

AFFILIATE INFORMATION FORM

Date: _____

Interviewed by: _____

Affiliate Name: _____

Email Address: _____

Send affiliate kits to: Office #1 Office #2 Home / Other Fax to:

Nearest metro area (within 20 miles): _____

Office 1	
Street:	Phone:
City/State/Zip:	Fax:

Office 2	
Street:	Phone:
City/State/Zip:	Fax:

Other offices? *Please elaborate on back of form.*

Clinical Experience				
Degree(s):	License(s):			
Number of years in private practice:				
Number of years of EAP experience:				
<p>Please number (1-3) your top areas of expertise and check (✓) all other areas where you can provide assessment.</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Addictions <input type="checkbox"/> Anger Management <input type="checkbox"/> Anxiety <input type="checkbox"/> ADD & ADHD <input type="checkbox"/> Blended Families <input type="checkbox"/> Career <input type="checkbox"/> Chronic Illness/Pain <input type="checkbox"/> Codependency <input type="checkbox"/> Crisis Intervention </td> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Critical Incidents <input type="checkbox"/> Depression <input type="checkbox"/> Domestic Violence <input type="checkbox"/> EAP Specialist <input type="checkbox"/> Eating Disorders <input type="checkbox"/> Elder Issues <input type="checkbox"/> Gay/Lesbian <input type="checkbox"/> Grief <input type="checkbox"/> Parenting </td> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Personality Disorders <input type="checkbox"/> Psychosis <input type="checkbox"/> Relationships <input type="checkbox"/> Sexual Abuse <input type="checkbox"/> Sexual Issues <input type="checkbox"/> Stress Management <input type="checkbox"/> Trauma <input type="checkbox"/> Work/Life Balance <input type="checkbox"/> Workplace Issues </td> </tr> </table>		<input type="checkbox"/> Addictions <input type="checkbox"/> Anger Management <input type="checkbox"/> Anxiety <input type="checkbox"/> ADD & ADHD <input type="checkbox"/> Blended Families <input type="checkbox"/> Career <input type="checkbox"/> Chronic Illness/Pain <input type="checkbox"/> Codependency <input type="checkbox"/> Crisis Intervention	<input type="checkbox"/> Critical Incidents <input type="checkbox"/> Depression <input type="checkbox"/> Domestic Violence <input type="checkbox"/> EAP Specialist <input type="checkbox"/> Eating Disorders <input type="checkbox"/> Elder Issues <input type="checkbox"/> Gay/Lesbian <input type="checkbox"/> Grief <input type="checkbox"/> Parenting	<input type="checkbox"/> Personality Disorders <input type="checkbox"/> Psychosis <input type="checkbox"/> Relationships <input type="checkbox"/> Sexual Abuse <input type="checkbox"/> Sexual Issues <input type="checkbox"/> Stress Management <input type="checkbox"/> Trauma <input type="checkbox"/> Work/Life Balance <input type="checkbox"/> Workplace Issues
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Other areas of expertise:				
Populations you work with: <input type="checkbox"/> Groups <input type="checkbox"/> Children <input type="checkbox"/> Adolescents <input type="checkbox"/> Individual females <input type="checkbox"/> Individual males <input type="checkbox"/> Couples <input type="checkbox"/> Families				
Other EAPs you affiliate with:				

Accessibility	
Can you accommodate a client within 72 hours for an assessment?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Evening and/or weekend hours?	<input type="checkbox"/> Evening <input type="checkbox"/> Weekend
Is your office handicap accessible?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is your office available by public transportation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you speak languages besides English?	<input type="checkbox"/> Yes <input type="checkbox"/> No
List:	

Professional Liability	
Liability Insurance info being sent: (Must be included with affiliate's information)	
Have you ever incurred a claim against your insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has your liability coverage ever been revoked, suspended, or not renewed because of a claim?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are there any pending legal actions against you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are there any pending claims / complaints against you by your Board of Registration?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If answer is "Yes" to any of the preceding questions, please explain:	
Insurance provider networks:	<input type="checkbox"/> Yes <input type="checkbox"/> No

Provider Panels	
Check all that apply; add any panels to which you belong that are not listed below:	
<input type="checkbox"/> Aetna <input type="checkbox"/> Blue Cross HMO <input type="checkbox"/> Blue Cross PPO <input type="checkbox"/> Blue Shield (CA only) <input type="checkbox"/> Cigna <input type="checkbox"/> Fallon <input type="checkbox"/> Great West Healthcare <input type="checkbox"/> Harvard Pilgrim	<input type="checkbox"/> MassHealth <input type="checkbox"/> Medicaid <input type="checkbox"/> Neighborhood Health Plan <input type="checkbox"/> Private Health Care Systems <input type="checkbox"/> Tufts <input type="checkbox"/> United Behavioral Health <input type="checkbox"/> Unicare
Other panels:	

Training	
Do you have experience providing EAP Manager Training, Stress Management or other training?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If so, would you consider being available to provide training in your area on behalf of KGA?	<input type="checkbox"/> Yes <input type="checkbox"/> No

About KGA (Internal Use Only)	
Describe KGA and use of affiliates	<input type="checkbox"/> Yes
Short-term nature of EAP	<input type="checkbox"/> Yes
Assessment fee per session	\$
Children and/or adolescents guidelines	<input type="checkbox"/> Yes
Self-Referral guidelines	<input type="checkbox"/> Yes
Extended Wellness Program	<input type="checkbox"/> Yes
Overview of RFS Packet	<input type="checkbox"/> Yes