

Horizon Health EAP Services, Inc.
Practitioner Credentialing Application Document Checklist

Refer to this checklist to identify all documents required along with your completed application.

ALLIED MENTAL HEALTH PROFESSIONAL

- Completed Application** – Must have original signatures (NO STAMPS). **Please do not sign and date until you are ready to mail.**
- Current Curriculum Vita** – Must show current position and indicate both months and years positions were held. Please attach a written explanation for any work gaps of six months or greater.
- Copy of State License or State Certifications** – Must be current and show expiration date.
- Copy of Current Malpractice Insurance Certificate** – Must be \$1 million / \$3 million coverage.
- Nurse Practitioner** – Copy of DEA and Protocol Agreement.
- Signed Services Agreement and Reimbursement Schedule**
- Completed W-9 Form** or substitute Tax Identification Number Form

M.D. / D.O. LICENSED PROFESSIONAL

- Completed Application** – Must have original signature (NO STAMPS). **Please do not sign and date until you are ready to mail.**
- Current Curriculum Vita** – Must show current position and indicate both months and years positions were held. Please attach a written explanation for any work gaps of six months or greater.
- Copy of State License or State Certifications** – Must be current and show expiration date.
- Copy of Current Malpractice Insurance Certificate** – Must be \$1 million / \$3 million coverage.
- Copy of American Medical Board Certification** – Please send letter explaining your intention, if not currently Board Certified.
- Copy of Current Federal and State DEA Certification (if applicable)** – Must be current and show expiration date.

*** See Criteria for Special Privileges, for any additional documentation needed***

ALL REQUESTED DOCUMENTS SHOULD BE RETURNED TO:
Horizon Health EAP Services, Inc.
Provider Services Department
PO BOX 293508
Lewisville, Texas 75029-3508
Phone: 800-872-7322

HORIZON HEALTH EAP SERVICES, INC. - CREDENTIALING CRITERIA

CRITERIA PERTAINING TO ALL PROFESSIONALS

1. Must hold a current license in their specialty at the highest level in the state in which they practice. Licensure must be for independent practice and vendor eligible (if applicable).
2. Must have 3 years experience post-licensure.
3. Practitioners must carry minimum malpractice and liability insurance coverage of \$1,000,000 per occurrence and \$3,000,000 aggregate.
4. Must provide services in professional office building. **Horizon Health does not allow home offices.**

ADDITIONAL PROFESSIONAL CRITERIA

Psychiatrists and Other Physicians (M.D. or D.O.)

1. Psychiatrists must have completed a psychiatric residency program.
2. Hold a current and unrestricted state Controlled Dangerous Substances Registration (if applicable).
3. Hold a current and unrestricted Federal Drug Enforcement Administration Registration.

Psychologists

1. Licensed as a clinical psychologist at the doctoral level, in the state in which they practice.

Master's Prepared Therapists (other than Nurses)

1. A master's degree or doctoral degree in a behavioral health science.
2. Licensed certified at the highest level in the state for independent practice.

CRITERIA FOR PRIVILEGING

1. Psychopharmacology

- a. Physician licensed by the state in which he/she practices; AND
- b. Completion of a psychiatric residency approved by the AMA, APA, and/or AOA; AND
- c. Has prescribed medication on a regular basis within the past year, in the treatment for psychological/neurological disorders; AND
- d. Qualifications have been reviewed & approved by the Network Credentialing Committee.

2. Withdrawal from Drug/Alcohol Addiction (Detox)

- a. Physician licensed by the state in which he/she practices; AND
- b. Has utilized medication & withdrawal techniques; and procedures in therapy for alcohol and drug related disorders within the past year; AND
- c. Qualifications have been reviewed and approved by the Network Credentialing Committee.

3. Substance Abuse Professional (SAP)

- a. Practitioner must provide documentation that he/she is an alcohol and drug abuse counselor certified by NAADAC Certification Commission or ICRC Alcohol and Other Drug Abuse.
- b. Practitioner must provide documentation of passing grade on NAADAC examination
- c. Qualifications have been reviewed and approved by the Network Credentialing Committee.

4. Addictions Therapy

- a. Practitioner licensed in the state in which he/she practices.
- b. Practitioner must provide documentation of 90 hours of training in the field of Drug & Alcohol Addictions Theory and treatment, and/or is a Certified Addictions Professional in the state in which he/she practices.
- c. Qualifications have been reviewed and approved by the Network Credentialing Committee.

5. Critical Incident Stress Management or Critical Incident Stress Debriefing (CISM/CISD)

- a. Practitioner must provide documentation that he/she is CISM or CISD certified.
- b. Qualifications have been reviewed and approved by the Network Credentialing Committee.

6. Diagnostic Assessment/Testing

- a. Practitioner licensed in the state where he/she practices
- b. Practitioner provides documentation of training in testing, including administration, scoring and interpretation of tests (either course is listed on transcript or provides documents of verification from a trainer or supervisor).
- c. Practitioner must supply documentation of verification from a trainer or supervisor of having administered testing effectively in the past six months.
- d. Qualifications have been reviewed and approved by the Network Credentialing Committee.

PRIVILEGING FOR TREATMENT OF CHILDREN

If any of the preceding privileges are to be exercised with patients 12 years of age or younger, the clinician must, in addition to meeting the criteria stated under each procedure:

1. Provide documentation from the institution of having received supervised clinical experience in the treatment of children for a minimum of six (6) months in post-graduate training, (clinical practicum, internship, or residency); AND
2. Provide written documentation (detail work history on CV) of having engaged in the treatment of children in clinical practice for a period of three (3) continuous years; AND
3. Provide documents of verification and recommendations from two (2) psychiatrists or psychologists in the practitioner's area who can provide written verification of three (3) years continuous experience in the treatment of children under twelve (12) years of age.

Note: Letters of verification and recommendation must be specific to services provided to children 12 years of age and under. Should the documents received not address this specific area, additional information will be required, which will result in a delay of the granting of this privilege.

CRITERIA TO BE A DISPENSING PRACTITIONER LICENSED AS:

1. Practitioner(s) must hold active and current state license identified as either ARNP or RN-CS, issued by the state in which he/she practices. Practitioner(s) located in a state which will/can identify on the current license their status as a "dispensing practitioner" will be required to have this information displayed on the license.
2. Practitioner(s) must provide proof of a formal post-basic education for specialized and advanced nursing practice in the expanded role of psychiatric medicine.
3. Practitioner(s) have been engaged in the practice of professional nursing for at least five (5) years, at least two (2) of which must be in the specific area of psychiatric medicine. The two years should be the most current years of practice.
4. Practitioner(s) will comply with and maintain current knowledge of their state and federal laws and regulations applicable to dispensing practitioners.
5. Practitioner(s) will maintain medical malpractice insurance with the minimum limits of \$1,000,000/\$3,000,000 and provide an original certificate of insurance to Horizon Health.
6. Practitioner(s) will adhere to an established protocol regarding dispensing of psychotropic medication(s).
7. Practitioner(s) will limit their dispensing of medications to the area of psychotropic medications, referring all needs for any other medications to the primary care physician or the medical doctor of record.
8. Practitioner(s) will maintain all records for a minimum of four (4) years after the termination of the relationship with the supervising psychiatrist and/or Horizon Health.
9. Practitioner(s) will, on a bi-annual basis, attend a minimum of eight (8) hours of Continuing Education courses (CEU) which are specific to medication management.
10. Practitioner(s) must provide Horizon Health with a collaborative agreement, with Horizon Health network psychiatrist stating they are currently under supervision.

ECT GUIDELINES

Your malpractice insurance binder must specify your current ECT coverage to be considered for this privilege. In general, ECT is used following treatment failure of psychotropic agents after a reasonable attempt at using a multitude of different agents properly. There are three (3) situations when the above may not be true:

1. Where there is a need for rapid and definitive response to the manifestation of behaviors, whether on a medical or psychiatric basis.
2. When the risks of other treatments outweigh the risks of ECT.
3. When a history of poor drug response and/or good ECT response exists for previous episodes of illness.

As a rule, a trial of alternative therapy should be considered prior to referral for ECT. ECT usage should be based on at least one (1) of the following:

1. Treatment failure (taking into account issues such as choice of agent, dosage, and duration of trial)
2. Adverse effects which are unavoidable and which are deemed less likely and/or less severe with ECT.
3. Deterioration of the enrollee's condition, such that there is a need for a rapid and definitive treatment response on either medical or psychiatric grounds.

PRE-ECT EVALUATIONS SHOULD INCLUDE ALL OF THE FOLLOWING:

1. Psychiatric history and examination to assess the indication for ECT, as well as an assessment of the effects of any prior ECT's.
2. Medical examination to define risk factors (medical hx, physical exam, vital signs, hematocrit/hemoglobin, serum electrolytes and EKG).
3. Anesthetic evaluation addressing the nature and extent of anesthetic risk and advising of the need for modification in ongoing medications and/or anesthetic techniques.
4. Properly worded and executed informed consent.
5. An evaluation of an individual privileged to administer ECT, as well as a second opinion by a similarly credentialed psychiatrist.

The above information was excerpted from The Task Force Report of the APA Regarding the Practice of Electroconvulsive Therapy.

SECOND OFFICE INFORMATION

*** Attach a W-9 or TIN Form**

Legal Group Name: _____

Mailing Address: _____

City State Zip

Physical Address: _____

City State Zip

Type of Group:	Business Owned By:
<input type="checkbox"/> Solo Practice	<input type="checkbox"/> Veteran
<input type="checkbox"/> Group Practice	<input type="checkbox"/> Disabled Veteran
<input type="checkbox"/> Hospital	<input type="checkbox"/> Disabled
<input type="checkbox"/> Clinic	<input type="checkbox"/> Minority
	<input type="checkbox"/> Woman

Phone #: _____ Fax #: _____ Office Contact Name: _____

Office Setting (please indicate office type)

Office Hours:

- | | |
|---|---|
| <p>A. Home Office</p> <p>___ Separate Entrance</p> <p>___ Separate Waiting area</p> <p>___ Wheel Chair Access</p> <p>___ Public Transportation</p> <p>___ Off-Street Parking</p> | <p>B. Professional Building</p> <p>___ Separate Entrance</p> <p>___ Separate Waiting area</p> <p>___ Wheel Chair Access</p> <p>___ Public Transportation</p> <p>___ Off-Street Parking</p> |
|---|---|

Available Evenings? (Specify)

 Available Weekends? (Specify)

THIRD OFFICE INFORMATION

*** Attach a W-9 or TIN Form**

Legal Group Name: _____

Mailing Address: _____

City State Zip

Street Address: _____

City State Zip

Type of Group:	Business Owned By:
<input type="checkbox"/> Solo Practice	<input type="checkbox"/> Veteran
<input type="checkbox"/> Group Practice	<input type="checkbox"/> Disabled Veteran
<input type="checkbox"/> Hospital	<input type="checkbox"/> Disabled
<input type="checkbox"/> Clinic	<input type="checkbox"/> Minority
	<input type="checkbox"/> Woman

Phone #: _____ Fax #: _____ Office Contact Name: _____

Office Setting (please indicate office type)

Office Hours:

- | | |
|---|---|
| <p>A. Home Office</p> <p>___ Separate Entrance</p> <p>___ Separate Waiting area</p> <p>___ Wheel Chair Access</p> <p>___ Public Transportation</p> <p>___ Off-Street Parking</p> | <p>B. Professional Building</p> <p>___ Separate Entrance</p> <p>___ Separate Waiting area</p> <p>___ Wheel Chair Access</p> <p>___ Public Transportation</p> <p>___ Off-Street Parking</p> |
|---|---|

Available Evenings? (Specify)

 Available Weekends? (Specify)

Please indicate the type(s) of **treatment modalities** that you employ in your work:

<input type="checkbox"/> Behavioral	<input type="checkbox"/> Cognitive/Behavioral	<input type="checkbox"/> EMDR	<input type="checkbox"/> Psychoanalytic
<input type="checkbox"/> Biofeedback	<input type="checkbox"/> Developmental	<input type="checkbox"/> Family Systems	<input type="checkbox"/> Psychodynamic
<input type="checkbox"/> Client Centered	<input type="checkbox"/> ECT	<input type="checkbox"/> Interpersonal	<input type="checkbox"/> Reality
<input type="checkbox"/> Cognitive	<input type="checkbox"/> Ego Psychology	<input type="checkbox"/> Pharmacological Therapy	<input type="checkbox"/> REBT

Please indicate in which of the following areas you have **expertise**.

<input type="checkbox"/> ADHD	<input type="checkbox"/> Christian Counseling	<input type="checkbox"/> Gambling Addiction	<input type="checkbox"/> Schizophrenia Disorders
<input type="checkbox"/> Addictions Therapy	<input type="checkbox"/> Chronically Mentally ILL	<input type="checkbox"/> Gay/Lesbian Issues	<input type="checkbox"/> School Problems
<input type="checkbox"/> Adjustment Disorders	<input type="checkbox"/> Co-morbid Medical Conditions	<input type="checkbox"/> Gender Issues	<input type="checkbox"/> Sexual Abuse/Offenders
<input type="checkbox"/> Adoption	<input type="checkbox"/> Conflict Resolution	<input type="checkbox"/> Group Therapy	<input type="checkbox"/> Sexual Abuse/Survivors
<input type="checkbox"/> African American Issues	<input type="checkbox"/> Conjoint/ Couples Counseling	<input type="checkbox"/> HIV/AIDS Counseling	<input type="checkbox"/> Sexual Disorders
<input type="checkbox"/> Alcohol Abuse (Adol)	<input type="checkbox"/> Court Ordered Evaluations	<input type="checkbox"/> Hypnosis	<input type="checkbox"/> Sexual Dysfunction
<input type="checkbox"/> Alcohol Abuse (Adult)	<input type="checkbox"/> CISD/CISM (include certificate)	<input type="checkbox"/> Learning Disabilities	<input type="checkbox"/> Sign Language
<input type="checkbox"/> Alcohol Abuse (Child)	<input type="checkbox"/> Cultural Ethnic Issues	<input type="checkbox"/> Medication Management	<input type="checkbox"/> Smoking Cessation
<input type="checkbox"/> Anger Management	<input type="checkbox"/> Deaf/Hearing Impaired	<input type="checkbox"/> Neuropsychological Evaluations	<input type="checkbox"/> Social Skills Training
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Dementia	<input type="checkbox"/> Neuropsychological Testing	<input type="checkbox"/> Stress Management
<input type="checkbox"/> Ante Partum/Post Partum Depression	<input type="checkbox"/> Depression	<input type="checkbox"/> Obsessive/Compulsive Disorder	<input type="checkbox"/> Terminal Illness
<input type="checkbox"/> Art Therapy	<input type="checkbox"/> Detox (Outpatient)	<input type="checkbox"/> Occupational Problems	<input type="checkbox"/> Training – Standard
<input type="checkbox"/> Behavior Modification	<input type="checkbox"/> Developmental Disability	<input type="checkbox"/> Organizational Development	<input type="checkbox"/> Training – Compliance
<input type="checkbox"/> Bereavement/Grief Counseling	<input type="checkbox"/> Disability Assessments	<input type="checkbox"/> Pain Management	<input type="checkbox"/> Training – Supervisory
<input type="checkbox"/> Biofeedback	<input type="checkbox"/> Disability Management	<input type="checkbox"/> Parenting Education	<input type="checkbox"/> Training – Wellness
<input type="checkbox"/> Bipolar Disorder	<input type="checkbox"/> Divorce	<input type="checkbox"/> Personality Disorders	<input type="checkbox"/> Victims of Trauma
<input type="checkbox"/> Bisexual Issues	<input type="checkbox"/> Domestic Violence	<input type="checkbox"/> Phobias	<input type="checkbox"/> Vocational/Career
<input type="checkbox"/> Blind/Visually Impaired	<input type="checkbox"/> Eating Disorders (Anorexia)	<input type="checkbox"/> Physical Abuse	<input type="checkbox"/> Women's Issues
<input type="checkbox"/> Chemical Dep. (Adol)	<input type="checkbox"/> Eating Disorders (Bulimia)	<input type="checkbox"/> Physically Impaired	<input type="checkbox"/> Work Related Problems
<input type="checkbox"/> Chemical Dep. (Adult)	<input type="checkbox"/> Eating Disorders (Compulsive Overeating)	<input type="checkbox"/> Play Therapy	<input type="checkbox"/> Workers Compensations Evaluation & Treatment
<input type="checkbox"/> Chemical Dep. (Child)	<input type="checkbox"/> ECT	<input type="checkbox"/> Post Traumatic Stress	
<input type="checkbox"/> Child Abuse	<input type="checkbox"/> EMDR	<input type="checkbox"/> Psychological Testing	
<input type="checkbox"/> Childhood Disorders	<input type="checkbox"/> Family/Marital Issues	<input type="checkbox"/> SAP (include certificate)	

CURRENT FACILITY/PROGRAM AFFILIATION (S)

Please list all facilities that you currently provide service at including hospitals, substance abuse centers, rehabilitation clinics, nursing homes, etc.

Facility Name: _____ Phone #: _____

Facility Name: _____ Phone #: _____

Facility Name: _____ Phone #: _____

Please list all **insurances** you currently accept: _____

Please list the type(s) of **group therapies** provided: _____

If applicable, please list the type(s) of **training seminars** provided: _____

Are you a **Certified Employee Assistance Professional (CEAP)**?: _____

Are you a certified **Substance Abuse Professional (SAP)**?: _____

PROFESSIONAL LIABILITY INSURANCE INFORMATION *Required Minimum Coverage: \$1,000,000 / \$3,000,000*

Please include a copy of your current malpractice insurance COI with your completed application.

Do you currently have the required insurance? Yes No

Have there been, or are there currently, any malpractice actions or claims against you? Yes No
(If "Yes", please provide details on the Professional Malpractice Questionnaire.)

Is your insurance supplied by employer? Yes No

The following information on your previous insurance carrier is required if you have not been covered under your current policy for at least the past 5 years.

Name of previous carrier: _____ Policy #: _____

Street Address: _____ Telephone #: _____

City State Zip

LICENSURE/CERTIFICATION FOR PSYCHOLOGISTS, SOCIAL WORKERS, NURSES, AND OTHER CLINICIANS

CURRENT LICENSURE:

Licensure/Certification Type: _____ Date of first license/certification: ___/___/___

Issued by: _____ State: _____

Number: _____ Expiration Date: ___/___/___

Licensure/Certification Type: _____ Date of first license/certification: ___/___/___

Issued by: _____ State: _____

Number: _____ Expiration Date: ___/___/___

Licensure/Certification Type: _____ Date of first license/certification: ___/___/___

Issued by: _____ State: _____

Number: _____ Expiration Date: ___/___/___

PAST/EXPIRED LICENSURE: *(Complete only if in a different state than the state you are currently practicing in)*

Licensure/Certification Type: _____ Date of first certification: ___/___/___

Issued by: _____ State: _____

Number: _____ Expiration Date: ___/___/___

CLINICAL EDUCATION/TRAINING *(Name of College/University where your highest degree was conferred. Attach all applicable copies of certificates received.)*

Professional School: _____

Degree: _____ **Date Degree Conferred:** ___/___/___

Professional Organization Memberships: _____

PROFESSIONAL REFERENCES *(Provide 2 professional references who will attest to your clinical competency)*

Name:
Address:
Phone:

Name:
Address:
Phone:

APPLICABLE TO PHYSICIANS ONLY

(PLEASE ATTACH A COPY OF YOUR CURRENT LICENSE, DEA, AND BOARD CERTIFICATION)

ACTIVE STATE LICENSURE

License #: _____ State: _____ Expiration date: ___/___/___

Date of first licensure in this state: ___/___/___ **(Required Information)**

License #: _____ State: _____ Expiration date: ___/___/___

Date of first licensure in this state: ___/___/___ **(Required Information)**

REGISTRATION

Federal DEA Registration #: _____ Expiration date: ___/___/___

Date of first DEA registration received: ___/___/___

State DEA Registration #: _____ Expiration date: ___/___/___

Date of first DEA registration received: ___/___/___

PHYSICIAN CERTIFICATION **(THIS IS REQUIRED INFORMATION, PLEASE PAY SPECIAL ATTENTION)**

Board Certified?: Yes No

Certified by American Board of _____ ID# _____

Date of certification: ___/___/___

Certified by American Board of _____ ID# _____

Date of certification: ___/___/___

If not Board Certified, are you Board Eligible? Yes No

(Please list in which Specialties below)

Specialties: _____

THIS INFORMATION IS REQUIRED, **DO NOT LEAVE BLANK**

If you are not Board Certified, please indicate when you are scheduled or plan to take the exam ___/___/___.

If you are scheduled, please submit a copy of your notification letter. If you do not plan on taking the American Boards of Psychiatry, please include a written statement explaining why as part of your application materials.

Do you use physician's assistants and/or nurse practitioners?: Yes No

If "Yes", in what capacity? _____

APPLICABLE TO PHYSICIANS ONLY

COPIES OF ALL CERTIFICATES ARE REQUIRED

Medical Education *(List all institutions attended)*

Medical School of Graduation	Dates Attended From	To	
Street Address	City	State	Zip
ECFMG (if applicable) Certificate Number:		Date of Issue	

Internship

Medical Facility (Full Name)	Start Date	Completion Date	
Street Address	City	State	Zip
Type of Internship	Program Director Name		

Residency

Medical Facility (Full Name)	Start Date	Completion Date	
Street Address	City	State	Zip
Specialty	Program Director		
Chief of Staff	Chairperson of Department		

Fellowship

Medical Facility (Full Name)	Start Date	Completion Date	
Street Address	City	State	Zip
Specialty	Program Director		
Chief of Staff	Chairperson of Department		

Academic Appointments *(List all teaching appointments and the dates you held these positions.)*

List most recent first)

_____ Date: ___/___/___

_____ Date: ___/___/___

Military and/or Public Health Service

_____ Date: ___/___/___

_____ Date: ___/___/___

ALL APPLICANTS REQUIRED TO COMPLETE

SPECIAL INFORMATION

If you answer "YES" or "PENDING" to any of the following questions, please provide full details.

	YES	NO	PENDING
Have there ever been any actions against your professional license, including but not limited to; restrictions, limitations, denial, revocation, suspension or cancellation in any state?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been refused membership on a hospital medical staff?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has your request for any specific clinical privilege ever been denied or granted with stated limitations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have your privileges at any hospital ever been suspended, limited, revoked, or not renewed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever voluntarily or involuntarily surrendered a narcotics registration, or ever had one limited, suspended, or revoked? This question applies to both state and federal narcotics registration.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been denied membership, or renewal thereof, or been subject to disciplinary action in any professional sanctioned organization?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any physical or mental limitation that would interfere with the practice of your specialty, with or without accommodation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been convicted, pled guilty or nolo contendere to a felony? (If YES, provide a written statement including details)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been denied a medical or behavioral health therapy license or certification?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had any claims, suits, or settlements against you within the past 5 years? (If YES, provide full details and current status of claim)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been sanctioned for any action or omission by federal or state Medicare or Medicaid agencies?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
To your knowledge, are you now the subject of any investigation by a state license board, hospital, or managed care organization?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently using any illegal drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature

____/____/_____
Date

**HORIZON HEALTH EAP SERVICES, INC.
PROFESSIONAL MALPRACTICE QUESTIONNAIRE**

Name of Provider/Behavioral Health Organization	Date	
Street Address		
City	State	Zip

Please complete if applicable. On the application submitted to Horizon Health, either "Yes" was answered to an item asking about professional liability or there was a finding of such an item in the primary source verification process. The information requested on this questionnaire applied to mental health/substance abuse clinical care. Please answer the following questions regarding each lawsuit so we may proceed with your provider application. Please be complete in your responses.

Name of individual Provider/Employee (against whom lawsuit was filed)

Was lawsuit filed: Yes No

If no, please indicate by checking "No", signing the questionnaire, and returning to Horizon Health.

If yes, please provide the following information:

1. Date lawsuit filed: _____
Court (including city and state): _____
2. Name(s) of plaintiff(s)/claimant(s): _____
3. Name(s) of defendant(s)/respondent(s):

4. Patient's diagnosis at the time of incident:

5. Type and site of treatment patient was receiving at time of incident:

6. Relationship of patient(s) to Plaintiff(s):

7. Primary treatment provider:

8. Brief Summary of incident:

9. a. Your relationship to patient at time of incident: _____
b. Your relationship to/involvement in incident: _____

10. a. Nature of alleged harm to patient (be specific): _____
 b. To others: _____
11. List of allegations against you (Specifically, what actions or omissions are alleged to have caused harm to the patient or others?): _____
12. List of allegations against other defendants: _____
13. Summary of your defense: _____

14. Outcome of the lawsuit: _____
 _____ Pending
 _____ Set for trial: ___ / ___ / _____ (date)
 _____ Settled: Amount: \$ _____
 _____ Dismissed
 _____ Other – Describe: _____
 (If more space is needed, please attach a separate sheet)
15. Additional information/comments: _____

Examples of types of documents that will help us to process your material include:

- Sanction letters, consent orders, stipulations, and related documents from any licensing, certifying, or credentialing entity.
- Settlement agreements, petitions, complaints, answer, and demand letters.
- A chronology of the events involved in the incident and sanction, consent order, or stipulation, including your actions taken and date(s).

Possible decision outcomes include:

- Becoming a fully active provider, pending successful completion of the credentialing process;
- Placing you on a provisional status; or
- A decision of ineligibility or termination from the network.

 Practitioner's Signature

 Printed Name & Title

 Date

**PLEASE COMPLETE AND SUBMIT TO: HORIZON HEALTH EAP SERVICES, INC.
 PROVIDER SERVICES DEPARTMENT
 PO BOX 293508
 LEWISVILLE TX 75029-3508**

HORIZON HEALTH EAP SERVICES, INC. PRACTITIONER APPLICATION

Authorization for Release of Information

I hereby grant permission and consent for Horizon Health EAP Services, Inc. and/or its authorized representative to obtain and verify information contained on my Provider Application, and I hereby consent to the release of any person, organization, or other entity to Horizon Health and/or its authorized representative of all information, reports, records, or other documents that may be necessary for an evaluation of my professional competence, character and ethical qualifications.

I hereby release all persons, organization, or other entities and their respective employees and agents from all liability due to the release of such information or documents to Horizon Health and/or its authorized representative, including otherwise privileged or confidential information, made or given in good faith and relating to the subject matters addressed in my Provider Application.

Signature of Applicant _____

Printed name of Applicant _____

Date ____/____/____ **Date of Birth** ____/____/____ **Social Security Number** _____
(Mandatory)

My records may also arrive under the name of: _____

Statement of Truthfulness, Acceptance, and Onsite Requirements

I hereby verify that all of the information submitted in this application is correct and complete to the best of my knowledge. I understand that acceptance of this application does not guarantee that I will be accepted for participation in any health plan. I agree to notify the plan for whom I have completed this application of any material change in information supplied, including all time specific documents and all items in the confidential section, both before and after acceptance into the network.

I understand that if I am accepted for providership my office medical records (subject to proper confidentiality restrictions and authorizations) will be subject to an onsite inspection by a plan representative for utilization, peer review, and quality management purposes. In addition, an onsite office review may be conducted as part of the credentialing process.

Signature

_____/_____/_____
Date

NOTE: You have the right to request review of any information discovered through the Credentialing Process. You must do so via certified written request to: Horizon Health EAP Services, Inc. Provider Services, P.O. Box 293508 Lewisville, TX 75029-3508. If you have any questions, please contact our Provider Services at 1-800-872-7322.

HORIZON HEALTH EAP SERVICES, INC. REFERENCE FOR CHILD PRIVILEGES

*(Required: **Two** references from a child psychiatrist or child psychologist)*

Name of Applicant: _____

The above named applicant has applied for admission to Horizon Health provider network. The responses to the questions below are an attestation to the clinical competence of this professional.

How many years have you known this applicant? _____

What is your relationship to the applicant? Clinical Supervisor Colleague Other, please specify: _____

Are you a licensed mental health professional? Yes No Licensure Type _____ State _____

If you are a physician, are you board certified? Yes No

Please evaluate the applicant's overall clinical performance based upon your knowledge and observation of this individual. Circle one: 5=Superior, 4= Above Average, 3= Average, 2= Unsatisfactory, 1= Unable to Evaluate.

Clinical competence	5	4	3	2	1
Professional judgment	5	4	3	2	1
Rapport with patients	5	4	3	2	1
Psychiatric emergency/crisis	5	4	3	2	1
Alcohol & Drug assessment	5	4	3	2	1
Child Psychotherapy	5	4	3	2	1
Adolescent psychotherapy	5	4	3	2	1
Marital & Family therapy	5	4	3	2	1
Office appearance	5	4	3	2	1
Quality of record keeping	5	4	3	2	1
Overall evaluation	5	4	3	2	1

How many years of continuous experience has this clinician had with children under the age of 12? _____

Are you aware of a drug or alcohol problem that would affect his/her professional performance?
 Yes No

Are you aware of any mental or physical health problems that would affect his/her professional performance?
 Yes No

To your knowledge has the applicant ever been investigated by any professional association or licensing board?
 Yes No

Please explain any unsatisfactory ratings or "Yes" responses on a separate page.

I recommend this individual _____

I do not recommend this individual _____

Signature: _____ Date: _____

Print Name and Title: _____

Address: _____ Phone: _____

REQUEST FOR TAXPAYER IDENTIFICATION NUMBER (TIN)

RETURN TO: HORIZON HEALTH ATTN: PROVIDER SERVICES

PO BOX 293508 LEWISVILLE, TX 75029-3508

Please make sure form is complete and accurate, as payment will be rendered based on information provided.

PLEASE PRINT

() New address or tax I.D. # change within the past two years

PRIMARY OFFICE INFORMATION

☐ Tax # utilized exclusively by me

TAX ID #: _____

☐ Tax # utilized by multiple practitioners

*W-9 / LEGAL NAME: _____
"Legal name" that corresponds with Tax # on line above.

CORRESPONDING "Doing Business As" NAME: _____

PRIMARY SERVICE ADDRESS (NOT P.O. BOX): _____

CITY: _____ COUNTY _____ STATE: _____ ZIP: _____

PHONE: _____ FAX: _____

PRIMARY AUTHORIZATION ADDRESS: _____

CITY: _____ COUNTY _____ STATE: _____ ZIP: _____

CLAIMS/PAYMENTS ADDRESS: _____

CITY: _____ COUNTY _____ STATE: _____ ZIP: _____

TYPES OF SERVICES OFFERED: _____ MH OUTPT _____ CD OUTPT _____ MH IOP _____ CD IOP _____ EAP
_____ Inpatient _____ Partial _____ IOP _____ Other, specify: _____

SECONDARY OFFICE INFORMATION

☐ Tax # utilized exclusively by me

TAX ID #: _____

☐ Tax # utilized by multiple practitioners

*W-9 / LEGAL NAME: _____
"Legal name" that corresponds with Tax # on line above.

CORRESPONDING "Doing Business As" NAME: _____

SECONDARY SERVICE ADDRESS (NOT P. O. BOX): _____

CITY: _____ COUNTY _____ STATE: _____ ZIP: _____

PHONE _____ FAX: _____

AUTHORIZATIONS ADDRESS: _____

CITY: _____ COUNTY _____ STATE: _____ ZIP: _____

CLAIMS/PAYMENTS ADDRESS: _____

CITY: _____ COUNTY _____ STATE: _____ ZIP: _____

TYPES OF SERVICES OFFERED: _____ MH OUTPT _____ CD OUTPT _____ MH IOP _____ CD IOP _____ EAP
_____ Inpatient _____ Partial _____ IOP _____ Other, specify: _____

I ATTEST, ALL INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

Name: Type or Print _____

Title: Type or Print _____

Practitioner Signature _____

Date _____

(_____) Telephone _____