ESI EMPLOYEE ASSISTANCE GROUP
TotalCare EAP
Public Safety EAP
Educators' EAP
Higher Ed EAP
HealthCare EAP
Union AP

SERVICE PROVIDER APPLICATION FORM

100 American Road, Brooklyn OH 44144

☐Dr. ☐Mr. ☐Ms. ☐Mrs.	Date:
Name Organization/PC	Office Phone:
Practice Address:	Mobile:
Handicap Accessible ☐ No ☐ Yes	Fax No:
Second Location:	Email:
Handicap Accessible ☐ No ☐ Yes	Preferred Method of Contact:
Mailing Address:	☐ Email ☐ Text ☐ Phone
	Tax ID.
	NPI No.
License/Certifications Held	License No.

Optional, Voluntary and Not Required

The following information regarding sexual orientation, religious beliefs, and race/ethnic group is not used for purposes of denying an application for participation. Often clients will ask for a counselor who meets a specific preference within one of the following categories. If your application is approved, and you provide this information, your response will be entered into our database so that you can be identified for our use only if a client requests a counselor who meets a specific category. Any responses you provide or your decision to not provide this information will not be the basis for denying your application for participation.

☐ Female ☐ Male

☐ Christian ☐ Jewish ☐ Islam ☐ Non-Secular ☐ Other:_____

☐ Hispanic ☐ Caucasian ☐ Asian ☐ African American ☐ Native American

Are you willing to identify your military experience? ☐ Yes ☐ No, if so, are you a veteran? ☐ Yes ☐ No

Any other information that would help us place Members in your practice (e.g. experience with elderly, medical social work etc.…)? _____

☐ I do not wish to provide this information

Do you speak a second language? ☐ No ☐ Yes, please specify_____

Can you use sign language? ☐ No ☐ Yes

Office setting: ☐**Group Practice** ☐**Private Practice** ☐**Home Office** ☐ **Other** _____

Major Health Insurance Panels (Please check all that apply)

☐ **Aetna**	☐ **Fidelis**	☐ **Independent Health**	☐ **MVP**
☐ **BCBS**	☐ **Geisinger**	☐ **Kaiser**	☐ **NYSHIP**
☐ **Beacon/Carelon**	☐ **Harvard Pilgrim**	☐ **Magellan**	☐ **Optum**
☐ **BS of CA**	☐ **Health First**	☐ **Medicaid**	☐ **PHCS/Multiplan**
☐ **CDPHP**	☐ **Health New England**	☐ **Medicare**	☐ **Tricare/Champus**
☐ **Cigna**	☐ **Health Net**	☐ **MMO**	☐ **Tufts**
☐ **Connecticare**	☐ **Humana**	☐ **Moda**	☐ **UHC/UBH/UMR/Optum**

Other: _____

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Have you ever had a malpractice claim brought against you? ☐ **No** ☐ **Yes**
Has your professional license ever been limited, revoked or suspended? ☐ **No** ☐ **Yes**
Have you ever been disciplined by any professional association, organization, or professional society? ☐ **No** ☐ **Yes**
(If yes to any of the three previous questions, please attach documentation of final resolution.)

Modality

☐ Telehealth ☐ Face to Face

Areas of Specialization

☐ Affective Disorders	☐ Grief	☐ Drug/Alcohol Evaluation	☐ CISD/CISM
☐ Marriage/Couples	☐ Phobias	☐ Drug/Alcohol Treatment	☐ Trauma/PTSD
☐ Family	☐ Christian Counseling	☐ DOT Assessment/ SAP	☐ Public Safety
☐ Children Less than 8	☐ Anger Management	☐ Eating Disorders	☐ Military/Veteran
☐ Children Ages 8-13	☐ LGBTQ	☐ Administrative Referrals	☐ EMDR
☐ Children Ages 14-18	☐ LGBTQ- Transitioning		

Other: _____

Hours of Availability: ☐ Days ☐ Evenings ☐ Weekends

Workplace Services

Are you interested in providing on-site services indicated above? (**Attach experience and/or training**) ☐ No ☐ Yes

Do you or your organization provide direct services to employers? ☐ No ☐ Yes, please specify_____

I authorize Employee Services to verify any and all information provided in this application for the purpose of determining my professional competence, character, ethical qualifications and consideration for acceptance.

I also authorize any person or organization named in this application to release relevant information to Employee Services for the purposes stated above.

I hereby certify that the information contained in the foregoing application is true and complete to the best of my knowledge and belief.

_____ _____

Applicant Signature Date

Any questions comments or concerns please reach us at 800-821-5040 Opt 7

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Dear Valued Partner,

We are pleased to offer texting and emailing to connect with you regarding new referrals and critical incident responses. If you would like to be contacted via text or email, please provide your information below. We will not provide private health information or personal identifying information via text. If you are not interested, simply reply to this email indicating you prefer phone contacts.

Please send the following information to ESI if you would like to receive:

- New client referrals via text or email
- Critical incident/Trauma Response requests via text or email

Your Name: Click or tap here to enter text.
Referral Preference (check all that apply): ☐ **Text** ☐ **Email**
Mobile Phone (for texting): Click or tap here to enter text.
Email Address: Click or tap here to enter text.

Additional Instructions/comments: Click or tap here to enter text.

Information EAP can share with Members being referred to you:

☐ **Yes,** Members may email to coordinate their first appointment.
☐ **Yes**, Members may text me to coordinate their first appointment.
☐ **No**, do **NOT** share my email address with Members receiving referrals.
☐ **No**, do **NOT** ask Members to text me to coordinate their first appointment.

Please return by:

Email: providers@theeap.com
Fax: 585.593.9058
Mail: ESI EAP, 100 American Rd., Brooklyn, OH 44144
Any questions or concerns please call: 800-821-5040

Thank you,