LifeWorks EAP Affiliate Provider Application

Before beginning the application process to join our EAP provider network, please review the Network Eligibility Requirements listed below. If you do not meet the minimum criteria, please do not complete this application until you meet these requirements. Thank you for your interest in joining our network.

Network Eligibility Requirements

1. Master's Level graduate degree or higher in counseling, social work, psychology, or related mental health profession
2. MINIMUM of 3 years post-graduate mental health counseling experience
3. MINIMUM of 3 years with EAP clinical functions, including:
   - Assessment
   - Short-term solution focused counseling
   - Assisting with work/life issues that impact job performance
   - Connecting clients to resources and long term care
   - Assessing and referring clients with alcohol and substance abuse issues
4. Licensed within the state to practice independently, without supervision
5. Carry minimum Malpractice and Liability Insurance Coverage of $1,000,000 per occurrence and $3,000,000 aggregate
6. A valid e-mail address to be used for business purposes is required to participate in the LifeWorks EAP Network. This e-mail address will receive secure, encrypted e-mails containing client authorization details.

Per standard EAP practices, we respectfully request that our providers return all telephone calls within one (1) business day, *offer* appointments for routine referrals within three (3) business days, and *offer* appointments for urgent referrals within one (1) business day. For the convenience of our clients, if you do not have any openings for new appointments within five (5) business days or longer, please notify us so that we may place a *temporary* hold on new referrals to your practice. If you are unable to meet these requirements, please do not continue with the application process. Thank you.

Required Documents

1. All current licenses and certifications.
2. Copy of current professional liability insurance face sheet
3. Completed W-9 form (W-9 must show name registered with IRS and billing address)
4. Resume (work history must show 3 years post masters clinical experience)

Please return the completed application and all required documents via one of the following options:

Via E-mail Attachment: **pnsinquiries@lifeworks.com**

Via Fax To: **703-842-8518**

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Practice Information

Type of Practice: ☐ Corporation ☐ Partnership ☐ Solo Practitioner ☐ Are you a certified small business or Minority/Women/Veteran owned business?

Individual/Practice Name: *(As registered with the IRS)* ______ SSN/Tax ID ______

Applicant's Primary Practice Address: ______

☐ Office Building
☐ Home Office
☐ Religious Institution

Wheelchair Accessible?		Smoke Free?		Accessible to Public Transportation?		Parking Available?	
☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No

Mailing/Billing/Tax Address:
(For payments and 1099 forms) ______

Applicant's Secondary Practice Address: ______

☐ Office Building
☐ Home Office
☐ Religious Institution

Wheelchair Accessible?		Smoke Free?		Accessible to Public Transportation?		Parking Available?	
☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No

Provider Demographic Information

Gender: ☐ Male ☐ Female Date of Birth: ______

Name: (Last, First, M.I.): ______

Primary Phone Number ______ Fax Number: ______

Business E-mail ______ Provider's personal e-mail ______

Alternate Phone Number: ______ Can your alternate phone number be given to clients? ☐ Yes ☐ No CAQH #: ______

How many years of experience do you have?
-Conducting Bio/Psycho/Social Assessments
-Short-term solution focused counseling
-Assisting with work/life issues that impact job performance
-Connecting clients to resources and long term care ______

How many years of post-graduate direct clinical experience do you have? ______

Education Details

School Name ______

Degree Awarded ______

Date Degree Awarded ______

Applicant's Primary Practice Address hours:

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY

Applicant's Secondary Practice Address hours:

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY

LifeWorks

- Are you SAP qualified (DOT Substance Abuse Professional)?
- Are you CEAP qualified (Certified Employee Assistance Professional)?
- Are you an EAS-C?
- Are you Critical Incident Stress Debriefings (CISD) Certified?

Provider Characteristics

Clientele served: (check if applicable)

- Adolescent (age 13-17)
- Children (age 05-12)
- Couples
- Elderly (ages 65 +)
- Family
- Family with children under 12 and Adolescent (age 13-17)
- Individual

Check list of services provided:

- ADD / ADHD
- Adult Survivor of Childhood Sexual Abuse
- Aging / Elder Care
- Alcohol / Substance Abuse
- Anger Management
- Divorce / Separation
- Experience Supporting First Responders
- Experience Supporting Military Families
- Family Counseling
- Family Violence
- Gender Identity Issues
- Grief and Loss
- Internet Addiction
- Parenting Issues
- Relationship Counseling
- Sexual Addiction
- Sexual Orientation (LGBTQ)
- Trauma
- Workplace / Occupational Issues

What is your religious affiliation? (optional question)

What is your race/ ethnicity? (optional question)

Additional Questions:

- Do you have a minimum of 2 years of clinical experience working in outpatient or inpatient substance abuse treatment setting? If Yes, please also answer the next question.
- Would you like to receive Mandated Substance Abuse Referrals? (Please note: You would be required to do assessments and give feed back directly to case managers regarding recommendations)
- Are you interested in receiving work-related Mandated Referrals (non-substance abuse)?
- Do you have the ability to provide counseling in a language other than English? Specify other languages(s)
- Are you willing to do face-to face counseling while using a telephonic interpretation service using a speaker phone for non-English speaking clients?
- Are you willing to do face-to-face counseling while having an interpreter in the room for non-English speaking clients?
- Do you have an interpreter in your office? Specify interpreter's languages(s)
- Do you have experience conducting workshops/trainings/seminars?

Authorization and Release

I hereby authorize LifeWorks to consult with any educational institution, board, other licensing or certification entities, former employer or any other professional organization, including past and present malpractice and/or professional liability carriers, who may have information bearing on my professional competence, character, or ethical qualifications. Upon request by LifeWorks, I will obtain and provide to LifeWorks documentation and materials pertaining to my qualifications and/or competence, including, but not limited to, any disciplinary action, suspension, or felony. I hereby consent to the inspection by LifeWorks, or its representatives, of all documents that it determines to be material to this evaluation of my professional competence.

I hereby release from liability all individuals, institutions, and entities with which I have been or am associated, including but not limited to professional liability carriers, previous employers, clinics, hospitals, state licensing organizations, professional societies, and health plans to provide any relevant information requested by LifeWorks or its representatives. In the event that I am accepted for participation in LifeWorks EAP Provider Network, I hereby consent to LifeWorks inspection of my client records relating to LifeWorks participants as necessary for its utilization, clinical quality programs, and complaint resolution processes. I understand and agree that the authorizations and releases given by me are irrevocable as long as I am an applicant for participation status with LifeWorks or am participating in LifeWorks EAP Provider Network.

I further agree to notify LifeWorks in a timely manner (not to exceed 30 days) of any changes to the information requested on the initial application. I understand that LifeWorks does not discriminate on the basis of race, sex, age, sexual orientation, or national origin. I further acknowledge that I have completely read and fully understand this application, Authorization and Release. I hereby certify that all information contained in this Application and all of its attachments is complete, true and correct.

Lastly, I acknowledge that this authorization of release of information shall be effective upon the date of my signature and, furthermore shall remain in effect for the duration of my agreement with LifeWorks.

Signature of Affiliate and/or Applicant:

Name (Print):

Date of Birth:

Date of Signature:

ATTESTATION STATEMENT

All information submitted by me in this application, as well as any attachments or supplemental information, is true, current, and complete to the best of my knowledge and belief as of the date of the signature below. I fully understand that any information provided during the application or recredentialing process is subject to LifeWorks' investigation and review. I understand that if any information contained in this application is determined to be false or constitutes a material misstatement, my application may be denied or my affiliate status may be terminated by LifeWorks immediately. I further understand that in that event, LifeWorks may be required to submit a report to state licensing authorities. By signing this form, I certify that all of my answer a complete, true, and correct.

Provider Signature: ______________________________ Date: ______________

Print Name:

DISCLOSURE STATEMENT If you answer "YES" to any of the below questions, please provide an explanation of your clinical involvement, date of action, status/outcome, amount of judgment/settlement, adverse decision, AND a copy of any order or settlement for each proceeding. If case is pending, please provide a letter from your attorney detailing the current status.	**Yes**	**No**
Have you ever been convicted of a misdemeanor related to your professional functions?	☐	☐
Have you ever been charged or convicted of a felony in any state?	☐	☐
Have you ever been expelled from or disciplined by any professional association or organization?	☐	☐
Has your clinical license, certification, or ability to practice in any jurisdiction ever been stipulated, denied, restricted, suspended, reduced, revoked, not renewed, or placed on probation by a licensing agency or other regulatory body?	☐	☐
Has your competency to practice ever been impaired due to physical, mental causes, or from the abuse of alcohol or other chemical substances?	☐	☐
Has it ever been determined that you have operated outside the recognized boundaries of your professional competencies?	☐	☐
Are you currently engaged in the illegal use and/or abuse of drugs and/or controlled substances?	☐	☐
Do you have any physical or mental condition, treated or untreated, which in any way impairs your ability to practice to the fullest extent of your licensure and qualifications or in any way poses a risk of harm to your clients?	☐	☐
Are there any formal disciplinary or criminal charges pending against you?	☐	☐
Have you ever voluntarily relinquished your professional license or membership in any organization as an alternative to disciplinary action?	☐	☐
Have any malpractice suits, professional liability suits, arbitration, or other proceedings ever been instituted against you?	☐	☐
Have you ever had a non-professional relationship with a client or former client that was sexual in nature or otherwise in violation of any ethical rules of your profession?	☐	☐
Have you ever been investigated by any board, organization, or authority for any acts alleging dishonesty, fraud, deceit, misrepresentation, or ethical/moral violations?	☐	☐
Has your professional employment or membership in a professional organization, society, professional standards review organization, including but not limited to any government sponsored health plan, or any third party payer, ever been subject to disciplinary proceedings, denied, limited, restricted, reduced, suspended, revoked, not renewed, or voluntarily relinquished during or under threat of termination for any reason?	☐	☐
Have you ever been reprimanded, censured, excluded, suspended, or disqualified by the Medicare or Medicaid programs?	☐	☐
Has a professional liability carrier ever denied, limited, failed to renew, or cancelled your coverage?	☐	☐
Have you ever been terminated or removed from a panel or EAP organization, including LifeWorks, in the past?	☐	☐
Are you currently under investigation or suspension by any other EAP organization for which you are currently working?	☐	☐