



EMPLOYEE ASSISTANCE PROGRAM

**1660 South Highway 100
Minneapolis, MN 55416
(612) 332-4805 * 1-800-367-3271
Fax: (612) 342-2422**

Affiliate Application

Here is a checklist of the documents needed:

- Copy of malpractice insurance coverage (Minimum coverage of at least \$1,000,000 per occurrence, \$3,000,000 aggregate is required.)
- Completed W-9 for the group's tax identification number signed by authorized representative.
- Copy of current State License(s) as either a social worker, psychologist professional counselor **-OR-** copy of a CEAP certificate & Masters diploma (or higher) in a counseling discipline.
- Completed application form which includes:
 - an organizational information form.
 - an EAP counselor information form for each counselor providing service in your organization.
 - an additional information form.

Organization Information

Organization Name:

Tax ID # or Social Security Number:

Mailing and Billing Address:

<hr/>		
Name of Contact		
<hr/>		
Street		
<hr/>		
<hr/>		
<hr/>	<hr/>	<hr/>
City	State	Zip Code
<hr/>	<hr/>	<hr/>
()	()	
Phone Number	Fax Number	
<hr/>	<hr/>	
E-Mail Address	Web Address	
<hr/>	<hr/>	

On the next page please list any of your additional office locations

Additional Office Locations

Please list only those offices that are part of your organization

1.

Street

City State Zip

Phone #

Is this location handicap accessible? Y N

4.

Street

City State Zip

Phone #

Is this location handicap accessible? Y N

2.

Street

City State Zip

Phone #

Is this location handicap accessible? Y N

5.

Street

City State Zip

Phone #

Is this location handicap accessible? Y N

3.

Street

City State Zip

Phone #

Is this location handicap accessible? Y N

6.

Street

City State Zip

Phone #

Is this location handicap accessible? Y N

Additional Information About Your Organization

Can you provide the following?

- | | | |
|--|------------------------------|-----------------------------|
| Critical Incident Stress Debriefing | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Critical Incident Stress Management | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Trainings | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Orientations | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| DOT/SAP evaluations | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Supervisory consultations | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Formal Supervisory Referrals | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Drug Free Work Place/ Chemical Health Screenings and Referrals | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

How would we make a referral to you?

How are appointments scheduled?

How are client complaints handled?

Are you also a mental health provider? Yes No

If so, how do you inform the client about the transfer from EAP services to mental health services within your organization

Does your organization follow the standards and practice put forth by the Employee Assistance Professionals Association (EAPA)? Yes No

Employee Assistance Counselor Information Form

(please copy and complete for each counselor providing service in your organization)

EA Counselor Name	Degree	State License	CEAP (date expires)

EA Counselor Competencies and Specialties (may attach separately)

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

EA Professional Profile.

(please circle)

1. Is there any action pending to revoke, suspend or limit your certification or license **YES** **NO**
2. Is there any action pending related to your practice **YES** **NO**
3. Have you ever been subject to disciplinary proceedings by any professional organization or state board? **YES** **NO**
4. Have you ever been convicted of a felony? **YES** **NO**
5. Have you had any malpractice claims? **YES** **NO**

If you have answered yes to any of the above please provide a written explanation, current status and copies of any official documentation. You can include this on a separate sheet.

6. Are you a member of Employee Assistance Professionals Association (EAPA) **YES** **NO**
7. If you are not a member of EAPA, do you follow EAPA standards of practice? **YES** **NO**

I acknowledge that the above information to the best of my knowledge is true. I also understand that this application is voluntary and does not guarantee an affiliate arrangement.

Counselor Signature

Date