



## **WellSpan EAP Participating Provider Application** *Instructions and Check Sheet*

Enclosed is a Provider Application for your consideration as an Employee Assistance Program Participating Provider for *WellSpan Employee Assistance Program*.

### **The following documents are required to complete your application:**

- 1. A completed application.
- 2. A signed Release of Information form.
- 3. Copy of current licenses and certifications.
- 4. Copy of a current Certificate of Malpractice Insurance.
- 5. Curriculum Vitae (*Please explain any gaps in work history*).
- 6. Diploma (*highest academic degree*).
- 7. W-9 Form
- 8. A list of insurances with whom you are currently credentialed.

If you have any questions or need further clarification regarding this application, please call Andy Seebold, Director, at 717-851-4171.

Mail the completed packet of information to:

WellSpan Employee Assistance Program  
Attn: Andy Seebold  
P.O. Box 1827  
York, PA 17405-1827



**Reimbursement Information:** (if different than primary contact above)

Attention \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ County \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

**Languages:** ( Please check all languages that are used in your office.)

- |  |                                  |                                      |
|--|----------------------------------|--------------------------------------|
| <input type="checkbox"/> Arabic        | <input type="checkbox"/> Chinese | <input type="checkbox"/> French      |
| <input type="checkbox"/> German        | <input type="checkbox"/> Hindi   | <input type="checkbox"/> Italian     |
| <input type="checkbox"/> Japanese      | <input type="checkbox"/> Korean  | <input type="checkbox"/> Spanish     |
| <input type="checkbox"/> Sign Language | <input type="checkbox"/> Braille | <input type="checkbox"/> Other _____ |

Please indicate who in your office can utilize the above languages and how:

Provider \_\_\_\_\_ Written  Spoken

Provider \_\_\_\_\_ Written  Spoken

Staff \_\_\_\_\_ Written  Spoken

Staff \_\_\_\_\_ Written  Spoken

**Total number of staff or partners with:**

Doctorate \_\_\_\_\_ Masters \_\_\_\_\_ Bachelors \_\_\_\_\_

Certified Addictions Counselors \_\_\_\_\_ Certified Employee Assistance Professionals \_\_\_\_\_

**C. Personal Information:**

**Education and Training**

**Graduate School** \_\_\_\_\_

City/State \_\_\_\_\_

Degree \_\_\_\_\_ Graduation Date (Mo/Yr) \_\_\_\_\_

**Undergraduate School** \_\_\_\_\_

City/State \_\_\_\_\_

Degree \_\_\_\_\_ Graduation Date (Mo/Yr) \_\_\_\_\_

**Personal Information (continued):**

**CERTIFICATIONS / LICENSES:**

State \_\_\_\_\_ License # \_\_\_\_\_ Issue Date \_\_\_\_\_ Expiration Date \_\_\_\_\_  
State \_\_\_\_\_ Certificate # \_\_\_\_\_ Issue Date \_\_\_\_\_ Expiration Date \_\_\_\_\_  
State \_\_\_\_\_ Certificate # \_\_\_\_\_ Issue Date \_\_\_\_\_ Expiration Date \_\_\_\_\_

**LIABILITY INSURANCE INFORMATION:**

Current Carrier \_\_\_\_\_  
Address \_\_\_\_\_  
City/State/Zipcode \_\_\_\_\_  
Policy Number \_\_\_\_\_ Group / Individual Policy (Circle One)  
Coverage Limits \$ \_\_\_\_\_ (occurrence) \$ \_\_\_\_\_ (aggregate)  
Date Coverage First Began \_\_\_\_\_ Expiration Date \_\_\_\_\_

**CLINICAL INFORMATION:**

***Populations Served:*** (Check all that apply)

- Children (0 - 12)  Adults (18 - 60)  
 Adolescents (13 -17)  Geriatrics (65 and older)

***Specialties:*** (Check all that apply)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> ADHD / ADD          | <input type="checkbox"/> Addictions            | <input type="checkbox"/> Alcohol / Drugs         |
| <input type="checkbox"/> Anxiety Disorders   | <input type="checkbox"/> Bereavement           | <input type="checkbox"/> Biofeedback             |
| <input type="checkbox"/> Career              | <input type="checkbox"/> Christian / Spiritual | <input type="checkbox"/> Developmental Disorders |
| <input type="checkbox"/> Domestic Violence   | <input type="checkbox"/> EAP Training          | <input type="checkbox"/> Eating Disorders        |
| <input type="checkbox"/> Family / Couples    | <input type="checkbox"/> Financial             | <input type="checkbox"/> Group                   |
| <input type="checkbox"/> Incest/Sexual Abuse | <input type="checkbox"/> Mediation             | <input type="checkbox"/> Men's Issues            |
| <input type="checkbox"/> Mood Disorders      | <input type="checkbox"/> Multi-Cultural Issues | <input type="checkbox"/> OCD                     |
| <input type="checkbox"/> Pain Management     | <input type="checkbox"/> Parenting             | <input type="checkbox"/> Personality Disorders   |
| <input type="checkbox"/> Phobias             | <input type="checkbox"/> PTSD                  | <input type="checkbox"/> SAP / DOT Evaluations   |
| <input type="checkbox"/> Sexual Disorders    | <input type="checkbox"/> Sexual Orientation    | <input type="checkbox"/> Stress Management       |
| <input type="checkbox"/> Women's Issues      | <input type="checkbox"/> Work Issues           | <input type="checkbox"/> Other _____             |

***Affiliated Hospitals / Inpatient Treatment Facilities:***

1. Name/Type \_\_\_\_\_  
City/State \_\_\_\_\_ Phone number \_\_\_\_\_  
2. Name/Type \_\_\_\_\_  
City/State \_\_\_\_\_ Phone number \_\_\_\_\_

**ATTESTATION:**

Please check the appropriate box, if “Yes” is answered for any questions please explain on a separate sheet of paper.

- 1. Do you currently have any physical, mental, or emotional conditions which may impair your ability to render professional services?  Yes  No
- 2. Has your professional liability insurance coverage ever been denied, canceled, or non-renewed or initially refused upon application?  Yes  No
- 3. Have you ever been named in any malpractice action?  Yes  No  
(If yes, please attach a copy of the complaint filed stating the allegations).
- 4. Has your medical or professional license or certification in any state ever been revoked, suspended, placed on probation, or limited?  Yes  No
- 5. Has your membership in any professional society or association ever been canceled, revoked, or censured?  Yes  No
- 6. Have you ever been convicted of a felony or involved in charges relating to moral or ethical turpitude? (Do not report misdemeanors)  Yes  No

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**WELLSPAN EAP**  
***Release of Information***

I hereby certify that all information contained in this application are correct and complete. I further understand that any information entered into this form which subsequently is found to be false could result in termination of any contract I may enter into with *WellSpan Employee Assistance Program*.

I hereby grant permission and consent for *WellSpan Employee Assistance Program*, and/or its designee, to obtain and verify information contained on my application and consent to the release by the person, organization, or other entity to *WellSpan Employee Assistance Program* and/or its designee, of all information that may be reasonably relevant to an evaluation of my professional competence, ability to render services, character, and moral and ethical qualifications, and agree to hold harmless any such person or organization or other entity from any cause or action based on the release of such information to *WellSpan Employee Assistance Program* and/or its designee.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name