HealthyMinds, LLC

HealthyMinds is pleased that you are interested in being an affiliate provider for our Employee Assistance Program!

Please send us the following application materials:

□ Completed application (see below)
□ Resume/Vita
□ Proof of licensure issued by current State board
□ A copy of any specialized certifications and/or additional licenses held
□ CEU Certificates documenting continuing professional education concerning Critical Incident Stress Debriefings (CISDs) or trauma debriefings, if applicable.
□ Proof of malpractice liability insurance ($1,000,000/$3,000,000 minimum)
□ Signed W-9
□ Completed ACH direct deposit form (included)

Please fax the application materials to (608) 841-1200.

If you have any questions or need additional information, please contact our office at (855) 458-4966.

6510 Grand Teton Plaza, Suite 402, Madison, WI 53719
Phone 1.855.458.4966 | Fax 608.841.1200

HealthyMinds, LLC

Organization Information

Name of Clinic _____

Office Location(s)

Street	City	State	Zip	Phone	Handicap accessible?	
					□ Yes	□ No
					□ Yes	□ No

Office Hours	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Applicant Information

Name of applicant _____

Email address _____ Phone: _____ Fax: _____

Licensure(s)

Type _____ State _____ Year obtained _____ License # _____

Type _____ State _____ Year obtained _____ License # _____

Certification(s) _____

1.	Are you a qualified Substance Abuse Professional?	□ Yes	□ No
2.	Do you have expertise in treating children and adolescents?	□ Yes	□ No
3.	Has your professional license and/or certification to practice in any state or jurisdiction ever been revoked, suspended, or subject to probation or any conditions or limitations? *	□ Yes	□ No
4.	Is there any action pending to revoke, suspend, or limit your professional license and/or certification? *	□ Yes	□ No
5.	Has your professional liability insurance ever been cancelled, or has your renewal for such insurance ever been denied? *	□ Yes	□ No
6.	Have there ever been any claims or actions against your liability insurance coverage? *	□ Yes	□ No
7.	Have you ever been convicted of a felony? *	□ Yes	□ No
8.	Have you ever been involved in malpractice litigation in which there was a settlement or judgment against you? *	□ Yes	□ No
9.	Have you ever been the subject of a formal complaint or investigation wherein the fitness for duty or ability to act as a mental health provider has been questioned? *	□ Yes	□ No

* If you answered yes to any of the questions 4-9, please attach further detailed information with your application packet.

Check the problem areas that you have expertise in and are qualified to assess:

☐ Adjustment/Life transitions
☐ Alcohol/drugs
☐ Anger management
☐ Anxiety disorders
☐ Blended family/divorce
☐ Child abuse issues
☐ Chronic Mental Illness
☐ Chronic/Terminal Illness/Health
☐ CISD/CIR
☐ Depression
☐ EAP/work-related
☐ Developmental disorders
☐ Domestic violence
☐ Eating disorders
☐ Family
☐ Financial
☐ Gambling
☐ Grief/bereavement
☐ Marital/couples
☐ Medical issues
☐ Mood Disorders
☐ Multi-cultural issues
☐ OCD
☐ Pain management
☐ PTSD
☐ Sexual abuse
☐ Sexual issues
☐ Stress management
☐ Veterans/Veterans' Readjustment
☐ Women's Issues
☐ Work issues
☐ Other, please specify: _____

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Check the population areas that you have expertise in and are qualified to assess:

☐ African American	☐ Hearing Impaired	☐ Ages 12-18
☐ Asian American	☐ LGBTQ	☐ College student population
☐ Hispanic	☐ Ages under 5	☐ Law enforcement/first responders
☐ Native American	☐ Ages 6 to 12	☐ Other, please specify: _____

Attestation

I hereby submit this application for participation with HealthyMinds, LLC. I understand that this application will be reviewed based on the information I have provided herein. I understand and agree that the certifications, authorizations and other provisions contained herein shall remain in force for so long as this application is pending and, if accepted for participation, for so long as my participating Provider agreement with HealthyMinds remains in force. I understand and consent that HealthyMinds has sole authority to accept or deny my application, as an affiliate Provider, and that I will not appeal a denial of my application. If HealthyMinds does not credential me as an affiliate Provider, I agree not to initiate legal action in response to such determination.

I hereby certify that the information contained herein is correct, accurate and complete to the best of my knowledge and belief. I understand that misrepresentations or omissions from this application may be cause for denial or dismissal from HealthyMinds, LLC's affiliate Provider Network, now or in the future. I agree to promptly notify HealthyMinds, LLC if there are any material changes in the information provided, whether prior to or after my acceptance as a HealthyMinds, LLC participating affiliate Provider.

By applying for participation in the HealthyMinds, LLC affiliate Provider Network, I hereby authorize any hospital, agency or group practice, other clinical employer, professional society, malpractice carrier, or other agency or organization with information regarding my credentials to release, furnish copies, or give details of my professional credentials and qualifications related to my clinical practice, competence and qualifications, including my moral and ethical qualifications. I hereby release from liability any and all individuals and organizations that, in good faith and without malice, provide information to HealthyMinds, LLC for the purpose of evaluating this application and release HealthyMinds, LLC from liability for its use of the information it gathers in the application process.

A photocopy of this permission will be as valid as the original.

This authorization to obtain confidential information about me remains in effect until I notify HealthyMinds, LLC otherwise in writing, or am no longer a HealthyMinds, LLC participating affiliate provider.

Printed name of applicant _____

Signature of applicant _____

Date Signed _____

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Authorization for Direct Deposit

I authorize HealthyMinds, LLC to deposit my reimbursement automatically to the account indicated below and, if necessary, to adjust or reverse a deposit for any entry made to my account in error. This authorization will remain in effect until I cancel it in writing and in such time as to afford HealthyMinds, LLC a reasonable opportunity to act on it.

Name on bank account: _____
Bank account number: _____
Bank routing number: _____

Account type:

- ☐ Checking
- ☐ Savings

Important: Please attach a voided check for the bank account to which funds should be deposited.

Account owner signature: _____
Date: _____

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