fei workforce resilience

FEI Behavioral Health EAP Affiliate Application

Be sure you meet requirements posted on the website prior to completing

Please fill out all fields unless otherwise noted

Business Information

Business Name: ____

Physical Business Address: ______________________________________

City: _________________________________ State/Province: __________

Zip/Postal Code: _____________ Country: _________________________

Phone Number for Referrals: (_____) _____-_____

Fax Number for Referrals: (_____) _____-_____

If mailing/billing address is different from physical address, please submit details

If any additional practice locations please submit details

Is your clinic in compliance with ADA? _______

The following information may be used for U.S. government work & proposals

Is this business owned by a woman? ______

Is the business owned by a member of a minority group? ______

Is the business owned by a U.S. Military Veteran? ______

Is the business owned by a service-disabled U.S. Military Veteran? ______

Is the business identified as a small disadvantaged business? ______

Is this a HUBzone business? ______

Is this business a member of the Alliance for Strong Families and Communities? ______

If no, is your agency a 501c3 human services nonprofit? ______

EAP Coordinator/Main Contact Person Information

EAP Coordinator/Main Contact Name: ____

EAP Coordinator Direct Phone Number: (_____) _____-_____

Email Address for Business Communication: ___________________________________

Cell Phone: (_____) _____-_____
(not given to clients only used for emergencies such as office phone outage, etc)

Clinician Information

Clinician First Name: ____

Clinician Last Name: ____

Gender: ___________

Race (optional): ___________________________________

Clinician Cell Phone Number: (_____) _____-_____

Email Address for Business Communication: ___________________________________

If you practice at multiple locations of this clinic, please submit details.

Do you offer evening or weekend appointments? _________ (Required)

In which other language(s) can you conduct sessions? ___________________________

Do you see clients in your home? _________

** Please submit a current copy of your resume highlighting your EAP experience - years of experience, and networks that you've worked with**

Please indicate any areas of specialty you have:

_____ African American

_____ Asian

_____ Hispanic

_____ LGBT

_____ Geriatric or Dependent Care Management

_____ Veteran/Military

_____ Substance Abuse

_____ Grief/Loss

_____ Child/Adolescent/Parenting

_____ Domestic Abuse

_____ Couples

_____ CISD

_____ Sexual Abuse

_____ EMDR

_____ General Faith Based Counseling

_____ Religion-Specific Faith Based Counseling (Identify) ________________________

_____ Working with Employer-Mandated Referrals

_____ Higher Education

_____ Law Enforcement

_____ Mediation

_____ Telephonic EAP Counseling

_____ Video EAP Counseling

Do You Have Experience

Providing EAP orientations/trainings? _____

Providing critical incident stress debriefings (on-site)? _____

Treating clients with substance abuse/dependence? _____

To receive referrals for the above special services, please submit the appropriate specialty application found on our website.

Please List Health Insurance Panels You Are On

____

____

____

____

____

____

Agreement

My signature below or my electronic submission certifies the following:

- That I have provided complete, true and correct information and that I meet and will comply with the requirements of this position.
- I will not disclose any client-related information to anyone other than FEI Behavioral Health.

(Additional information is available at http://www.feinet.com/provider)

Signature: ____

Date: ____

Document Checklist

- ☐ Current resume with EAP experience (years and networks) highlighted
- ☐ A current copy of your professional liability coverage

Attach the following if applicable, on separate sheet(s)

- ☐ Mailing/Billing Address (if different from physical business address)
- ☐ Additional Office Locations – The Business in General (please include: physical address, phone and fax numbers (if different from referral numbers) – if applicable
- ☐ Clinician's Additional Office Locations – (please include: Physical address and clinician's direct phone number(s) if applicable)

If you practice in a country outside the United States, please include:

- ☐ A current copy of your professional license/certification

** Please be sure each document submitted clearly states provider and/or clinic name. Required documents must be received within 7 days, or the application cannot be processed**

Send signed application and all relevant documents via email or fax to:

Email: network@feinet.com

Secure Fax: (414) 359-6519