EAP Counselor Application

Please attach:

1. Current VITAE
2. Face sheet for liability insurance
3. Copy of license
4. Copy of CEAP certification
5. Completed W-9

Date of application: _____ DOB: _____

Name: _____
Last First MI

Name of group or clinic_____

Social Security #_____ TAX ID # _____

Make checks payable to:_____
(name must correspond with Tax ID or SS#)

Mail checks to:_____

Phone number:_____ E-Mail_____

State license #_____ Issue Date_____ Exp.Date_____

CEAP #_____ From_____ Through_____

Other licenses/ certifications: (CAP, SAP, CAAP, etc.)

License/Cert. #_____ Issue Date_____ Exp. Date_____

License/Cert. #_____ Issue Date_____ Exp. Date_____

License/Cert. #_____ Issue Date_____ Exp. Date_____

Professional Liability Insurance

Insurance carrier_____

Policy #_____ Coverage dates from_____to _____

Coverage limits: Per occurrence_____ Aggregate_____

Education:

Type of bachelor's degree _____ College_____

College location _____ Year of graduation_____

Type of master's degree _____ College_____

College location_____ Year of graduation_____

Post graduate degree_____ College _____

College location _____ Year of graduation_____

Do you speak a language other than English? If yes, please specify_____

Office Location

Primary Office Address	Secondary Office Address
_____	_____
_____	_____
_____	_____
( ) _____ Telephone	( ) _____ Telephone
( ) _____ FAX	( ) _____ FAX
E- Mail _____	E-Mail_____

Hours of Operation and Location

Monday _____ Tuesday _____

Wednesday _____ Thursday _____

Friday _____ Saturday _____

Are you able to schedule an initial EAP appointment within three working days of our call to you? _____

Do you have a 24-hour answering service? _____

What is your procedure in handling urgent or emergent problems?

_____

_____

What percentage of your clients completes therapy in less than six sessions?

1-5%_____ 6-10%_____ 11-20%_____ 21% or more_____

Therapeutic orientation (please circle)

□	Biological/pharmacological	□	Cognitive/behavioral
□	Family systems	□	Psychodynamic/insight oriented
□	Solution-focused	□	Spiritual/faith based

Other(specify)_____

Employee Services
Please check the three (3) areas which you have expertise.

- □ Confidential and timely problem identification/assessment services for employees/dependents
- □ Short-term intervention
- □ Assistance to employees regarding ways to improve job performance
- □ Supervisory Referrals (job performance is suffering due to absences, etc).
- □ Mandatory Referrals (ex. positive drug screen)
- □ Information and education to employees/dependents (Lunch and Learns)
- □ Psychological First Aid

Disciplinary Actions

Have any of the following ever been, or are currently in the process of being denied, revoked, suspended, reduced, limited, placed on probation, not renewed, investigated, or voluntarily relinquished? **OR** Have you ever withdrawn or failed to proceed with an application for any of the following? **If yes, please provide a full explanation on a separate sheet of paper.**

License in any state yes ____ no ____

Other health -related professional registration/license yes ____ no ____

Malpractice suit yes ____ no ____

Conviction of a felony, moral or ethical crime yes ____ no ____

Subject to discipline by any licensing authority or professional organization yes ____ no ____

Do you have ownership interest in any medical facility or joint ownership of any medical services or equipment with a facility to which you might refer patients? yes ____ no ___

Have you ever been convicted of or pleaded no contest to any criminal charges (other than motor vehicle violations) brought against you? yes ____ no___

Have you ever been convicted of or pleaded no contest to a drug or alcohol related offense? yes ___ no ___

Do you currently, or have you ever had a physical or mental health condition (including alcohol/substance abuse) that currently affects, ever affected, or could reasonably affect your ability to perform professional or medical practice duties appropriately? yes ___ no ___

Do you presently have a physical or behavioral health condition, including alcohol or substance abuse, that affects or that may reasonably be expected to progress within the next two years to the point of affecting your ability to practice your profession or place your clients at increased risk? yes___ no ___

Have you ever had any such condition in the past that is now resolved without the need for continuing therapy or medication? yes___ no ___

Are you currently or at any time during the last ten years been hospitalized or received any other type of institutional care for any such condition/problem? yes___ no ___

Other Professional Activities

Please list any professional organizations or committee memberships, which you have participated in the last five- (5) years.

_____
Professional Organization/Committee

_____
Professional Organization/Committee

_____
Professional Organization/Committee

References

Please list three professional colleagues experienced with your professional work that we may contact for references:

_____ _____
Name Title

_____ _____
Company Phone

_____ _____
Name Title

_____ _____
Company Phone

_____ _____
Name Title

_____ _____
Company Phone

Specific Waiver and Consent for Credentialing, Utilization Information and Data

I, the undersigned, (hereinafter referred to as "Participating Provider") apply to become a member of the provider network of MehraVista Health, LLC.

I, fully understand and agree, that if there is any significant misrepresentation, misstatement, or omission of any information provided by me to MehraVista Health whether intentional or not, shall constitute cause for an automatic termination of my membership.
I request that MehraVista Health process my application with regards to credentialing as a Participating Provider of MehraVista Health. As a condition of application and membership, I agree that to the fullest extent permitted by law, I extend immunity to release and hold harmless MehraVista Health, its successors and assigns together with any of their employees, agents, independent contractors and physicians from liability relating to the sharing of information concerning my credentials to become a Participating Provider of MehraVista Health, together with all organizations or persons participating in obtaining or providing information relative to my application and/or membership in the MehraVista Health network, for any communications, reports, records, statements, documents, recommendations or disclosures involving my credentials to become and/or remain a Participating Provider of MehraVista Health.

I recognize that this release and hold harmless agreement shall have continuing effect, such that any information which is subsequently developed, or any decision subsequently rendered by MehraVista Health which affects, restricts, or terminates my application or membership to the MehraVista Health network shall also be subject to release, and to immunity, and held harmless by me, my heirs and any assigns.

I the undersigned EAP Counselor also agree that MehraVista Health may obtain utilization and/or cost data about MehraVista Health employees/dependents referred to my practice. I understand that the above mentioned data may be reviewed by insurance companies, and accreditation organizations considering or contracting with MehraVista Health, by the medical/clinical staff or reviewers of MehraVista Health and by MehraVista Health, itself. In addition, I authorize that this data may be obtained and provided from other sources.

Furthermore, I agree to provide face-to- face services for which I have been contracted, and may not delegate such services to any other practitioner whether a participating provider or not with MehraVista Health.

I grant this permission continuously to the above mentioned party, beginning with the date of submission of my application to become a Participating Provider of the MehraVista Health network for as long as I am a member of the MehraVista Health network.

APPLICANT SIGNATURE _____ Date_____

Please print name_____

ATTENTION: PROFESSIONAL LIABILITY INSURACE CARRIER

_____

_____

_____

ADDRESS TO NOTIFY: MehraVista Health, LLC
32196 US Highway 19 N. Suite B
Palm Harbor, Fl. 34684

Please consider this letter your instruction to authorization to notify MehraVista Health if there should be any change or lapse in my medical malpractice insurance.

_____ _____
Signature Date

_____
Print or type name