



Employee Support Network Affiliate Provider Application / Referral Form

Date: _____

Background Information:

First Name, Last Name: _____ Social Security Number: _____

National Provider ID# _____ Years in Practice: _____ Date of Birth: _____

License Class (must be for Independent Practice)

___MFT ___NP ___Psychiatrist ___Psychologist ___SW ___LMHC Other_____

License type as indicated on the state license: _____ License Number _____ LIC State_____

Are you applying to receive referrals? Y/N

Are you applying to ESN to become an affiliate provider to perform employee assistance assessments? Y/N

Office Information:

Primary Phone # _____ Primary Secure Fax# _____ 24/7 Access or Answering Service _____

Secure Email Address _____ Secure TTY/TTD# _____

Tax ID if applicable for this practice location: _____ Office is handicap accessible? Y/N

Billing/Mailing address: _____

General range of hours you are available at this address:

Monday _____ to _____ Tuesday _____ to _____ Wednesday _____ to _____ Thursday _____ to _____

Friday _____ to _____ Saturday _____ to _____ Sunday _____ to _____

This office is located in a Home _____ Office _____ Religious institution _____

Please explain how confidentiality is maintained if this office is in a home or religious institution:



Liability Insurance Information:

Name of Liability Carrier: _____ Policy Number: _____

Effective Date: _____ Expiration Date: _____ Limit per Occurrence: _____

Limit Aggregate: _____ Please attach a copy of the current policy.

Disclosure:

Please answer YES or NO to the following questions, if you answer YES to any questions, please attach a detailed explanation.

1. Have you ever been convicted of a misdemeanor related to your professional functions? _____
2. Have you ever been charged or convicted of a felony in any state? _____
3. Have you ever been investigated by any professional agency or licensure board, professional association, private payor, state or federal agency, or other authority? _____
4. Has your clinical license, certification, or ability to practice in any jurisdiction ever been stipulated Denied, restricted, reduced, revoked, not renewed, placed on probation, or otherwise limited in any way by a licensing agency or any other licensing body? _____
5. Have you ever voluntarily relinquished your professional license, certification or other authority to practice for any reason, including as an alternative to disciplinary actions? _____
6. Are you aware of any formal disciplinary action or criminal charges pending against you? _____
7. Are you aware of any complaints against you filed with any licensing, certification, or other regulatory body? _____
8. Has it ever been determined that you practiced outside of your professional competencies? _____
9. Are you aware of any disciplinary actions that have been initiated against you by a professional Employer, hospital staff, managed care organization, EAP or any other organization that granted you privileges or participation status? _____
10. Has a professional liability carrier ever denied, limited, not renewed or canceled your coverage? _____

Training and Qualifications:

Do you have formal training in alcohol and substance abuse? Y/N List credentials _____

Please describe _____

Are you a qualified Substance Abuse Professional (SAP) under the Department of Transportation?

Do you have formal training in trauma response services? Please describe _____



Employee Support Network
EAP COUNSELING & REFERRAL ASSISTANCE

Do you have experience providing EAP training? Yes ___ No ___ If yes, please describe the type of training delivered and years of experience _____

EAP Experience:

Do you have experience providing EAP counseling? Y/N If yes, how many years? _____

Do you have experience with short-term solution focused counseling? Y/N

Please indicate below if you are qualified to provide counseling in any of the following areas:

Mental Health _____

Substance Abuse _____

Relationships/Family _____

Children _____

Workplace Conflict _____

Please list EAP's for which you are currently providing services: _____

After providing an EAP assessment, you may need to make a referral for the client. Are you comfortable making a referral that may include; contacting the insurance company to locate an in-network provider, interviewing referral options as needed, referring the client to a specific provider and contacting the provider to pass along assessment information? Y/N

Are you skillful in providing substance abuse assessments to determine what level of care the client may need to be referred to? Y/N

Do you have experience providing services to clients that are mandated through their workplace? Y/N

Do you have experience and understanding of dual client relationships where one is simultaneously serving the client, the client company, and the payer of services? Y/N

Additional Practice Information: Please indicate treatment specialties:

ACOA Codependency _____

ADD/ADHD _____

Adjustment disorders _____

Adoption _____

Anger Management _____

Anxiety _____

Children under 6 _____

Children Under 12 _____

Adolescents _____



Employee Support Network

EAP COUNSELING & REFERRAL ASSISTANCE

Career counseling ___

Couples/Marital ___

Depression ___

Domestic violence ___

Eating Disorders ___

Executive Coaching ___

Family ___

Fertility ___

Gambling ___

Grief/Loss ___

Mediation ___

Medical issues ___

Mood Disorders ___

OCD ___

Parenting ___

Perpetrators ___

PTSD ___

Psychological testing ___

Personality disorders ___

Sexual abuse/Rape ___

Sexual disorders ___

Stress Management ___

Sleep Disorders ___

Smoking cessation ___

Trauma/Abuse ___

Womens' issues ___

Other _____

Insurance Panel Information:

Please indicate which of the following panels you participate in:

Aetna/US ___

Humana ___

Anthem BC / BS ___

Magellan ___

APS ___

Medicaid ___

CIGNA ___

Medicare ___

Empire BC/BS ___

MHN ___

First Health ___

My Great West ___

Guardian ___

Multi-Plan ___

Health Net ___

Oxford ___

HIP ___

United Behavioral Health ___

Horizon ___

Value Options ___

Please indicate Union Plans: _____

State Plans: _____

Languages spoken other than English: _____



Employee Support Network

EAP COUNSELING & REFERRAL ASSISTANCE

I certify that all information provided in this application is true and correct to the best of my knowledge. I authorize Employee Support Network to verify my license, malpractice coverage and 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 imply acceptance into the Employee Support Network, LLC system.

Date:

Applicant Name (Please Print):

Applicant Signature:

Please include the following information along with this application:

- Current resume/curriculum vitae (c.v.)
- Certificate of Insurance and copy of license
- Clinic brochure, website address, and /or business card

Thank you for filling out this application, please mail it to :

Provider Relations
Employee Support Network, LLC
150 Motor Parkway, Ste #LL40
Hauppauge, NY 11788

Thank you for your interest in Employee Support Network.