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 download 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 204
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 800-577-4727.
Thank You!

NuVantage
Employee Resource

PROVIDER PROFILE - AGENCY

BUSINESS AND CONTACT INFORMATION

Clinic/Agency name: _____

Contact name: _____

Mailing address: _____ County: _____

City: _____ State: _____ Zip: _____

Intake/Referral phone #: ____ Tax ID #: _____

Fax #: _____

Non-Business Hours #: _____ TDD#: _____

ORGANIZATION INFORMATION

Licensure and Accreditation (check all that apply)

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

☐ Other: _____ ☐ Other: _____

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: _____
Limits of Liability per Occurrence/Aggregate: $ _____
Effective date: _____ Expiration Date: _____

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

NuVantage
Employee Resource

PRIMARY SERVICE LOCATION INFORMATION (complete for each site):

Clinic/Site name: _____
Contact name: _____
Mailing address: _____
City, State, Zip: _____ County: _____

Intake/Referral phone #: _____ Fax #: _____
Non-business hours #: _____ TDD#: _____

Days and hours of operation:
Monday: ____ Tuesday: _____
Wednesday: ____ Thursday: _____
Friday: ____ Saturday: _____

***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: _____ Date: _____

NUVANTAGE AFFILIATE CLINICAL STAFF LISTING

Clinician Name: **Site Location**:

Gender: ☐ Female ☐ Male ☐ Other (please list):

Race/Ethnicity: **Veteran Status**: Select

Alternative Languages: ☐ (please list): ☐ (please list):

Does clinician provide **Critical Incident Response Services**? Select

Does clinician provide **customized trainings**? Select If yes, list topics:

Degree:

Licensure Areas (check all that apply): ☐ LPC ☐ LPCC ☐ LICSW ☐ LMFT ☐ LGSW ☐ LP ☐ LADC

☐ Other (please list):

Licensure exp. date: Licensure #2 exp. Date (if applicable):

Specialties (choose all that apply):

- ☐ Abuse
- ☐ ADD/ADHD
- ☐ Anger Management
- ☐ Anxiety
- ☐ Caregiver Stress
- ☐ Communication Issues
- ☐ Depression
- ☐ Domestic Violence
- ☐ Eating Disorders
- ☐ EMDR
- ☐ Family Stress
- ☐ First Responders
- ☐ Gender Identity
- ☐ Grief/Loss
- ☐ LBGTQIA+
- ☐ Marital / Relationship
- ☐ Medical Related Stress
- ☐ Men's Issues
- ☐ Multi-Cultural Issues
- ☐ Pain Management
- ☐ Parenting
- ☐ Phobias
- ☐ Self-Esteem
- ☐ Separation / Divorce
- ☐ Sexual Assault / Rape
- ☐ Spirituality
- ☐ Stress Management
- ☐ Trauma
- ☐ Veterans
- ☐ Women's Issues
- ☐ Work Stress

☐ Other (please list):

Client Types: ☐ Adults ☐ Children ☐ Adolescents ☐ Families ☐ Couples ☐ Other (please list):

At times, clients ask for a clinician that identifies as LGBTQIA+. While we don't require this info, please feel free to let us know if you would like us to include this info in your clinical profile. You can email us confidentially at nuvantage@lssmn.org