip Code*

Phone Number __________________ Fax Number __________________

Emergency Contact Number ____

E-mail Address ____

Tax ID # & Name listed with the IRS: ____

Primary Contact (Name/Title) ____

Phone Number __________________ E-mail Address__________________

**** Please list any additional offices on a separate sheet of paper.**

Reimbursement Information: (if different than primary contact above)
Attention________________________________

Address ____

____
City *State* *County* *Zip Code*

Phone Number _______________________ Fax Number _________________________

Languages: (Please check all languages that are used in your office.)

☐ Arabic ☐ Chinese ☐ French

☐ German ☐ Hindi ☐ Italian

☐ Japanese ☐ Korean ☐ Spanish

☐ Sign Language ☐ Braille ☐ Other ___________________________

Please indicate who in your office can utilize the above languages and how:

Provider _________________________________ Written ☐ Spoken ☐

Provider _________________________________ Written ☐ Spoken ☐

Staff ____________________________________ Written ☐ Spoken ☐

Staff ___________________________________ Written ☐ Spoken ☐

Total number of staff or partners with:

Doctorate _________ Masters ___________ Bachelors __________

Certified Addictions Counselors ______ Certified Employee Assistance Professionals _________

C. Personal Information:

Education and Training
Graduate School ____

City/State ____

Degree _______________________ Graduation Date (Mo/Yr) ____________________

Undergraduate School ____

City/State ____

Degree _______________________ Graduation Date (Mo/Yr) ____________________

Personal Information (continued)**:**

CERTIFICATIONS / LICENSES:

State __________ License # ___________________ Issue Date __________ Expiration Date _______________

State __________ Certificate # ________________ Issue Date __________ Expiration Date _____________

State __________ Certificate # ________________ Issue Date __________ Expiration Date _____________

LIABILITY INSURANCE INFORMATION:

Current Carrier ____

Address ____

City/State/Zipcode ____

Policy Number ________________________________ Group / Individual Policy (Circle One)

Coverage Limits $______________________(occurrence) $____________________(aggregate)

Date Coverage First Began _____________________ Expiration Date _________________

Affiliated Hospitals / Inpatient Treatment Facilities:

1. Name/Type ____

City/State _____________________________ Phone number _________________________

2. Name/Type ____

City/State _____________________________ Phone number _________________________

Please indicate any specialties from the list below. The specialties you indicate below will be used on the WellSpan EAP website search tool. This search tool will list your name and contact information, by area, under that specific specialty.

Populations served (check all that apply):

☐ Children (0-12)

☐ Adolescents (13-17)

☐ Adults (18-64)

☐ Geriatrics (65 and older)

Specialties (check all that apply):

☐ Abuse Issues (Physical/Mental/Emotional/Sexual/ Neglect)

☐ Addictions

☐ ADHD/ADD

☐ Adjustment Disorders

☐ Adolescent Therapy

☐ Alcohol/Drugs

☐ Alzheimer's / Dementia

☐ Anger Management

☐ Anxiety Disorders

☐ Autism

☐ Bariatric Surgery Evaluations

☐ Bereavement / Grief Counseling

☐ Biofeedback

☐ Bipolar Disorder

☐ Bisexual Issues

☐ Career

☐ Child Therapy

☐ Childhood Disruptive Disorders

☐ Christian Counseling

☐ Chronic Mental Illness

☐ Cognitive Behavioral Therapy

☐ Conduct Disorders

☐ Critical Incident Responder

☐ Depression

☐ Developmental Disorders

☐ DBT (Dialectical Behavioral Therapy)

☐ Dissociative Disorders

☐ Domestic Violence

☐ Dual Diagnosis

☐ EAP Training

☐ Eating Disorders

☐ Eldercare

☐ Elective/Selective Mutism

☐ EMDR (Eye Movement Desensitization and Reprocessing)

☐ Family Therapy

☐ Financial

☐ Fire-Setting Behaviors

☐ Foster Care/Adoption

☐ Functional Behavioral Assessment

☐ Gambling Addiction

☐ Gay and Lesbian

☐ Gender Identity

☐ Geriatrics

☐ Health Counseling

☐ HIV/AIDS

☐ Hypnosis

☐ LGBTQ

☐ Life Coaching

☐ Marital and Couples Therapy

☐ Men's Issues

☐ Mood Disorders

☐ Multi-Cultural Issues

☐ Music Therapy

☐ OCD (Obsessive Compulsive Disorder)

☐ ODD (Oppositional Defiant Disorder)

☐ Pain Management

☐ Panic

☐ Parenting

☐ Personality Disorders

☐ Phobias

☐ Play Therapy

☐ Postpartum Depression

☐ Psychodynamic Psychotherapy

☐ Psychosis

☐ PTSD (Post-Traumatic Stress Disorder)

☐ Relationship Counseling

☐ Sand Play Therapy

☐ SAP/DOT Evaluation

☐ Schizophrenia

☐ School Related Problems

☐ Sex Therapy

☐ Sexual Addictions

☐ Sexual Disorders

☐ Sexual Offenders

☐ Sexual Orientation

☐ Sleep Disorders

☐ Spiritual Counseling

☐ Stress Management

☐ Substance Abuse

☐ Suicide

☐ Thanatology, End of Life Issues

☐ Transgender

☐ Trauma

☐ Victim of Violence

☐ Women's Issues

☐ Work Issues

ATTESTATION:

Please check the appropriate box, if "Yes" is answered for any questions please explain on a separate sheet of paper.

1.	Do you currently have any physical, mental, or emotional conditions which may impair your ability to render professional services?	☐ Yes	☐ No
2.	Has your professional liability insurance coverage ever been denied, canceled, or non-renewed or initially refused upon application?	☐ Yes	☐ No
3.	Have you ever been named in any malpractice action? (If yes, please attach a copy of the complaint filed stating the allegations).	☐ Yes	☐ No
4.	Has your medical or professional license or certification in any state ever been revoked, suspended, placed on probation, or limited?	☐ Yes	☐ No
5.	Has your membership in any professional society or association ever been canceled, revoked, or censured?	☐ Yes	☐ No
6.	Have you ever been convicted of a felony or involved in charges relating to moral or ethical turpitude? (Do not report misdemeanors)	☐ Yes	☐ No

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WELLSPAN EAP

Release of Information

I hereby certify that all information contained in this application are correct and complete. I further understand that any information entered into this form which subsequently is found to be false could result in termination of any contract I may enter into with *WellSpan Employee Assistance Program*.

I hereby grant permission and consent for *WellSpan Employee Assistance Program*, and/or its designee, to obtain and verify information contained on my application and consent to the release by the person, organization, or other entity to *WellSpan Employee Assistance Program* and/or its designee, of all information that may be reasonably relevant to an evaluation of my professional competence, ability to render services, character, and moral and ethical qualifications, and agree to hold harmless any such person or organization or other entity from any cause or action based on the release of such information to *WellSpan Employee Assistance Program* and/or its designee.

_______________________________________ _____________________

Signature Date

____

Printed Name