**Thank you for your interest in joining the Alternatives EAP Provider Network. Please complete the following information so we may efficiently process your application. A complete and up-to-date CAQH application is required.**

**How did you hear about Alternatives EAP?**

[ ]  A colleague

[ ]  A mailing from Alternatives

[ ]  Internet search

[ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Select one:

[ ]  Provider in Private Practice

[ ]  Group (if you are adding a provider to an existing group, please complete the “Adding a Provider to a Group” form)

**Return form to:**

|  |
| --- |
| Cathy Titus, Client Services Coordinator at Ctitus@commcare1.org. You can also reach Cathy by phone at (913) 378-4043 with any questions.  |

**Required Documentation (Please return all of the below forms with the completed application)**

|  |
| --- |
| 1. Completed Application
2. Current Resume(s)
3. Copy of current license(s) and certification(s) for all states in which a license is held. If this is a group application, provide licensure and certifications for all providers that will be participating.
4. Verification of business and liability insurance (Minimum $1 Million per claim and $3 Million aggregate)
5. Copy of completed and signed W-9 (s)
6. Signed Affidavit and Release of Information
7. Signed Group Attestation (if applicable)
8. Completed Provider Agreement
9. Signed Telehealth Video Counseling Guidelines Acknowledgement (if applicable)
 |

**Contact Information**

|  |
| --- |
| Name (Individual or Organization/Group): Click to enter text. |
| Office Address: Click to enter text. | Mailing Address (if different):Click to enter text. |
| Work Phone: Click to enter text. | Cell Phone: Click to enter text. |
| E-Mail (Required): Click to enter text. | Fax: Click to enter text. |
| What is the best way to reach you in an urgent situation during business hours?Click to enter text. | What is the best way to reach you in an urgent situation after-hours and weekends?Click to enter text. |
| **What number does the employee/family member call to make an appointment?** Click to enter text. |

**Accessibility – Check box(s) for all that apply.**

|  |
| --- |
|[ ]  Is the office disabled accessible? Click to enter text. |
|[ ]  Is public transportation available? Click to enter text. |
|[ ]  Do you provide Virtual Counseling? List all states: Click to enter text. |
|[ ]  Do you provide in-person counseling? List all states: Click to enter text. |
|[ ]  Are you or someone in your group Substance Abuse Professional (SAP) qualified? If yes, who?Click to enter text. |
|[ ]  Are you or someone in your group Certified Employee Assistance Professional (CEAP) certified? If yes, who?Click to enter text. |
|[ ]  Can you or someone in your group provide chemical dependency evaluations? If yes, who?Click to enter text. |
|[ ]  Do you specialize or prefer to work with particular client populations? If yes, list in next section:Click to enter text. |
|[ ]  Are you or someone in your group available to provide on-site Critical Incident Response (CIR) consultations? If yes, who? Click to enter text. |
|[ ]  Are you or someone in your group available to provide any basic organizational development services such as conflict resolution, management coaching, or team building? If yes, list: Click to enter text. |
|[ ]  Do you or someone in your group hold certifications? If yes, list: Click to enter text. |

**Individual or Group Affidavit and Release of Information – Check box(s) for all that apply.**

|  |  |
| --- | --- |
| [ ]  | Have you or anyone in your group everbeen notified by any state, territory, district, country, U.S. government agency, or state-licensing board of anycomplaint filed against them? This includes, but is not limited to, any allegations currently pending. If yes, please explain: Click to enter text. |
| [ ]  | Has any disciplinary action ever been taken against you or anyone in your group regarding licensure? This includes any disciplinary actions by the U.S. military, U.S. Public Health Service, or other U.S. federal governmental entity. (Disciplinary actions include, but are not limited to, suspension, revocation, probation, practice limitations, reprimand, letter of admonition, censure, and any allegations currently pending.) If yes, please explain: Click to enter text. |
|[ ]  Have you or any member of your group ever had staff privileges limited or reduced, denied, suspended or revoked, or has resigned from a staff position in lieu of disciplinary action? If yes, please explain: Click to enter text. |
|[ ]  Have you or a member of your group ever been convicted of, or pled guilty or nolo contendereto, any felony in any state, territory, district, the U.S., or foreign country? If yes, please explain: Click to enter text. |
|[ ]  Have you or a member of your group ever entered into a malpractice settlement or had any malpractice judgment entered against you in a court of law? If yes, please explain: Click to enter text. |
|[ ]  I affirm that as an organization or a group practice, that all practitioners who provide services are at a minimum, masters’ level, licensed and credentialed by the organization.  |
|[ ]  Have you ever been terminated or removed from a panel or EAP organization? If yes, please explain: Click to enter text. |
|[ ]  I affirm that the information I have provided above regarding myself or the group is true and accurate. I understand that Alternatives EAP will investigate my/our licensure status with the state(s) in which I or our group/agency is licensed to practice professionally, as well as other certification(s) and/or staff privileges represented herein. I also understand that Alternatives EAP will use other subjective and objective criteria in evaluating my/our application(s) and has a right to reject any application.  |

 **Signature Date**

|  |  |
| --- | --- |
| Click to enter text. | Click to enter a date. |

**Individual and Group Practice Information (add additional lines as needed)**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Counselor Name** | **Degree** | **Years in Practice** | **Years of EAP Experience** | **Specialties** | **CAQH ID\*** | **NPI** | **States Where Licensed** | **Additional Languages** |
| Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. |
| Click or tap here to enter text. | Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. |
| Click or tap here to enter text. | Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. |
| Click or tap here to enter text. | Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. |
| Click or tap here to enter text. | Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. |
| Click or tap here to enter text. | Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. |
| Click or tap here to enter text. | Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. |
| Click or tap here to enter text. | Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. |
| Click or tap here to enter text. | Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. |

**\*A complete and up-to-date CAQH application is required.**

**Group Practice Information**

**Group Attestation (for group applications only)**

On behalf of

|  |
| --- |
| Organization or Group Name: Click or tap here to enter text. |

I attest that this agency maintains current licensure for each clinician who provides services for clients referred through Alternatives EAP by checking the box below.

**The agency provides -** **Check box(s) for all that apply.**

|  |
| --- |
|[ ]  Malpractice insurance on each clinician providing services. |
|[ ]  Individual clinicians carry their own malpractice insurance. |
|[ ]  Licensure is maintained on file at this agency and can be provided upon request to Alternatives EAP. |
|[ ]  Proof of coverage is attached. |

**Agency Representative Signature Date**

|  |  |
| --- | --- |
| Click to enter text. | Click to enter a date. |

|  |
| --- |
|[ ]  **Form uploaded in PROVIDERfiles– For Internal Use only.** |

**Provider Partnership Agreement**

This Agreement is entered into this date of

|  |
| --- |
| Click here for date  |

by and between Alternatives EAP LLC a wholly owned subsidiary of CommCARE Behavioral Health, 1627 Main St., Suite 200, Kansas City, Missouri, 64108 ("Alternatives EAP") and,

|  |
| --- |
| Provider Individual or Group Name: Click to enter text. |

herein referred to as "Provider.” In consideration of the covenants set forth herein and other valuable consideration, the sufficiency of which is hereby acknowledged, Alternatives EAP and provider hereby agree as follows:

 I. Provider:

1. To provide the Employee Assistance Program (EAP) services outlined in the attached ***Reimbursement Schedule***.
2. To follow Alternatives EAP working protocols, to use the Alternatives EAP Electronic Health Record (EHR), EAP Expert PROVIDERfiles, and related ***Client and Provider Forms*** (located on the [www.alternativeseap.com](http://www.alternativeseap.com) website) when performing professional services for Alternatives EAP clients. Certain Alternatives EAP client employees, dependents, and significant others, herein referred to as "client employees.” referred to provider may require modification of standard policies and procedures. Deviations from Alternatives EAP standard policies and procedures must be approved by Alternatives EAP in advance.
3. To practice and behave in a manner consistent with individual clinical licensure. To avoid conflicts of interest in carrying out EAP responsibilities, it is required to also follow the Employee Assistance Program Association (EAPA) Code of Ethics and Conduct. It is the responsibility of our EAP providers to keep abreast of relevant regulatory and legislative developments impacting EAP practice. A copy of the EAPA Code of Ethics and EAPA Code of Conduct can be obtained from [eapassn.org](http://www.eapassn.org). Please sign and return the attached ***Code of Ethics and Conduct Attestation*** form.
4. To direct bill Alternatives EAP, through PROVIDERfiles, for all professional services performed in accordance with the rate(s) shown in the attached ***Reimbursement Schedule***. **Provider agrees to not bill the client for any reason.** Alternatives EAP will not reimburse for any services that are more than three months old.

E. The Provider should obtain from each referred client employee and/or family memberthe ***Client Statement of Understanding*** (or any other document required by local/state statute). It is preferable, however not required, to upload the form to PROVIDERfiles. The form is compliant with the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”).

F. To maintain for the duration of this Agreement, at minimum $1,000,000.00 per occurrence/$3,000,000.00 aggregate professional liability insurance in force while providing services to Alternatives EAP client employees, and to provide Alternatives EAP with evidence of such coverage.

G. That because Alternatives EAP client employees originally contact Alternatives EAP for EAP services and because of the contractual relationship between Alternatives EAP and Provider, there is no confidentiality requirement regarding communications or information exchanged between Alternatives EAP and provider with respect to said covered members.

H.Provider will maintain in a complete clinical, administrative, and financial file relating to services provided to Alternatives EAP client employees and family members pursuant to this agreement and the licensing and certification of provider as a professional and in accordance with state and federal law. The file will also contain any necessary releases of confidential information. Prior to the first appointment, Employees and family members are asked by Call Center staff to complete a ***Client Information Form (CIF)***. If completed, please keep this form as part of the clinical record. Provider will document if the client declines to complete the CIF. Alternatives EAP will have the right to inspect and make copies of additional records during the contract period and, as required by law, for a period of up to seven years. It is preferable, however not required, that client documents be uploaded into PROVIDERfiles.

I. To assure that said client employee is considered an Alternatives EAP client/client employee and/or family member unless Alternatives EAP designates otherwise in writing to provider.

J. To keep strictly confidential all information concerning Alternatives EAP clients, client employees and the terms, including pricing, of the business relationship between Alternatives EAP and provider.

K. To refrain from engaging in any activity that may adversely interfere with the business relationship between Alternatives EAP and its clients.

L. That upon termination of the relationship between provider and Alternatives EAP and for a one (1) year period after termination of said relationship for any reason; provider will not personally interfere with the business relationship between Alternatives EAP and its clients.

M. Provider will regularly update the EAP Expert PROVIDERfiles and, as needed, the Chief Clinical Officer of any changes, renewals of insurance, licenses, certifications, pending lawsuits, etc. Alternatives EAP will re-credential every three years. A complete and up-to-date CAQH application is required.

 II. Provider warrants:

1. The assigned practitioner will render the highest possible level of care in providing the

 Professional EAP services set forth in this Agreement.

B. All professional services provided to Alternatives EAP client covered employees pursuant to this Agreement shall be provided by experienced, competent, professional personnel who hold at least a Master's degree in psychology, social work, counseling, or a related discipline, are licensed/credentialed to practice in their respective State, and brief solution focused EAP counseling experience is preferred.

C. Alternatives EAP shall have the exclusive rights to bill and collect fees from client organizations of Alternatives EAP for services rendered to their employees/dependents/significant others pursuant to this Agreement. **Provider warrants that they will not attempt to collect any co-pay, deductible, or fee of any kind from the covered member or the client company.**

D. That provider shall not directly or indirectly communicate with any Alternatives EAP client employee organizations or their personnel with respect to any Alternatives EAP client employees, and shall submit any and all such proposed communications through Alternatives EAP unless Alternatives EAP agrees that provider may do so.

E**.** Provider agrees to never recommend time off for any reason for the covered member without consultation with the Alternatives EAP Director of Clinical Operations.

III. Alternatives EAP:

1. To furnish to provider with a copy of Alternatives EAP ***Provider Manual*** ***Client and Provider Forms*** (located on the [www.alternativeseap.com](http://www.alternativeseap.com) website), and any other information needed to service the covered member.

1. To promptly remit payment within thirty [30] days to provider upon receipt of appropriate PROVIDERfiles invoice.
2. To keep strictly confidential the terms of the business relationship between Alternatives EAP and Provider.
3. Other terms and/or provisions as set forth in the attached ***Reimbursement Schedule***, the ***Provider Manual***, and related binding documents.

IV. Provider in performing the services contemplated herein shall for all purposes be deemed an independent contractor. In no event shall this Agreement be construed to create a partnership, agency, joint venture, employment or other similar relationship between the parties.

V. Provider agrees to fully indemnify and hold harmless Alternatives EAP, its officers, directors, representatives, shareholders, and employees for all claims, demands, and losses, including costs and attorney's fees, arising out of or related to this Agreement and any services performed pursuant to this Agreement for services provided by Provider. Alternatives EAP agrees to fully indemnify and hold harmless Provider, its officers, directors, representatives, shareholders, and employees for all claims, demands, and losses, including costs and attorney's fees, arising out of or related to this Agreement and any services performed pursuant to this Agreement for services provided by Provider.

VI. This Agreement shall be interpreted, construed, and governed according to the laws of the State of Missouri. This Agreement shall supersede any oral and written statements or agreements relating to the items covered in this Agreement and shall constitute the complete Agreement between Alternatives EAP and Provider. No modification of this Agreement is binding upon Alternatives EAP or provider unless it is expressly agreed to in writing and signed by Alternatives EAP and Provider. If any provision of this Agreement is in conflict with any existing or future state or federal law, such provision of this Agreement shall be severable, and the remainder of this Agreement shall not be impaired and shall remain in full force and effect.

VII. This Agreement shall be in effect upon the affixing of signatures hereto and may be terminated by written thirty (30) day notification of either party, by mutual agreement of the parties.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the date and year first above written.

|  |  |
| --- | --- |
| **Alternatives EAP, LLC**1627 Main St., Suite 200 Kansas City, Missouri, 64108816-472-9012 ext. 101  | **Individual or Group Name and Address**Click to enter text. |

**Alternatives EAP Designee Date**

|  |  |
| --- | --- |
|  |  |

**Provider Signature Date**

|  |  |
| --- | --- |
|  |  |

**Code of Ethics and Conduct Attestation**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, attest that I have read and adhere to the EAPA Code of Ethics and Conduct for clients referred through Alternatives EAP.

**Provider Signature Date**

|  |  |
| --- | --- |
|  |  |

**Reimbursement Schedule**

1. Services offered by Provider:
2. Assessment, brief solution focused counseling, support/monitoring, and referral (if needed) of covered member for personal problems including, but not limited to, chemical dependency, emotional/psychiatric problems, marital, family, and relationship problems. Covered members are entitled to a maximum number of sessions based on their employer's contract with Alternatives EAP. When a covered member is referred the session parameters will be supplied to the Provider.
3. Will see referred members within two to three business days or at the client’s choosing, whichever is best.
4. If agreeable, perform on-site Critical Incident Response (CIR), conflict resolution, education, and training activities at client locations as specified by Alternatives EAP. Initial, if providing:

|  |
| --- |
| Provider Initials:  |

1. If agreeable, will provide Substance Abuse Professional Services (SAP). Initial, if providing:

|  |
| --- |
| Provider Initials:  |

1. Alternatives EAP agrees to reimburse provider for services at the following rates:
2. Assessment, brief solution focused counseling, referral, and support/monitoring for the hourly rate of:

|  |
| --- |
|  |

1. Travel when approved by Alternatives EAP based upon Federal Reimbursement Guidelines.

 [ ]  Provider acknowledges and agrees to this fee schedule.

Provider agrees to remind all Alternatives EAP clients that Alternatives EAP will request, by e-mail and/or phone, a Satisfaction Survey after the conclusion of the first session. Additionally, provider will remind clients that they will be asked to complete a pre- and post-counseling Workplace Office Suite (WOS) questionnaire. Client is aware that the Satisfaction Survey may be voluntarily completed online at [www.AlternativesEAP.com](http://www.AlternativesEAP.com) .

|  |
| --- |
| Provider Initials:  |

**TeleHealth Video Counseling Guidelines**

These guidelines are developed to serve as a reference to clinicians to assist in providing TeleHealth counseling to clients. The primary purpose of these guidelines is to support clinicians in establishing effective and safe practices to meet client needs. The guidelines are not meant to be requirements. (See signature page)

**Definitions:** The following words when used in this document have the following meaning.

**Video counseling**: Counseling between the client and the clinician that is held live over distances using a telecom platform or software.

**TeleHealth:** The use of telecommunication technologies for clinical care counseling with clinicians for planning, and other diverse aspects of behavioral health care delivery system.

**General Protocols**

□ The guidelines for TeleHealth counseling will describe roles, responsibilities, communication, and procedures to address counseling and emergency issues. The level of involvement of TeleHealth clinicians will significantly vary depending on remote work sites, local resources, and availability.

□ TeleHealth counseling is limited to coaching and consultations, psychotherapy, counseling, psychiatric diagnostic assessments, and discharge planning.

□ The following will NOT be considered as TeleHealth video counseling; telephone conversation, electronic mail messages, facsimile correspondence.

□ Clinicians will NOT provide TeleHealth counseling to clients who are accessing session from a physical site that is located outside of the United States of America.

□ TeleHealth clinicians will ensure that proper staff is available to meet client needs prior, during, and after tele-video counseling interactions.

□ TeleHealth clinicians will be aware of the requirements for privacy and confidentiality that is applicable to clients receiving tele-video counseling services.

□ Clinicians will use the same process for documentation, storage, and retrieval of TeleHealth counseling records. Specific agreements will be in place to identify who will be granted access to the records.

□ TeleHealth clinicians will comply with consents to treat clients that apply to the applicable area of mental health.

□ Clinicians should inform clients of their client rights through TeleHealth, including the right to not use TeleHealth counseling.

**Clinical Protocols**

□ Clinicians will maintain appropriate clinical licensure for their area of practice and abide by professional standards set by the regulatory body, as well as maintain appropriate education, training, and professional development.

□ Clinicians will ensure that the standard of care that is delivered through TeleHealth is comparable to other types of care that would otherwise be delivered by in-person care.

□ Clinicians will be responsible for maintaining professional discipline and practice standards when delivering care in the TeleHealth setting, and make changes as needed.

**Session Checklist**

CommCare recommends that clinicians reference the following checklist for each TeleHealth counseling session that is completed.

**Before the Session:**

□ Are you logged into a secure tele-communication website, platform, or software?

□ Have you reviewed client information, if available?

□ Have you located the specific appointment for your session?

□ Are you or your client experiencing technical difficulties?

**After the Session:**

□ Have you scheduled the follow-up appointment with the client?

□ If available, have you added the follow-up appointment to your tele-communications software or platform?

□ Have you contacted the client with the follow-up appointment information?

□ Have you completed your clinical notes?

**TeleHealth Conferencing Equipment**

Telehealth technologies can be utilized by clinicians through several options. This may include:

□ Encrypted Internet connections.

□ Broadband networks, and high lines, through a secure connection which allow clinicians to connect with other sites with similar connectivity.

□ Single-line telephone and video lines, which allow clinicians to connect with clients remotely.

**Utilizing TeleHealth Counseling**

□ All individuals present in the room at both sites should be introduced prior to beginning the session to assure privacy and confidentiality. It is acceptable for client to verbally consent for additional individuals to be in the room at the client site location. If there are safety concerns which mandate that another individual participate in the session, then it is not required to obtain client’s permission.

□ Clinicians will have access to relevant clinical information when possible, as would typically be offered if the client were to be seen in-person.

□ Clinicians will have agreements in place for securely sharing clinical data with collateral contact when appropriate by licensing standards, laws or other regulations.

□ There should be a trackable method to demonstrate that a clinical event occurred. It is expected that clinicians will document in the client’s health record any services that were performed, as well as correspondence.

□ Clinicians should comply with standard practice guidelines for counseling within the TeleHealth video counseling setting. Clinicians should use evidence-based practice treatment and adapt as appropriate for video-counseling.

□ Clinicians will use video-conferencing from a private room for the duration of Telehealth counseling and no unauthorized individuals will be allowed without consent and/or client agreement, in order to protect client’s confidentiality.

□ Clinicians will consider wearing headphones which will help create privacy.

□ Clinician should exercise precaution to protect the privacy of the TeleHealth counseling session.

□ Clinician will be well lit, using natural light from a window for daylight when possible.

□ Clinician will try to setup a backdrop that is free of distractions (bookshelves, posters, office paper, etc.

**Managing Technical Issues Before or During TeleHealth Appointments**

**How does a client access their appointment?**

Client will connect to their session through a computer or mobile device, as available. This connection may require downloading the app or software onto either their phone or onto their computer or tablet.

**Troubleshooting Technical Issues**

If a clinician or a client has a technical issue while trying to connect to an appointment the clinician needs to attempt to resolve the issue. If the issue cannot be resolved, then as a last resort the clinician should reschedule the appointment with the client.

**Emergency Protocols**

Due to the nature of TeleHealth clinicians should not provide direct clinical interventions to clients experiencing a psychiatric emergency. The role of the clinician in addressing a psychiatric emergency should be to triage clients to an appropriate resource who can better assess, provide treatment, and manage behavioral health risks. The following are steps for clinicians to consider:

□ This may include assessment of client’s intent, plan or means to harm self or others.

□ Clinician should consider contacting emergency personnel response by calling 911 or other action to ensure that client receives immediate intervention.

□ Identify plan for client to start admission process for voluntary hospitalization, as appropriate. Clinician will follow duty-to-warn expectations as outlined in licensing standards, laws or other regulations.

□ Create a safety plan as appropriate.

□ Clinician will schedule a follow-up session with client, as needed.

References:

1) American Telemedicine Association: Practice Guidelines for video conferencing-based tele-mental health.

2) Oklahoma Medical Board: Telemedicine Policy 9/18/2008

3) Tele-health Start Up and Resource Guide

**TeleHealth Video Counseling Guidelines Acknowledgement**

My signature indicates that I have read this guideline, and understand it. I acknowledge that consumer information should be treated confidentially, and I understand the business need for confidentiality of proprietary information as outlined above, which such information is identified as proprietary and confidential. I understand that the confidentiality of the information continues even after my association with Alternatives EAP has ended.

Print Name of Clinician

Signature of Clinician Date