

# CONCERN: EAP PROVIDER PRACTICE PROFILE

**Please complete the following three pages:**

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Phone #: \_\_\_\_\_

Office address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Fax #: \_\_\_\_\_

Emergency #: \_\_\_\_\_

Additional office(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Mailing Address if different from office:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is either of the offices listed above a home office?     Yes     No

If yes, please mark all that apply:

- |  |  |
|--|--|
| <input type="checkbox"/> Office has a private entrance                                   | <input type="checkbox"/> No animals are in the office      |
| <input type="checkbox"/> Office has professional furnishings                             | <input type="checkbox"/> Office has "client only" bathroom |
| <input type="checkbox"/> Clients are not visible to others in the home or family members |  |

Please provide your e-mail address: (For CONCERN internal use only. This information will not be given to clients): \_\_\_\_\_

If you have a website, please provide the website address: \_\_\_\_\_

**What is your preferred way to receive information and forms/paperwork from CONCERN?**

- FAX     U.S. Mail     E-Mail

Highest degree: \_\_\_\_\_    Obtained from: \_\_\_\_\_

Date awarded: \_\_\_\_\_    Professional License Type and #: \_\_\_\_\_

Years post-licensure experience: \_\_\_\_\_    Practice is:  Full Time     Part Time (# of days:\_\_\_\_)

Practice setting(s):     Individual  
 Group    Name of group: \_\_\_\_\_  
 Agency    Name of Agency: \_\_\_\_\_

**Days & hours in office (specify which office if multiple offices):**

- Monday \_\_\_to\_\_\_     Tuesday \_\_\_to\_\_\_     Wednesday \_\_\_to\_\_\_     Thursday \_\_\_to\_\_\_  
 Friday \_\_\_to\_\_\_     Saturday \_\_\_to\_\_\_     Sunday \_\_\_to\_\_\_

- Populations treated:     Children     Adolescents     Adults  
                                   Ages 3 - 6     Couples     Families  
                                   Ages 6 - 12     Groups

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**Clients often request providers with special knowledge and training related to the problem categories listed below. Please indicate the categories in which you feel your extra training and/or substantial experience in your practice would likely satisfy such a request. (Note: Please do not include categories in which you have an interest but no special knowledge or training.) Check all that apply:**

- Anger management (focused approach)
- Anxiety disorders e.g. panic, GAD.
- Compulsive/Addictive behaviors, e.g. gambling; pornography viewing or online usage, etc.
- Childhood disorders, e.g. Asperger's syndrome, Autism, ADHD, developmental disabilities
- Domestic violence
- Eating disorders
- Gay and lesbian issues (GLTB)
- Gerontology
- Grief and bereavement
- Medical problems e.g. acute and chronic illness, cancer, pain, HIV, AIDS
- Mood disorders e.g. bi-polar disorder, major depression
- Parenting
- Pregnancy/fertility/adoption issues
- Serious mental illness
- Smoking/weight reduction
- Trauma recovery, PTSD
- Victims of abuse e.g. violence, sexual abuse
- Sexual dysfunction
- Step-parenting/blended families
- Workplace/job-related issues

**Do you consider yourself proficient in initial substance abuse assessment and treatment planning? This would include having an awareness of local resources (not necessarily providing the treatment itself).**

Yes     No

**Are you proficient in working with individuals and families who have been impacted by living or dealing with someone struggling with addiction or substance abuse? (e.g., ACA, co-dependency, etc.)**

Yes     No

**Do you consider yourself to have a Christian orientation such that clients requesting a Christian counselor could be referred to you?**

Yes     No

**Do you have special expertise in cognitive behavioral therapy?**

Yes     No

**Do you have advanced training in EMDR *and* use it in your practice?**

Yes     No

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## Other Services

- Are you certified to do D.O.T. (Department of Transportation) Substance Abuse Professional work?  Yes  No
- Do you do onsite CISM/crisis intervention work?  Yes  No
- Do you do onsite training for other EAPs or organizations?  Yes  No
- Would you like to be contacted about doing Mandatory and Supervisor Referrals for CONCERN?  Yes  No

## Practice Features

- Can you offer routine appointments in 3-5 working days?  Yes  No
- Does your answering machine message include emergency instructions?  Yes  No
- Does your answering service understand emergency procedures?  Yes  No
- Is your office wheelchair/handicap accessible?  Yes  No
- Do you provide EAP services in any other languages besides English? If yes, please list below:

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Do you use American Sign Language:  Yes  No

Do you provide telephonic counseling in your practice?  Yes  No

If your response is "yes", would you be interested in providing telephonic EAP counseling for CONCERN: EAP in special circumstances?  Yes  No

Are you a provider for other EAP or Mental Health Care panels?  Yes  No

If yes, please indicate EAP or Mental Health Care panels that apply to you:

- UBH       MHN       PacifiCare       Cigna       Magellan  
 Blue Cross       Humana       Aetna       ComPsych       Other (please list)

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Thank you very much for your assistance with this.