EFR EMPLOYEE & FAMILY RESOURCES **Employee & Family Resources, Inc.®**

EAP Provider Credentialing

Part 1: Administrative

One copy is to be completed for the practice/agency. Return with an *EAP Provider Credentialing Part 2: Clinical* form for each clinician providing EAP services.

Administrative Information

Practice Name: _____ Date: _____

Director/Owner:_____

Primary EAP Contact:_____Tax ID_____

Mailing/Billing Address:_____

Address City State Zip

Clinical Locations

Address	City	State/Zip	Days/Hrs of availability
Primary:			
Others:			

Scheduling and Correspondence

Phone # for intake/scheduling ( )_____ (800)_____
Please note any special intake instructions that would aid EFR and its clients with most efficiently accessing your services_____
_____
_____
Phone # for all other calls, if different from above ( )_____Fax ( )_____
Emergency/After hours phone number and process _____
_____
Administrative email address_____
Recipient of administrative email_____

Accessibility

Are your services accessible to individuals with physical disabilities? _____ Yes _____ No
Does your practice provide a private waiting area for clients? _____ Yes _____ No
Are clients able to get to your office via public transportation? _____ Yes _____ No

Multicultural Services

Does your practice provide cultural competency training for staff? _____ Yes _____ No
Are clinicians able to provide clients with local diversity resources? _____ Yes _____ No

Liability

Has this practice or any individual within this practice at any time had licensure, certification and/or accreditation suspended or revoked and/or received a reprimand or been involved in a judicial proceeding due to improprieties with respect of their professional practice? _____ Yes _____ No
If yes, please explain the circumstances and outcome in detail and attach to this application.

Does your practice perform either a pre-employment or post-employment criminal background checks on all counselors? _____Yes _____No

Does your practice have a plan and/or provide training to staff to protect clients, staff and clinicians in potentially violent situations? _____ Yes _____No

The following must accompany this form for completion of a provider contract:

_____ Copy(s) of professional liability insurance reflecting each clinician covered.

_____ Completed W-9 form for each applicable tax ID.

_____ Completed EAP Provider Credentialing: PART 2: Clinical form for each clinician serving EAP clients.

_____ Resumes for each clinician seeking credentialing, if available.

_____ Licenses/certifications for each clinician seeking credentialing.

Return this application to:

Provider Relations
Employee & Family Resources, Inc.
505 5th Avenue, Suite 600
Des Moines, IA 50309-2319
Phone (800) 327-4692 · Fax (515) 284-5201
Website: www.efr.org/eap · Email: ProviderRelations@efr.org

Thank you for your interest in being a provider for Employee & Family Resources EAP!