alliance work partners
A wap Program

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

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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:

☐ D0 Drug and Alcohol - General
☐ D2 Drug and Alcohol - Assessment

☐ F1 Abortion
☐ F2 ACOA – COA
☐ F4 Addictions
☐ F5 Adjustment Disorders
☐ F6 Adolescents
☐ F8 AIDS / HIV
☐ F9 Anger
☐ F10 Anxiety
☐ F12 Assertiveness
☐ F14 Attention Disorders
☐ F15 Bilingual Services
☐ F17 Blind - Visually Impaired
☐ F18 Chemical Dep Aftercare
☐ F19 Children
☐ F20 Children of Divorce
☐ F21 Codependency
☐ F22 Communication Issues
☐ F23 Compulsions
☐ F24 Crime Victims
☐ F25 Deaf – Hearing Impaired
☐ F26 Depression
☐ F27 Developmental Issues
☐ F28 Divorce
☐ F29 Eating Disorders
☐ F32 Family
☐ F33 Family Violence
☐ F34 Gay / Lesbian
☐ F35 Grief & Loss
☐ F37 Smoking Cessation
☐ F38 Homicide
☐ F40 Illness Issues
☐ F41 Life Transitions
☐ F42 Marital - Couples
☐ F43 Men's Issues
☐ F44 Mentally Disabled
☐ F46 Nutritional
☐ F47 Pain Management
☐ F48 Parenting
☐ F49 Phobias
☐ F50 Physically Disabled
☐ F51 Play Therapy
☐ F52 PTSD
☐ F53 Relationships
☐ F54 Sexual Abuse
☐ F55 Sexual Dysfunction
☐ F57 Spiritual - Christian
☐ F58 Step-Families
☐ F59 Stress-Burnout
☐ F61 Suicide
☐ F63 Women's Issues
☐ 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
- Resume or Curriculum Vitae (post graduate training, professional experience, etc.)

RECOMMENDED ADDITIONAL MATERIALS TO INCLUDE:
- Copy of highest degree attained (transcript or diploma)
- Additional certifications or licenses if applicable (ex. SAP certification and CEU's, CISD certification, LADC certification)

We will be moving to a digital platform for signing contracts called Eversign. The digital signature process will send you a copy of the fully signed document once we sign it as well. In order to send the contract, please complete the following.

Person who will be signing the contract:

___

If you are under an agency, and not able to sign on your own behalf, please list the agency signatory

Email address the digital contract should be sent to:

___

If you prefer to receive a contract in another manner instead, please indicate below

Fax

Fax Number____________________________________

PDF by email

Email address_______________________________________