BEST CARE EAP AFFILIATE PROVIDER APPLICATION

Business or Individual Practitioner Name _____

Address _____

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

Phone _____ **Fax** _____ **Email** _____

Payment address (if different from above)_____

Individual practice _____ **Group practice** _____ **If group, how many total providers at all locations?** _____

Additional Locations:

Address	Phone	Fax	Email	# of Providers

If more space is needed please include an additional page.

Are you able to provide:

Substance Use Assessments ☐ Yes ☐ No
Critical Incident Response ☐ Yes ☐ No
Education/Training ☐ Yes ☐ No
Telephonic Counseling ☐ Yes ☐ No
Video Counseling ☐ Yes ☐ No

Evening Hours ☐ Yes ☐ No
Weekend Hours ☐ Yes ☐ No

States of Licensure _____

Languages Spoken (other than English) _____

Preferred Method to receive Authorization ☐ **Email** ☐ **Fax**

Please indicate areas of specialty:

☐ African American ☐ Asian ☐ Hispanic ☐ Geriatric
☐ Parenting ☐ Grief/Loss ☐ Child/Adolescent ☐ Domestic Abuse
☐ Couples ☐ EMDR ☐ Sexual Abuse ☐ Faith Based
☐ LGBT ☐ Substance Abuse

Please include the following documents with your application:

☐ Professional liability insurance (at least $1,000,000 – $3,000,000 minimums)
☐ Copy of current licenses
☐ W9 or W8BEN (Canada)