MYgroup
McLAUGHLIN YOUNG

Provider Application

If you are interested in becoming a Provider for McLaughlin Young Group, please email this completed form to myprovider@mygroup.com or fax to 704.529.5917. We will assess the need within your area, and you will be contacted within a few weeks of receipt. *Thank you for your interest.*

Date of application: _____ How did you learn about us?: _____

Name: _____ Check One: ☐ Solo ☐ Group Practice

Business Name: _____ Tax ID (include dashes): _____

Business Phone: _____ Cell: _____ Fax:: _____

Email Address (please print clearly): _____

Clinical Office Location (provide address for each office location providing clinical services): _____

_____

_____

Office Hours (Typical Days/Times): _____

Nearest Major City: _____ Is your practice minority owned?: ☐ Yes ☐ No

Languages spoken: _____ Culture/Ethnicity: _____

Is it okay to leave referral information as a phone message without direct contact? ☐Yes ☐No

Are you available for Critical Incidents in your area (CISD/CIR)? ☐Yes ☐No

Are you available to facilitate workplace trainings and/or workshops? ☐Yes ☐No
(All PowerPoint presentations/handouts are provided by MYgroup.)

If yes, please indicate which topics you are interested in facilitating:

- ☐ EAP Orientation Overview
- ☐ Compliance Trainings (ie. sexual harassment in the workplace, diversity, etc)
- ☐ DOT/Substance Abuse
- ☐ Lunch and Learn (ie. stress management, time management, etc)

If applicable, please list additional topics/experience or attach resume: _____

_____

Has your organization ever been involved with legal actions or suits pertaining to your practice? ☐ Yes ☐ No

If yes, please explain: _____

_____

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Provider Application (continued)

If this application is being completed for a Group Practice, provide a copy of this page for each clinician applying for credentialing with McLaughlin Young.

**Qualified providers must be 5-years post graduate from a Master's program, fully licensed (not provisional), and must be covered by malpractice insurance with minimums of 1 million individual & 3 million aggregate.*

Name:_____ Years of Post-Grad Experience:_____

License(s) Held in Good Standing with expiration dates:_____

_____

Are you A CEAP (Certified Employee Assistance Professional)?	☐Yes ☐No
Are you trained in CISD (Critical Incident Stress Debriefing)?	☐Yes ☐No
Are you a Clinical Addictions Specialist or Substance Abuse Professional?	☐Yes ☐No
Are you a Distance Credentialed Counselor (DCC)?	☐Yes ☐No

Other Certifications Held:_____

Check any of your following specialties:

☐ Alcohol/Substance Use	☐ Fear/Compulsion	☐ Stress/PTSD
☐ Anxiety	☐ Financial	☐ Transitional Stress
☐ Caregiving Concerns	☐ Grief/Loss	☐ Trauma- Accident
☐ Child/Adolescent: Ages:_____	☐ IP Violence	☐ Trauma- Death
☐ Conflict/Anger Management	☐ Legal	☐ Trauma- Suicide
☐ Depression	☐ LGBTQ	☐ Trauma- Violence
☐ Divorce/Separation	☐ Mandated Treatment	☐ Virtual Therapy
☐ Eating Disorders	☐ Marital/Relational	☐ Workplace Concerns
☐ Faith Based Therapy	☐ Personality Disorders	☐ Other:_____
☐ Family Therapy	☐ Physical Health	☐ Other:_____

Do you participate with any other EAP or Insurance Providers? Check all that apply:

☐ Aetna	☐ Humana	☐ Tricare
☐ Blue Cross Blue Shield	☐ Magellan	☐ United Healthcare
☐ Ceridian	☐ Medicaid	☐ Value Options
☐ Cigna	☐ Medicare	☐ Other: _____
☐ Coventry	☐ Primary Care Physician	_____

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Provider Application (continued)

Please answer the following questions in regards to your location:

1. Do you comply with the legal requirements concerning public accessibility, health and safety? ☐ Yes ☐ No
2. Does the location have handicap and wheelchair accessibility? ☐ Yes ☐ No
3. Is this location convenient for public transportation? ☐ Yes ☐ No
4. Is adequate parking available at the location? ☐ Yes ☐ No
5. Is each location equipped with security devices? ☐ Yes ☐ No
6. Is there adequate lighting in the parking lot? ☐ Yes ☐ No
7. Is a Fire Emergency Plan posted at your location? ☐ Yes ☐ No
8. Is the office located inside a religious institution? ☐ Yes ☐ No
9. Is the office based in a home? ☐ Yes ☐ No
10. Are directions easily accessible for the location? ☐ Yes ☐ No
11. Do the waiting areas and counseling offices provide confidentiality? ☐ Yes ☐ No
12. Are records locked up when the office is closed? ☐ Yes ☐ No
13. Is the location child friendly? ☐ Yes ☐ No
14. Explain the safety and security measures of the facility:_____

_____

_____

If you have any questions, please do not hesitate to call us at 866.850.2175. Thank you in advance for your efforts.

Sincerely,

McLaughlin Young Group
Provider Management
5925 Carnegie Boulevard, Suite 350
Charlotte, NC 28209
866.850.2175, FAX: 704.529.5917