

 **Aurora Health Care[®]**
Aurora Employee Assistance Program

Affiliate Application- Clinic

Clinic Information

Clinic Name: _____ Tax ID: _____

Clinic Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Clinic Email: _____ Internet accessible to staff? Yes No

Billing Address: _____

City, State, Zip: _____

*Please attach a list of any additional locations (include staff names)

Contact Person (see Affiliate Manual for detail): _____

Insurance:

Insurance Carrier: _____ *Attach certificate of liability insurance

Expiration Date: _____ Coverage Limits: _____

EAP Information:

1. Number of years clinic has been providing EAP Services: _____

2. Number of Masters Level staff available to provide EAP Services: _____

3. Number of Masters Level Certified AODA staff available to provide EAP Services: _____

4. Number of staff who are Certified Employee Assistance Professionals (CEAP): _____

5. Number of staff qualified to provide DOT assessments as a Substance Abuse Professional (as defined by DOT regulation- 49 C.F.R. Part 40): _____

6. Do you have staff available to conduct an Onsite Crisis Response if requested? Yes No

7. Do you have staff available to conduct an Onsite Training if requested? Yes No

8. Do you have staff available to conduct an Onsite Promotional Event if requested? Yes No

9. Do you have staff available to conduct an Onsite Consultation if requested? Yes No

10. Do you have staff available to provide EAP Services in other languages? Yes No

If yes, please list: _____

11. Please describe the ethnicity of the counselors in your clinic.

12. Is your office space handicap accessible: Yes No

Please describe any limitations: _____
