# *Palmetto EAP Provider Application*

You may fax, email or mail your information to

**Palmetto EAP**
**2711 Middleburg Dr. Suite 205**
**Columbia, SC 29204**
**Fax: 803-929-0762**
**Email: info@palmettoeap.com**

***A form should be filled out for each counseling site.***

Practice/Clinician Name: _____ Application Date: _____

Mailing Address: _____

Street Address if different: _____

Phone Number (to be published): _____ Fax: _____

Practice Email Address: _____

Do you have more than one counseling site: ☐ Yes ☐ No If yes, please attach info to application

To whom should your payment checks be made out?

☐ Practice Name (Use practice W-9 information- please attach)

☐ Individual Counselor (Use individual counselor's W-9 information- please attach)

Emergency after-hours number for use by EAP Consultant only: _____

Person to Call in Emergency: _____ Phone # _____

Facility is Handicap Accessible: ☐ Yes ☐ No Do you file insurance on behalf of the patient ☐ Yes ☐ No

Who handles after hour calls?_____

How do you handle patients needing financial counseling? ☐ On Site ☐ Referred out to_____

Please add any additional information that you think would be helpful for us to know.
For example, additional credentials/certifications, areas of clinical expertise and any specialized services you offer.

_____

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Practice/Agency Name: _____ Application Date:_____

*Each clinician applying to Palmetto EAP Provider Network should fill out this form and attach the following:*
**Copy of resume, proof of liability coverage, current copies of credentials, W-9 forms**

Clinician Name:_____ Credentials: _____

DOB:_____ Male: ☐ Female: ☐

Email Address: _____

Phone Numbers: Cell: _____ Home:_____

Work:_____x_____ Fax:_____

**Age Group Served:** ☐ Child (1-5) ☐ Child (6-13) ☐ Adolescent (13-18) ☐ Adult ☐ Senior (60+)

**Appointment Availability:** ☐ 8:30 a.m. – 5:00 p.m M-F *or as below (note evening/weekend availability)*

Mon _____Tue _____Wed _____

Thurs _____Fri _____ Sat _____ Sun _____

Do you have staff trained and able to provide on-site crisis counseling i.e. in a workplace critical incident? ☐ Yes ☐No

Do you wish to be called to provide onsite CI services? ☐ Yes ☐No

Military background? ☐ Yes ☐No Police, Fire, or First Responder background? ☐ Yes ☐No

Foreign Language? ☐ Yes ☐No If yes, which language (s)_____

Sign Language? ☐ Yes ☐No

**Do you have staff available to do outside training?** ☐Yes ☐No If so, what topics?

☐ Balancing Work & Family
☐ Being Single
☐ Bereavement/Grief Groups
☐ Childcare Issues
☐ Communication Skills
☐ Creating Happier Holidays
☐ Crisis Intervention Services
☐ Critical Incident Stress Debriefing
☐ Dealing with Difficult People
☐ Parenting Groups
☐ Downsizing Groups
☐ Eldercare Issues
☐ Employee EAP Training
☐ Maintaining a Healthy Lifestyle
☐ Manager Training (EAP)
☐ Managing Workplace Violence
☐ Conflict Management
☐ Stress & Time Management
☐ Substance Abuse Training
☐ DOT Training
☐ Other: _____
☐ Other:_____

Please list the health insurance and EAP panels to which you belong_____
_____
_____

Other:_____