1040 Vestal Parkway East
Vestal, NY 13580

Prospective Providers,

Thank you for your interest in joining the **eni** EAP provider network. **eni** EAP also offers, phone, and video counseling to our clients so let us know if you are interested in providing these services as well.

Please feel free to contact us with any questions that you may have. Send in the completed application along with a copy of your professional license, liability insurance, and a completed W9. Please note that if you are applying as a facility, and billing as such, you only need to complete one application. This will cover all providers working under your facility. We will just need you to provide a roster of their names so that we can add them to our system under your facility.

We look forward to working with you in the future.

Sincerely,
The **eni** Provider Network Team

Bethany Menc
Provider Relations Coordinator
bmenc@eniweb.com

Jonathan Raymondi
Provider Network Administrator
jraymondi@eniweb.com

PROVIDER APPLICATION

GENERAL INFORMATION
Name of Organization or person to which payment should be made
Please provide your Tax ID #

CONTACT INFORMATION			
Name of person to contact when making referrals			
Phone number for referrals		Professional phone number to be given to clients	
Fax number Website (if applicable):		Email for referrals (internal use only)	
Mailing Address			Apartment/Unit #
City		State	ZIP
Office 1 Address			Apartment/Unit #
City		State	ZIP
If this is a home office, is there a separate entrance?	Yes ☐ No ☐	Is this office handicap accessible?	Yes ☐ No ☐
Is there a waiting room?	Yes ☐ No ☐	Is this office easily accessible via public transportation?	Yes ☐ No ☐
Office 2 Address			Apartment/Unit #
City		State	ZIP
If this is a home office, is there a separate entrance?	Yes ☐ No ☐	Is this office handicap accessible?	Yes ☐ No ☐
Is there a waiting room?	Yes ☐ No ☐	Is this office easily accessible via public transportation?	Yes ☐ No ☐

TYPICAL AVAILABILITY			
☐ Days	☐ Evenings	☐ Saturdays	☐ Sundays

Please include hours of operation above.

LICENSURE

Please list all professional licensures for all of your members:

Please be sure to submit a copy of all listed licensures & insurance with this application

LANGUAGES

Please list any languages your members speak in addition to English:

CLINICAL SPECIALTIES:

Please check all that apply:

☐ ADD/ADHD	☐ Depression	☐ Trauma
☐ Addictions: Non-chemical	☐ Domestic Violence: Perpetrator	☐ Trauma: Sexual/Physical Abuse
☐ Adolescents: 13-15 years old	☐ Domestic Violence: Victim	☐ Video Counseling
☐ Adolescents: 16-18 years old	☐ Eating Disorders	☐ Work Issues
☐ Anger Management	☐ Eldercare Issues	
☐ Anxiety Disorders	☐ Families	
☐ Autism/Aspergers	☐ Formal Referrals/Mandates	
☐ Career Planning/Counseling	☐ Marital	
☐ CBT	☐ Grief/Loss	
☐ Children: 5 years and under	☐ Military	
☐ Children: 6-8 years old	☐ Psychological Testing	
☐ Children: 9-12 years old	☐ Substance Abuse	
☐ Christian Counseling	☐ EMDR	
☐ Couples	☐ LGBTQ	

Are you interested in providing telephonic or video counseling?: ☐ Telephonic ☐ Video

How many years of EAP experience do your members have?

Are any of your members a **DOT Substance Abuse Professional (SAP)**? ☐ Yes ☐ No

If YES, please provide a copy of his/her original SAP Certificate and CEUs for the past three (3) years

Are any of your members a **Certified Employee Assistance Professional (CEAP)**? ☐ Yes ☐ No

If YES, please provide an updated copy of his/her CEAP Certificate

Would any of your members be interested in providing **CISD services**? ☐ Yes ☐ No

If YES, please provide a copy of current CISD certificates or CEUs they have completed

Would your members be interested in providing **Trainings** or **Mediations**? ☐ Yes ☐ No

If YES, please list the trainings he/she would be willing to present:

Are any of your members a **Certified Smoking Cessation Professional**? ☐ Yes ☐ No

INSURANCE/MANAGED MENTAL HEALTH PLANS ACCEPTED		
☐ Aetna	☐ Kaiser	☐ UniCare
☐ Anthem BCBS	☐ Magellan	☐ United Behavioral Health
☐ BCBS	☐ Mass Health	☐ United Health Care
☐ Beacon Health Strategies	☐ Humana	☐ Value Options
☐ Cigna	☐ Medicare	☐ None
☐ Empire BCBS	☐ Multiplan PPO	☐ Other:
☐ Fallon	☐ MVP	
☐ GIC	☐ Oxford Health Plan	
☐ Great Western	☐ PacifiCare	
☐ Harvard Pilgrim	☐ PHCS	
☐ Health New England	☐ TriCare	
☐ Individual Blue Plans	☐ Tufts	

APPLICANT ATTESTATIONS		
1. Has a licensing/certification board in any U.S. or foreign jurisdiction taken any disciplinary action against you?	☐ Yes	☐ No
2. Are you the subject of pending disciplinary actions by a licensing/certification board in any U.S. or foreign jurisdiction?	☐ Yes	☐ No
3. Have you ever voluntarily surrendered or resigned a professional license to a licensing/certification board in any U.S. or foreign jurisdiction?	☐ Yes	☐ No
4. Have you ever applied for and been denied a professional license in any U.S. or foreign jurisdiction?	☐ Yes	☐ No
5. Have you ever admitted to or been convicted of a felony or misdemeanor in any U.S. or foreign jurisdiction, other than a traffic violation?	☐ Yes	☐ No
Please state the details of any YES answer on a separate sheet, and attach the explanation to this application		

OPTIONAL INFORMATION			
This information is entirely optional, and may be used to meet clients' requests			
Age	**Race/Ethnicity**	**Religion**	**Gender**
☐ 20-29 years old	☐ African	☐ Christian	☐ Female
☐ 30-39 years old	☐ African American	☐ Jewish	☐ Male
☐ 40-49 years old	☐ Asian	☐ Muslim	
☐ 50-59 years old	☐ Caucasian	☐ Other:	
☐ 60 and over	☐ Hispanic/Latino		
	☐ Other:		

PRINT NAME:

SIGNATURE: **DATE:**

PARTICIPATION STATEMENT

I fully understand that if any matter stated in this application is or becomes false, Employee Network will be entitled to terminate my provider agreement for breach. All information submitted by me in this application is warranted to be true, correct and complete.

I authorize Employee Network *and/or its Credentials Verification Organization (CVO)* to consult with the National Practitioners Data Bank, state licensing board(s), educational institutions, specialty boards, malpractice insurance carriers, Educational Council for Foreign Medical Graduates, hospitals, professional references and any other person or entity from whom/which information may be needed to complete the credentialing process or to obtain and verify information concerning my membership, professional competence, character and moral and ethical qualifications, and I also authorize all of them to release such information to Employee Network *and/or its CVO*. I release Employee Network and its employees and/or its *CVO* and all those whom Employee Network and/or its *CVO* contacts from any and all liability for their acts performed in good faith and without malice in obtaining and verifying such information and in evaluating my application.

I consent to the release by any person to Employee Network and/or its *CVO* of all information that may reasonably be relevant to an evaluation of my professional competency, character and moral and ethical qualification, including any information relating to any disciplinary action or suspension or curtailment of privileges, and hereby release any such person providing such information from any and all liability for doing so.

_____ Date (mm/dd/yy):_____

Signature of Applicant

_____

Name (Please Print)

RETURN COMPLETED APPLICATION TO:

NEW PROVIDERS EMAIL: jraymondi@eniweb.com

CURRENT PROVIDERS EMAIL: bmenc@eniweb.com

OR PRINT AND RETURN TO:

Employee Network, Inc.
ATTN: Network Development
1040 Vestal Parkway East
Vestal, NY 13850

REQUIRED DOCUMENTATION TO ACCOMPANY THIS APPLICATION

- ***COPY OF CURRENT STATE LICENSE AND/OR LICENSE REGISTRATION CERTIFICATE***
- ***COPY OF CURRENT STATE CONTROLLED DANGEROUS SUBSTANCE (CDS) CERTIFICATE***
- ***COPY OF CURRENT FEDERAL DRUG ENFORCEMENT AGENCY (DEA) CERTIFICATE***
- ***COPY OF CURRENT MALPRACTICE INSURANCE FACE SHEET***
- ***COPY OF SMOKING CESSATION CERTIFICATE***
- ***COPY OF ANY OTHER MENTIONED DOCUMENT OR CERTIFICATE***