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:

_____
Name of Contact

_____
Street

_____

_____ _____ _____
City **State** **Zip Code**

( ) _____ ( ) _____
Phone Number **Fax Number**

_____ _____
E-Mail Address **Web Address**

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 ☐

2.

_____
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 ☐

4.

_____
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 ☐

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	☐ Yes	☐ No
Critical Incident Stress Management	☐ Yes	☐ No
Trainings	☐ Yes	☐ No
Orientations	☐ Yes	☐ No
DOT/SAP evaluations	☐ Yes	☐ No
Supervisory consultations	☐ Yes	☐ No
Formal Supervisory Referrals	☐ Yes	☐ No
Drug Free Work Place/ Chemical Health Screenings and Referrals	☐ Yes	☐ 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***