Affiliate Provider Application

Provider Name: _____
First *Middle Initial* *Last*

List Credentials: _____ ***Please attach copies of license(s)***

Organization Name: _____

Street Address:			
City:	**County:**	**State:**	**Zip:**
Billing Address:			
City:		**State:**	**Zip:**
Phone: ( ) -	**Notes:**		
Fax: ( ) -			
Email: *Not for use with client information*			

Do you provide any of the following?
- ☐ Substance Abuse Assessment
- ☐ CISM
- ☐ SAP

Please indicate which age groups you work with:
- ☐ Children 1-9
- ☐ Children 10-12
- ☐ Adolescents 13-19
- ☐ Adults
- ☐ Older Adults

Do you speak a second language?
Please list.

_____
_____
_____
_____
_____
_____

Insight Staff Only:

Reimbursement Rate: _____
Credentials Checked: _____
Entered into DB: _____
Contract Sent: _____
Contract Received: _____
Activated in DB: _____

Please indicate your specialties:

- ☐ ADHD/ADD
- ☐ Adolescent Disorders
- ☐ Adolescents
- ☐ Adults
- ☐ AIDS/HIV
- ☐ Anger Management
- ☐ Anxiety Disorders/Panic
- ☐ Autism/Asperger's
- ☐ Bipolar Disorder
- ☐ Borderline Personality Disorder
- ☐ Child Abuse
- ☐ Childhood Conduct Disorder
- ☐ Children
- ☐ Christian Counseling
- ☐ Critical Incident Response
- ☐ Depression
- ☐ Disability Management
- ☐ Domestic Abuse
- ☐ Eating Disorders
- ☐ Family Counseling
- ☐ Gambling
- ☐ LGBTQ Issues
- ☐ Housing/Shelter
- ☐ Insomnia
- ☐ Learning Disabilities
- ☐ Marital/Relationship Counseling
- ☐ Mediation
- ☐ Medical Issues
- ☐ OCD
- ☐ Pain Management
- ☐ Personality Disorders
- ☐ Phobias
- ☐ Physical Abuse
- ☐ PTSD
- ☐ Rape/Sexual Assault
- ☐ Runaways
- ☐ Schizophrenia/Psychosis
- ☐ Self-Help: Alcohol
- ☐ Self-Help: Cocaine
- ☐ Self-Help: Gambling
- ☐ Self-Help: Mental Health
- ☐ Self-Help: Narcotics
- ☐ Sex Therapy
- ☐ Sleep Disorders
- ☐ Substance Abuse – Alcohol
- ☐ Substance Abuse – Other Drug
- ☐ Suicide
- ☐ Trauma
- ☐ Other Specialty: _____

_____

Affiliate Provider Application

Please initial below:
_____ I agree to work on behalf of The Insight Program as a Contracted Affiliate Provider. _____ I attest that my license is valid and is not under any disciplinary action, and I agree to inform Insight of any changes in my status. _____ I agree to keep The Insight Program informed of changes in my contact information.
Signature: _____ Date: _____ *First Name* *Middle Initial* *Last Name* *Credentials*

We invite you to share more about the mission and values of your team and/or practice. Please feel free to include any additional information that you feel will help us get to know you better.

PLEASE RETURN COMPLETED APPLICATION BY EITHER FAX OR EMAIL. BE SURE TO INCLUDE COPIES OF LICENSE AND MALPRACTICE INSURANCE FOR ALL APPLICANTS.

Fax: (402)484-8545	**Email: frontdesk@insighteap.biz**