AFFILIATE PROVIDER INFORMATION

To become a network provider for NuVantage Employee Resource, we need to receive the following information from you:

AFFILIATE PROVIDER AGENCY PROFILE – If you have the information required for the profile prepared in another format, you may send us a copy of that format in place of our forms. However, all of the requested information must be contained in the profile and/or with other supporting documents.

AFFILIATE CLINICAL STAFF LISTING – Again, if you have such listing in a different format, you may submit that in place of our form. Please ensure that gender is listed for each clinician (used for clinical matching). Please note which clinical staff are certified to provide Critical Incident Stress Debriefing (CISD) services. In addition, please note which clinical staff can provide topical training and which specific topics each staff member can present. This form should be completed for EACH clinician who will be providing EAP services.

AFFILIATE PROVIDER EVALUATION FORM – Please download and complete this form.

W-9 FORM – Please down and complete this form so that we can pay you.

GROUP OR INDIVIDUAL PROFESSIONAL LIABILITY INSURANCE CERTIFICATE – Please return a current active policy for each site/clinician.

LICENSURE CERTIFICATE – Please send a current copy for each clinician who will be a provider in the NuVantage Affiliate Network.

AFFILIATE PROVIDER AGREEMENT – After you submit the above documentation by email or fax, we will send you an affiliate provider contract. Once you receive this document, please return a signed copy of the affiliate provider agreement.

THE ABOVE INFORMATION SHOULD BE RETURNED TO:

NUVANTAGE EMPLOYEE RESOURCE
424 W Superior St., Suite 500
Duluth, MN 55802
Fax: 218-302-6825

Or emailed to:
NuVantage@lssmn.org

All clinicians should review the current NuVantage Employee Resource provider manual located online at www.nuvantage.org. The login is your e-mail and the password is eap.

Any questions can be directed to us at 1-888-988-0098.
Thank You!

NuVantage
Employee Resource

PROVIDER PROFILE - AGENCY

BUSINESS AND CONTACT INFORMATION

Clinic/Agency name: Click here to enter text.

Contact name: Click here to enter text.

Mailing address: Click here to enter text. County: Click here to enter text.

City: Click here to enter text. State: Click here to enter text. Zip: Click here to enter text.

Intake/Referral phone #: Click here to enter text. Tax ID #: Click here to enter text.

Fax #: Click here to enter text.

Non-Business Hours #: Click here to enter text. TDD#: Click here to enter text.

ORGANIZATION INFORMATION

Licensure and Accreditation (check all that apply)

☐ JCAHO ☐COA ☐State Mental Health Licensure ☐Substance Abuse Licensure

☐ Other: Click here to enter text. ☐ Other: Click here to enter text.

Have there ever been any disciplinary actions taken against your organization by a state or other licensing body, professional organization or any other authority?

☐ Yes ☐ No If yes, please attach explanation.

PROFESSIONAL LIABILITY

Are affiliate's clinicians covered professionally through:
☐ their own individual policy ☐ a group policy held by your organization ☐ both

If your organization maintains and covers any of its clinicians under a group policy, please complete the remainder of this section and attach a copy of Group Professional Liability Insurance Certificate.

Group Professional Liability Carrier: Click here to enter text.
Limits of Liability per Occurrence/Aggregate: $ Click here to enter text.
Effective date: Click here to enter text. Expiration Date: Click here to enter text.

Has Affiliate ever had insurance cancelled? ☐ Yes ☐ No
Has Affiliate ever been party to any litigation? ☐ Yes ☐ No
Has Affiliate been notified that litigation to which Affiliate is party is pending? ☐ Yes ☐ No

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PRIMARY SERVICE LOCATION INFORMATION (complete for each site):

Clinic/Site name: Click here to enter text.
Contact name: Click here to enter text.
Mailing address: Click here to enter text.
City, State, Zip: Click here to enter text. County: Click here to enter text.

Intake/Referral phone #: Click here to enter text. Fax #: Click here to enter text.
Non-business hours #: Click here to enter text. TDD#: Click here to enter text.

Days and hours of operation:
Monday: Click here to enter text. Tuesday:Click here to enter text.
Wednesday: Click here to enter text. Thursday: Click here to enter text.
Friday: Click here to enter text. Saturday: Click here to enter text.

***Additional Service Locations:** *Please list the above information for each additional site that your clinic/agency has. Repeat phone numbers for intake if your organization has centralized intake and scheduling.*

I hereby certify that all of the responses and information provided pursuant to the above requests are complete, true and correct, to the best of my knowledge.

Signature of CEO/Corporate Officer: _____

Print name: Click here to enter text. Date: Click here to enter a date.

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AFFILIATE CLINICAL STAFF LISTING

Clinician Name: Click here to enter text.

Site Location: Click here to enter text.

Gender: ☐ Female ☐ Male ☐ Other (please list): Click here to enter text.

Alternative Languages: ☐ Spanish ☐ French ☐ Finnish ☐ German ☐ Japanese ☐ Russian ☐ Hmong ☐ Ojibwa
☐ Other (please list): Click here to enter text.

Does clinician provide Critical Incidence Response Services? Choose an item.

Does clinician provide customized trainings? Choose an item.
If yes, list topics: Click here to enter text.

Degree: Click here to enter text.

Licensure Areas (check all that apply): ☐ LPCC ☐ LICSW ☐ LMFT ☐ CISW ☐ LGSW ☐ LP ☐ Ph.D. ☐ CADC ☐ LADC
☐ Other (please list): Click here to enter text.

Licensure exp. date: Click here to enter a date. Licensure #2 exp. date (if applicable): Click here to enter a date.

Specialties (choose all that apply):

☐ Abuse	☐ Domestic Violence	☐ Multi-Cultural Issues	☐Sexuality
☐ ADD/ADHD	☐ Eating Disorders	☐ Pain Management	☐Spirituality
☐ Anger Management	☐ Family Stress	☐ Parenting	☐ Stress Management
☐ Anxiety	☐Gender Identity	☐ Phobias	☐ Substance Abuse/Dependency
☐ Caregiver Stress	☐ Grief/Loss	☐ Self-Esteem	☐ Trauma
☐ Communication Issues	☐ Marital/Relationship	☐ Separation/Divorce/Break-up	☐ Veterans
☐ Depression	☐ Medical Related-Stress	☐ Sexual Assault	☐ Women's Issues
☐ Developmental Disabilities	☐ Men's Issues		☐ Work Stress

☐ Other (please list): Click here to enter text.

Client Types: ☐ Adults ☐ Children ☐ Adolescents ☐ Families ☐ Couples ☐ Other (please list): Click here to enter text.