

US AFFILIATE APPLICATION

* required field

OUR CORPORATE REQUIREMENTS TO BECOME AN AFFILIATE PROVIDER IN OUR US EAP NETWORK INCLUDE:

- Must be fully licensed and able to practice without supervision
- Must have 3 or more years of post-graduate counseling experience
- Must have Professional Liability Insurance with a minimum of \$1,000,000 per claim and \$3,000,000 per aggregate

DO YOU MEET THE CORPORATE REQUIREMENTS OUTLINED ABOVE?* Yes No

PRACTICE INFORMATION

INDIVIDUAL/ PRACTICE NAME*

SSN/TAX-ID*

PRACTICE WEBSITE

BILLING EMAIL*

TYPE OF PRACTICE* Corporation Partnership Solo Practitioner

PRIMARY PRACTICE TYPE* Office Building Home Office Religious Institution

PRIMARY OFFICE ADDRESS* SUITE

CITY* STATE* ZIP CODE* COUNTY*

WHEELCHAIR ACCESSIBLE? * Yes No PUBLIC TRANSPORTATION ACCESSIBLE?* Yes No

SECONDARY PRACTICE TYPE Office Building Home Office Religious Institution

SECONDARY OFFICE ADDRESS SUITE

CITY STATE ZIP CODE COUNTY

WHEELCHAIR ACCESSIBLE? Yes No PUBLIC TRANSPORTATION ACCESSIBLE? Yes No

INSURANCE PANELS*

DEMOGRAPHIC INFORMATION

LAST NAME* FIRST NAME* MIDDLE NAME

GENDER* Male Female CAQH # NPI #

LANGUAGE(S) YOU CAN CONDUCT SESSIONS IN* English Spanish Other:

PRIMARY PHONE NUMBER* NUMBER TYPE* HAS VOICEMAIL* FOR CLIENT USE*

Office Mobile Home Other Yes No Yes No

SECONDARY PHONE NUMBER NUMBER TYPE HAS VOICEMAIL FOR CLIENT USE

Office Mobile Home Other Yes No Yes No

* Would you like to receive referrals by email or text message

* Office EMAIL TEXT NUMBER for referrals

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 and connecting clients to resources and long-term care?*

years

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

years

EDUCATION DETAILS

UNIVERSITY*	STATE*	YEAR RECEIVED*
DEGREE*	MAJOR*	
MENTAL HEALTH LICENSE TYPE*	MENTAL HEALTH LICENSE NUMBER*	
CHECK ALL THAT APPLY		
SAP Qualified (DOT Substance Abuse Professional)		
CEAP Qualified (Certified EAP Professional)		
CISD (Critical Incident Stress Debriefing)		

PROVIDER CHARACTERISTICS

MODALITIES*				
Face-to-Face	Tele Counseling	Video counseling		
STATES LICENSED IN		HIPAA COMPLIANT VIDEO PLATFORM YOU WOULD USE		
CLIENTELE SERVED*				
Individual	Couples	Family	Adolescents (13+)	Children Under 12
PRESENTING ISSUES YOU ARE COMFORTABLE WORKING WITH*				
Addiction	Crisis Intervention	Executive	Military Families Experience	Trauma
ADHD/ Learning Disabilities	Cross-Cultural Issues	Expat Counseling	Parenting	Workplace Issues
Adoption	Depression	Fertility Issues	Postpartum Depression/ Anxiety	
Anger Management	Discrimination	First Nations/ Aboriginal Issues	Return to Work	
Anxiety	Divorce/ Separation	First Responders Experience	Sexual Abuse	
Career/ Job Concerns	Domestic Violence	LGBTQ+	Sexual Harassment	
Faith Based Counseling	Aging/ Elder Care	Grief/ Bereavement	Transgender/ Gender Identity Issues	

CHECK ALL THAT APPLY

I have a minimum of two years clinical experience working in outpatient or inpatient substance abuse treatment setting and I would like to receive mandated substance abuse referrals.
(Note: You would be required to do assessments and give feedback directly to case managers regarding recommendations)

I am interested in receiving work-related mandated referrals *(Non- Substance Abuse)*

I have experience conducting workshops/trainings/seminars.

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 recertification process is subject to LifeWorks by Morneau Shepell 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 by Morneau Shepell immediately. I further understand that in that event, LifeWorks by Morneau Shepell 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 NAME

PROVIDER SIGNATURE

DATE

In order to complete the credentialing process please submit the below documents

Please submit the following documents through email at USrecruiter@lifeworks.com.

- Copy of liability insurance with expiration date
- Copy of all Licenses and Certificates with expiration date
- W-9
- Resume
- Disclosure form