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McLAUGHLIN YOUNG

Provider Application

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:_____

Business Email Address: _____ Share with clients? ☐ Yes ☐ No

Business Website: _____

Office Hours (Typical Days/Times):_____

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

Primary: _____

Secondary:_____

Nearest Major City:_____

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

*If yes, please explain:*_____

_____

Please answer the following questions in regard to your location(s):

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

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12. Are records locked securely 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 this application is being completed for a Group Practice, provide a copy of the following pages for each clinician applying for credentialing with MYgroup.

Email entire 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.

If you have any questions, please do not hesitate to call Provider Relations Manager at 866.850.2175, extension 7945. Thank you in advance for your efforts.

Sincerely,

MYgroup

Provider Relations Manager

866.850.2175, ext. 7945

FAX: 704.529.5917

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**In order to qualify for consideration, providers must be at least 5 years post-graduate from a master's program, fully licensed (not provisional), and covered by malpractice insurance with minimums of $1 million individual & $3 million aggregate.*

Name:_____Years of Post-Grad (masters) Experience:_____

License(s) Held (include state, number, and expiration date):_____

Has your professional license ever been limited, revoked, or suspended? ☐ Yes ☐ No

Have you ever been disciplined by any professional association, organization, or professional society? ☐ Yes ☐ No
***If yes to any of the two previous questions, please attach documentation of final resolution.**

Are you a Certified Employee Assistance Professional (CEAP)? ☐ Yes ☐ No
Are you a Clinical Addictions Specialist or Substance Abuse Professional (SAP)? ☐ Yes ☐ No

Other Certifications Held:_____

Optional, Voluntary and Not Required

Often clients will ask for a provider who meets a specific preference within one of the following categories. If your application is approved and you provide this information, your response will be entered into our database so that you can be identified only if a client requests a provider who meets a specific category. Any responses you provide or your decision to not provide this information will not be the basis for denying your application for participation.

Gender Identity: _____

☐Hispanic ☐Caucasian ☐Asian ☐African American ☐Native American ☐Multiracial ☐ Other: _____

Is this practice qualified as a Historically Underutilized Business (HUB) or Minority and Women Owned Business Enterprise (MWBE)? ☐ Yes ☐ No

Languages spoken:_____

Do you incorporate a faith-based perspective as an option in therapy? ☐ Yes ☐ No

If yes, specify the religious organization or faith-based group (e.g., Christian, Jewish): _____

Do you offer telemental health therapy (online/virtual sessions)? ☐ Yes ☐ No

If yes, specify the HIPAA-compliant platform you use: _____

Are you a Board-Certified TeleMental Health Provider (BC-TMH)? ☐ Yes ☐ No

Are you trained in Critical Incident Response (e.g., CISD)? ☐ Yes ☐ No
Are you available for **onsite** responses to Critical Incidents in your area? ☐ 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 list experience/topics facilitated (or attach resume):*_____

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Check any topics within your scope of practice (i.e., comfortable with and competent to discuss and provide initial assessment for clients with these presenting issues):

☐ Active-Duty Military	☐ Family Therapy	☐ Stress
☐ Parenting issues re: adolescents	☐ Fear/Compulsion	☐ Transitional Stress
☐ Alcohol/Substance Use	☐ First Responders	☐ Trauma – Accident
☐ Anxiety	☐ Financial	☐ Trauma – Death
☐ Bipolar Disorder	☐ Grief/Loss	☐ Trauma – Suicide
☐ Borderline Personality Disorder	☐ IP Violence	☐ Trauma – Violence
☐ Caregiving Concerns	☐ LGBTQIA	☐ Unemployment Issues
☐ Parenting issues regarding children	☐ Mandated Treatment	☐ Veterans' Issues
☐ Conflict/Anger Management	☐ Marital/Relational	☐ Virtual Therapy (i.e., telehealth)
☐ Depression	☐ Maternal Issues	☐ Women's Issues
☐ Divorce/Separation	☐ Personality Disorders	☐ Workplace Concerns
☐ Eating Disorders	☐ Physical Health	☐ In-person Therapy
☐ Faith Based Therapy	☐ PTSD	☐ Other:_____

Check the Age Range of Clients You Have Training and/or Experience with:

☐ Child (ages 3-12)	☐ Young Adult (ages 18-30)
☐ Adolescent (ages 12-18)	☐ Adult (ages 30 +)

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	☐ Medcost	☐ Beacon Health Options
☐ Cigna	☐ Medicaid	☐ Other: _____
☐ Coventry	☐ Medicare	☐ Other: _____

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I authorize MYgroup to verify any and all information provided in this application for the purpose of determining my professional competence, character, ethical qualifications, and consideration for acceptance.

I also authorize any person or organization named in this application to release relevant information to MYgroup for the purposes stated above.

I hereby certify that the information contained in the foregoing application is true and complete to the best of my knowledge and belief.

Applicant Signature: Date: