

ResponseWorks, Inc.
285 South Main Street
Lambertville, NJ 08530

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Fax# (609)397-9587

ResponseWorks, Inc. Individual Provider Application

NAME: _____

TAX ID NUMBER: _____ NPI # _____

Applying to Provide: Trauma Response Student Assistance EAP

For Traumatic Stress Services:

Is Provider able to provide services to any location in the US? Yes No
Is Provider able to provide international services? Yes No

*Directions: Please complete at least one Service Address and Mailing Address section.
If you have more than two service locations, please include this information on a separate sheet or photocopy this page.*

PRIMARY SERVICE ADDRESS (1):

Address _____

City _____ State/Province _____ Zip _____

Phone Number _____ Fax Number _____

Emergency Number _____ cell # _____

Email address _____

Does this service location comply with ADA (American with Disabilities Act) Regulations? Yes No

Is this service location accessible by public transportation? Yes No

MAILING ADDRESS:

Address _____

City _____ State/Province _____ Zip _____

LIABILITY/INSURANCE INFORMATION

Please include a copy of faxesheet with limits and expiration date

Have you ever been the subject of any malpractice action/investigation? ___ Yes ___ No

If yes, please attach explanation

Company name of liability carrier: _____ Limits of liability: Per occurrence: \$ _____ Aggregate: \$ _____

For Coordination of care, please list major Health Plans and Behavioral Managed Care companies with which you participate:

AFTER HOURS COVERAGE

Please indicate the method used to provide 24/7 coverage for emergencies. Please include your cell phone/pager number:

LICENSURE/CERTIFICATION and/or ACCREDITATION

Licensed Discipline:

*Please indicate the discipline under which you are Licensed and/or Certified.
Please attach a copy of diploma for highest clinical degree and all current licenses/certifications*

- Psychologist Social Worker CAC LPC/MHC MFT/MFCC Other: _____
Specify

Additional Certification:

Please attach a current copy of all additional certifications

- CISD ATSS Certification BCATES Trauma Certification

How many years of postgraduate clinical experience do you have? _____

If applying as traumatic stress services provider, please indicate specific training you have received in this area, including dates and trainer. Please describe your most recent two occasions providing trauma response services, including dates:

CLINICAL AND PRACTICE PROFILE

Specialties *(Please indicate which of the following you provide)*

<input type="checkbox"/> Critical incident debriefing/trauma response services <input type="checkbox"/> Mass casualty disaster response services <input type="checkbox"/> Family assistance services <input type="checkbox"/> Supervisor/management training/consultation <input type="checkbox"/> Faculty/administration training or consultation <input type="checkbox"/> School violence intervention <input type="checkbox"/> Alcohol/Substance abuse <input type="checkbox"/> EMDR <input type="checkbox"/> Sexual assault/ Rape support	<input type="checkbox"/> LGBT and Q <input type="checkbox"/> Anger management <input type="checkbox"/> Adolescents/young adults <input type="checkbox"/> Veterans <input type="checkbox"/> Suicide intervention <input type="checkbox"/> Emergency evaluation <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Other: _____
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Special Populations and Foreign Languages *(check all that apply)*

<input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Visually Impaired <input type="checkbox"/> Speech Impaired <input type="checkbox"/> Other Disabled	<input type="checkbox"/> Arabic <input type="checkbox"/> Chinese <input type="checkbox"/> French <input type="checkbox"/> German	<input type="checkbox"/> Greek <input type="checkbox"/> Hebrew <input type="checkbox"/> Italian <input type="checkbox"/> Japanese	<input type="checkbox"/> Korean <input type="checkbox"/> Polish <input type="checkbox"/> Portuguese <input type="checkbox"/> Russian	<input type="checkbox"/> Spanish <input type="checkbox"/> Swedish <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other: _____
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I attest that all information provided to ResponseWorks, Inc. is true and correct to the best of my knowledge and belief. I agree to notify ResponseWorks, Inc. promptly if there are any material changes in the information provided. I hereby authorize ResponseWorks, Inc. to release information to any person, entity or governmental agency that has a legal right to know under any state or federal law. I agree to hold ResponseWorks, Inc. harmless from any liability for providing any such information as specified herein.

Provider Signature

Date

RESPONSEWORKS, INC.
PROVIDER APPLICATION CHECKLIST

Please check to ensure the following documents are present and completed before forwarding to ResponseWorks, Inc.

1. Letter of Agreement is executed, unaltered and includes all attachments _____
2. Application is completed, signed and dated _____
3. Copy of current malpractice insurance facesheet _____
4. Copy of current license _____
5. Copy of certifications in field of practice _____
6. Curriculum vitae _____
7. W-9 form (US ONLY) _____