

Alliance Work Partners
2525 Wallingwood Drive
Building 5
Austin, TX 78746-6900

Dear Prospective Affiliate:

We appreciate your interest in joining our clinical network. Please fill out the following application as thoroughly as possible. The more detailed you are in your description of your clinical expertise, the better our intake and referral staff can match the clients that we refer to you on an ongoing basis.

Affiliates of AWP are responsible for short-term, solution-focused counseling on a per problem basis. **We require providers to have a minimum of three years of post-license experience in direct counseling.** Due to the nature of our contracts with our customers, counseling interns do not qualify as EAP counselors. Our providers typically hold LPC, LMFT, LCSW licenses, equivalent masters level licenses, and PhDs. Please let us know of any additional certifications or licenses you hold, as we may have opportunities to contract for CISD, Training, SAP services and more.

Please mail your application to the above address to my attention, or fax it to 866-358-7745. You may also scan your application and the required documents and email to VTURULLOLS@ALLIANCEWP.COM

Please allow several weeks for receipt and processing of your application. If you have a client waiting on your acceptance into the network, please contact me directly to expedite the process. Feel free to contact me if you have any questions about the application.

Sincerely,

Valerie Turullols
Clinical Network Director
1-800-522-0550
Fax: 866-358-7745

HIPAA

Custodian of Records: Affiliate agrees to maintain and store the records of AWP clients with whom the affiliate has had contact. Records shall be and remain the property of affiliate. Affiliate agrees client records shall comply with applicable Federal, State and HIPAA standards and client records shall be sent to AWP upon request for auditing purposes.

CERTIFICATION

I certify that the information contained herein is correct and complete. I understand that significant misrepresentations or omissions from this application constitute cause for denial or dismissal from AWP's Employee Assistance Program Affiliate Network, now or in the future.

By applying for participation in AWP's Employee Assistance Program Affiliate Network, I hereby authorize AWP and its representatives to consult with individuals, institutions and professional organizations with which I have been associated, and with others including past and present malpractice carriers, who may have information bearing on my professional competence.

Signature of applicant

Date

CLINICAL PROVIDER APPLICATION

Last Name First Name Middle Initial

Social Security # or Tax ID #

NPI # _____

If you are working for an agency (not an individual practitioner)

Group/Agency Name Tax ID #

PRIMARY BUSINESS ADDRESS (LOCATION WE WILL GIVE TO CLIENTS)

Street Address Suite

City County State Zip

Office Telephone Fax Number

Cell Phone (*will not be given to clients*) Home Phone (*will not be given to clients*)

Email Address Website (if applicable)

IS BILLING ADDRESS SAME AS OFFICE ADDRESS? Yes No

If no, please provide billing address below

Street Address City State Zip

PROVIDER INFORMATION

State of Licensure Type of Licensure Date First Issued Expiration Date

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Do you have at least 3 years post license experience? Yes No

Yes No Do you have confidential voicemail?

Yes No Is your office located in a home?

Yes No Is your office located in a church?

Yes No Is your office wheelchair accessible (ADA compliant)?

Yes No Do you have evening hours?

Yes No Do you have weekend hours?

Gender (optional) _____ Ethnicity (optional) _____

What are your typical office hours?

Please list any language other than English in which you are fluent:

What cities, towns or counties does your practice service?

What part of the city is your practice located? (ex. *Northeast, downtown, or near landmark*)

Please indicate a rough percentage of how often you work with the following:

Adults: _____ Children: _____ Adolescents: _____ Couples: _____

Are you skilled in making substance abuse assessments and treatment recommendations? Yes No

Do you administer the SASSI or another substance abuse screening instrument? Yes No

Please check the topics you feel comfortable working on with clients:

- | | |
|--|---|
| <input type="checkbox"/> D0 Drug and Alcohol - General | <input type="checkbox"/> D2 Drug and Alcohol - Assessment |
| <input type="checkbox"/> F1 Abortion | <input type="checkbox"/> F24 Crime Victims |
| <input type="checkbox"/> F2 ACOA – COA | <input type="checkbox"/> F25 Deaf – Hearing Impaired |
| <input type="checkbox"/> F4 Addictions | <input type="checkbox"/> F26 Depression |
| <input type="checkbox"/> F5 Adjustment Disorders | <input type="checkbox"/> F27 Developmental Issues |
| <input type="checkbox"/> F6 Adolescents | <input type="checkbox"/> F28 Divorce |
| <input type="checkbox"/> F8 AIDS / HIV | <input type="checkbox"/> F29 Eating Disorders |
| <input type="checkbox"/> F9 Anger | <input type="checkbox"/> F32 Family |
| <input type="checkbox"/> F10 Anxiety | <input type="checkbox"/> F33 Family Violence |
| <input type="checkbox"/> F12 Assertiveness | <input type="checkbox"/> F34 Gay / Lesbian |
| <input type="checkbox"/> F14 Attention Disorders | <input type="checkbox"/> F35 Grief & Loss |
| <input type="checkbox"/> F15 Bilingual Services | <input type="checkbox"/> F37 Smoking Cessation |
| <input type="checkbox"/> F17 Blind - Visually Impaired | <input type="checkbox"/> F38 Homicide |
| <input type="checkbox"/> F18 Chemical Dep Aftercare | <input type="checkbox"/> F40 Illness Issues |
| <input type="checkbox"/> F19 Children | <input type="checkbox"/> F41 Life Transitions |
| <input type="checkbox"/> F20 Children of Divorce | <input type="checkbox"/> F42 Marital - Couples |
| <input type="checkbox"/> F21 Codependency | <input type="checkbox"/> F43 Men's Issues |
| <input type="checkbox"/> F22 Communication Issues | <input type="checkbox"/> F44 Mentally Disabled |
| <input type="checkbox"/> F23 Compulsions | <input type="checkbox"/> F46 Nutritional |
| | <input type="checkbox"/> F47 Pain Management |
| | <input type="checkbox"/> F48 Parenting |
| | <input type="checkbox"/> F49 Phobias |
| | <input type="checkbox"/> F50 Physically Disabled |
| | <input type="checkbox"/> F51 Play Therapy |
| | <input type="checkbox"/> F52 PTSD |
| | <input type="checkbox"/> F53 Relationships |
| | <input type="checkbox"/> F54 Sexual Abuse |
| | <input type="checkbox"/> F55 Sexual Dysfunction |
| | <input type="checkbox"/> F57 Spiritual - Christian |
| | <input type="checkbox"/> F58 Step-Families |
| | <input type="checkbox"/> F59 Stress-Burnout |
| | <input type="checkbox"/> F61 Suicide |
| | <input type="checkbox"/> F63 Women's Issues |
| | <input type="checkbox"/> F64 Workplace Issue |

List issues or populations with which you are least comfortable:

Please list any insurance panels you are on. Attach additional sheet if necessary:

In the near future, we may require affiliates to enroll in direct deposit to receive payments. We will provide technical assistance as needed. Are you willing to enroll?

- Yes No Maybe, need more information

PLEASE CHECK ANY ADDITIONAL CERTIFICATIONS YOU HOLD:

SAP (Substance Abuse Professional, certified to work with DOT clients)

If yes, please provide a certificate of completion of SAP training and required continuing education units.

HUB (Historically Underutilized Business)

If yes, provide your Certification Number _____

M/WBE (Women/Minority-Owned Business Enterprise)

If yes, provide your Certification Number _____

Are you interested in information on HUB/MBE/WBE certification Yes No

Yes No **Are you trained to provide Critical Incident Stress Debriefings?**

If yes, please provide a certificate of completion of CISD / CISM training

Yes No **Do you have training in Mediation?** *If yes, attach documentation.*

Periodically, our client companies request that we present trainings on-site at their facilities. These trainings have already been prepared, with the PowerPoint slides and handouts ready to present to an audience. All we need is experienced mental health professionals that feel comfortable speaking with and energizing an audience.

Yes No **Are you interested in training opportunities?**

If you are interested in training, we will follow up with more information.

Do you hold professional liability insurance with a minimum of \$1,000,000 per incident and \$3,000,000 aggregate? Yes No

Please attach copy of current insurance showing policy # and expiration date.

If you answer 'yes' to any of the following questions, please explain the circumstances in detail on a separate sheet of paper and include any pertinent legal or other documentation.

Have there been any disciplinary actions taken against you by a state licensing body or professional organization, or have you been party to any litigation related to your practice? Yes No

Have you or anyone insuring you or otherwise acting on your behalf settled a claim of error or omission relating to your practice, or have you ever had a claim filed, dismissed or tried against you relative to the practice of psychotherapy or any related counseling function? Yes No

Have you ever been charged with or convicted of a felony or involved in charges related to moral or ethical turpitude? Yes No

REQUIRED ADDITIONAL MATERIALS TO INCLUDE:

- Copy of current professional license (with expiration dates indicated)
- Proof of professional liability coverage
- Copy of highest degree attained (transcript or diploma)
- Resume or Curriculum Vitae (post graduate training, professional experience, etc.)

RECOMMENDED ADDITIONAL MATERIALS TO INCLUDE:

- Additional certifications or licenses if applicable (ex. SAP certification and CEU's, CISD certification, LADC certification)