

Jorgensen * Brooks

GROUP

EAP PROVIDER APPLICATION/AGREEMENT

APPLICANT INFORMATION (Please Print)

Name: _____ Social Security Number: _____ (Required)
Degree: _____ Date of Birth _____ (Required)
Phone Number _____ Fax Number _____ E-mail Address _____ (Required)

MAILING ADDRESS:

Address _____ City/State _____ Zip _____
Cell Phone # _____ Federal ID Number: _____

PRACTICE LOCATION (Where clients will be seen)

Address _____ Is this location a personal residence yes no
City/State _____ Zip _____ Phone Clients Call _____
Evening Hours Available _____ Weekend Hours Available _____

ADDITIONAL LOCATION:

Address _____ Is this location a personal residence yes no
City/State _____ Zip _____ Phone Clients Call _____
Evening Hours Available _____ Weekend Hours Available _____

ADDITIONAL INFORMATION:

Is your office wheelchair accessible? _____ Is public transportation available within a short distance? _____
Are you bilingual? _____ What languages? _____
CEAP Certified? _____ DOT/SAP Certified? _____ License(s) _____ Renewal Date _____
Professional Liability Insurance: Company _____ Renewal Date: _____
Are you willing and able to see an urgent client within 24 hours and routine client within 3 days? Yes No

SPECIALITY INFORMATION:

<input type="checkbox"/> Critical Incident Stress Debriefing	<input type="checkbox"/> Mood Disorders	<input type="checkbox"/> Brief Therapy
<input type="checkbox"/> HIV Positive/AIDS	<input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Sexual Disorders
<input type="checkbox"/> Mental Health	<input type="checkbox"/> Elder Issues	<input type="checkbox"/> Anxiety Disorders
<input type="checkbox"/> Occupational Issues	<input type="checkbox"/> Chronic Pain	<input type="checkbox"/> Child/Adolescent Evaluations
<input type="checkbox"/> Personality Disorders	<input type="checkbox"/> Relationship/Divorce	<input type="checkbox"/> PTSD
<input type="checkbox"/> Eating Disorders	<input type="checkbox"/> Anger	<input type="checkbox"/> Grief
<input type="checkbox"/> Gambling	<input type="checkbox"/> Other (Specify)	<input type="checkbox"/>

LEGAL & BACKGROUND INFORMATION:

Yes No Has your professional license/certification ever been revoked, suspended or limited?
 Yes No Have you ever voluntarily surrendered your license or certification?
 Yes No Have you ever been denied professional liability insurance or has your insurance ever been cancelled?
 Yes No Have you ever incurred a malpractice claim?
 Yes No Have you ever resigned from the staff of any organization because of problems regarding privileges or credentials?
 Yes No Have you ever been convicted of or plead guilty to a felony crime?
(If yes to any of the above; please enclose a separate sheet with explanation)

I affirm all above statements are true and accurate and that my professional license is in good standing.

Provider Signature _____
Revised 10/2010

Date _____

EAP Provider Agreement

I wish to participate in the Jorgensen/Brooks Group EAP provider network. I hereby certify that all information in this application and the copies of my state licenses, certifications and certificate of insurance are correct and complete. **I will forward with this application copies of my certification, degrees, and malpractice insurance.** I further understand that any information entered into this application, which subsequently is found to be false could result in termination of any contract I may enter into with Jorgensen/Brooks Group. I agree to maintain the professional liability insurance set forth in this application. I agree to abide by all Jorgensen/Brooks Group Employee Assistance Program policies and procedures and to hold Jorgensen/Brooks Group EAP and patients harmless for payment for any care determined not to be authorized.

I hereby grant permission to, and consent for Jorgensen/Brooks Group EAP or its designee to obtain and verify information contained on my application for membership and consent to release by any person, organization, or other entity to Jorgensen/Brooks Group and/or its designee, of all information that may be reasonably relevant to an evaluation of my professional competence, ability to render clinical services in a cost-effective manner, character and moral and ethical qualifications and agree to hold harmless any such person or organization or other entity from any cause of action based on the release of such information to Jorgensen/Brooks Group Employee Assistance Programs. I understand that participation, as a provider is dependent upon review of this application and completion of the credentialing process. If I use an answering service and/or a voice mail system, I agree to direct callers to call 911 if an emergency exists.

I agree to not directly or indirectly engage in any activities which are in competition with Jorgensen/Brooks Employee Assistance Programs contractual arrangements with any client company for the life of that contract and for a period of one year following the termination of the contract.

I agree to not self refer an EAP client to my private practice without the expressed consent from Jorgensen/Brooks Group. I understand that this is consistent with standard EAP practice.

I understand that I am not an employee of Jorgensen/Brooks Group. Affiliate shall act as an independent contractor and is not authorized to obligate Jorgensen/Brooks Group in any way with third parties.

I understand that I must submit, by the 10th of the following month, demographic and case information for each client including dates of service, and assessed problems prior to payment for services. I will provide each client a copy of their Clients Rights and HIPAA. I further understand that Jorgensen/Brooks Group is under contract to provide services for client companies and, I will hold all information confidential as allowed by law.

Signature: _____
Employee Assistance Provider

Date: _____

Print Name: _____

Signature: _____
Jorgensen/Brooks Group

Date: _____

To be completed by Jorgensen/Brooks Group
Date Received:
Effective Date:
Reimbursement Rate:
Resume Included <input type="checkbox"/> Copy of License <input type="checkbox"/> Copy of Liability Insurance <input type="checkbox"/>
JBG Signature:

Substitute Form W-9

IMPORTANT TAX DOCUMENT

REQUEST FOR TAXPAYER IDENTIFICATION NUMBER

As part of the contracting process we are requesting that you complete this Substitute Form W-9. We are required by law to obtain this information from you when making a reportable payment to you.

A. Taxpayer Name (to whom check is payable) _____ (A legal entity name if corporation)

Doing Business as: _____
(a division name if a corporation or
the name of the business if a sole
proprietor)

B. Taxpayer Address _____

C. Taxpayer Identification Number: _____

1. Corporation _____
List Employer Identification Number

2. Partnership _____
List employer Identification Number

3. Sole Proprietorship _____
List social security number or EIN

4. Tax Exempt Entity _____
List employer identification number

Effective date of taxpayer Name: _____

E. Form completed by: _____
Print Name and Title

F. Signature _____

G. Today's Date: _____

H. Daytime Telephone Number: _____

Please note: Information reported on lines A, B, and C must be consistent with data on file with the IRS and Social Security Administration.