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.

If you have any questions or need further clarification regarding this application, please call Wellspan EAP Client Services Department at 1-866-227-6527 or email wellspanEAP@wellspan.org

Mail, email or fax the completed packet of information to:

WellSpan Employee Assistance Program
Attn: Client Services Department
P.O. Box 1827
York, PA 17405-1827
Email: wellspaneap@wellspan.org
Fax: 717-851-4493

WELLSPAN EAP
AFFILIATE PROVIDER APPLICATION

A. General Information

☐ Dr. ☐ Mr.
☐ Mrs. ☐ Ms. _____ _____
Last First Middle Initial Title (i.e. PsyD, LCSW, LPC)

_____ ☐ Male ☐ Female _____ _____
Date of Birth 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 _____

Provider's Effective Date with Practice _____

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)
☐ 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)
☐ Faith Based Counseling
Name of Faith:
_____
☐ Family Therapy
☐ Financial
☐ Fire-Setting Behaviors
☐ First Responder Issues
☐ Foster Care/Adoption
☐ Functional Behavioral Assessment
☐ Gambling Addiction
☐ Gay and Lesbian
☐ Gender Identity
☐ Geriatrics
☐ Health Counseling
☐ HIV/AIDS
☐ Hypnosis
☐ Infertility/Pregnancy Loss
☐ 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
☐ Stress Management
☐ Substance Abuse
☐ Suicide
☐ Teletherapy
☐ 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? ☐ Yes ☐ No
(If yes, please attach a copy of the complaint filed stating the allegations).

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