Palmetto EAP Provider Application

You may fax, email or mail your information to

Palmetto EAP
6277 Carolina Commons Dr.
Suite 600-334
Indian Land SC 29707
Fax: 855-837-3363
Phone: 866-216-1996
Email: info@palmettoeap.com

A form should be filled out for each counseling site.

Practice/Clinician Name: _____ Application Date: _____

Mailing Address: _____County:_____

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, a form should be filled out for each counseling site**

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_____

Do you have staff available to do outside training? ☐Yes ☐No If so, please list the topics below:

_____

_____

_____

_____

_____

_____

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

Please check the types of therapy do you provide:

☐ ADHD	☐Development Disorders	☐ Mental Health Concerns due to Medical Issue
☐ Bereavement/Grief Groups	☐ Divorce/Separation	☐ Men's Issues
☐ Autism Spectrum Disorders	☐ Domestic Violence	☐ Pain Management
☐ Anxiety/ Panic Disorders	☐ EMDR Certified	☐ Parenting ☐ School related problems
☐ Anger	☐ Eating Disorders	☐ Pre-and Post Natal
☐Adolescent Disorders	☐ Women's Issues	☐ Personality Disorders
☐ Bipolar Disorder	☐ Faith Based Counseling	☐ Phobias
☐ Blended Families	☐ Financial Wellness	☐ PTSD
☐ Childhood Trauma	☐ Gay/ Lesbian/Transgender	☐ Sexual Trauma
☐Chronic/Terminal Illness	☐ Grief/Loss	☐ Schizophrenia/related disorders
☐ Critical Incident Response	☐ Housing-Shelter	☐ Substance Use Disorders ☐ Gambling
☐ Depression	☐ Learning Disabilities	☐ Sex Addition
☐ Disability Management	☐ Legal Issues	☐ Stress Management
☐ Other:_____	☐ Other:_____	☐ Other:_____
☐ Other:_____	☐ Other:_____	☐ Other:_____

☐ Other:_____ ☐ Other:_____ ☐ Other:_____

Please check the following you provide: ☐ Family counseling ☐ Pre-marital/marital ☐ Couples counseling

Please list all certifications or special practice areas (i.e. Trauma Focused Cognitive Behavioral Therapy TF-CBT, Dialectical Behavioral Therapy DBT, Play Therapy):

_____
_____
_____
_____
_____

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

Thank you for applying! After processing your application, we will email you with approval and further instructions for referrals/billing.