

# QUICK CHECK

Please be sure to include all of the information indicated on this checklist.

- Photocopy of state license and certificates with an expiration date clearly visible on the copy
  - State License
  - Critical Incident Certificate (ICISF, Red Cross)
  - CAC (Certified Addiction Counselor)
  - SAP (Substance Abuse Professional)
  - DOT SAP (DOT Substance Abuse Professional)
  - Criminal Clearance Certificates (State & FBI)
  - Child Abuse Clearance Certificate
  
- Photocopy of face sheet of insurance policy which exhibits proof of professional liability coverage, indicating limits of coverage and expiration date (provider must be named as the insured)
  
- Curriculum Vitae (resume) which includes dates and locations of education and post-graduate training. PLEASE DESCRIBE IN DETAIL the populations, problems and disorders treated as well as the theoretical orientation of your work.
  
- A list of Continued Education Programs or workshops attended over the last 24 months and credits received, including annual professional society certification when possible. (*This is required even if your state does not require continuing education to maintain state licensure.*)
  
- Information pertaining to closed and/or active malpractice suits and/or ethics board complaints within the past 5 years. Primary verification releases should be mailed to your licensing and malpractice insurance boards.
  
- W-9

\*Note: Incomplete and unsigned applications delay the credentialing process. If any information on your application is incomplete, your application will be returned to you. LMA will only review each provider's application a maximum of two times.

Using this **Quick Check** will help to ensure that your application is complete.

Return completed application and supporting documents to:

**LIFE MANAGEMENT ASSOCIATES**  
**1848 Charter Lane**  
**Lancaster, PA 17601-5896**  
Phone: 717-394-6688 / 800-327-7770  
Fax: 717-509-8879



**Life Management Associates  
Participating Practitioner Application**

1848 Charter Lane  
Lancaster, PA 17601-5896  
(717) 394-6688 / 800-327-7770

PLEASE COMPLETE ALL QUESTIONS. APPLICATION WILL BE RETURNED IF INCOMPLETE.

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**Provider Profile**

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*Last Name (Please type or print legibly)* *First Name* *Middle*

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*Degree* *License Type* *Social Security #*

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*Sex* *Birth Date* *My SS # is different from my Tax ID#*

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*School* *Location* *Date of Graduation*

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**OFFICE ADDRESS**

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*Street* *Suite*

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*City* *County* *State* *Zip*

---

*Office Telephone* *Fax Number*

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*E-mail* *Website Address*

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**SECOND OFFICE ADDRESS**

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*Street* *Suite*

---

*City* *County* *State* *Zip*

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*Office Telephone* *Fax Number*

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*E-mail* *Website Address*

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*\*Billing Tax ID Number (If different from Social Security Number)*

**Billing Address (If different from above)**

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*Street* *Suite* *City* *County* *State* *Zip*

Type of practice:  Solo  Group  Other

Corporation/Group Name (if applicable): \_\_\_\_\_

Checks should be made out to:  Individual Name  Group Name

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**Office Hours** (give specific hours):

	Sun.	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.
Days	_____	_____	_____	_____	_____	_____	_____
Evenings	_____	_____	_____	_____	_____	_____	_____



Do you have coverage for after hours?  No  Yes Please describe: \_\_\_\_\_

Do you have a live person answering the phone at all times? \_\_\_\_\_ No \_\_\_\_\_ Yes

Do you have a clinician on call at all times? \_\_\_\_\_ No \_\_\_\_\_ Yes

Please list any other employment in addition to private practice:

**Licensing**

List below all states in which you are licensed to practice:

<u>State</u>	<u>Actively in practice now</u>	<u>Original Date of License</u>	<u>Expiration Date</u>
_____	Yes _____ No _____	_____	_____
_____	Yes _____ No _____	_____	_____
_____	Yes _____ No _____	_____	_____

Other licensure or certification (ie: Diplomat or Fellowship Status with a national professional organization – note membership) \_\_\_\_\_

**Clinical Profile**

Please indicate areas of EXPERTISE and EMPHASIS in daily clinical practice.

<u>POPULATIONS</u>	<u>PROBLEMS</u>	<u>DISORDERS</u>
_____ Adults	_____ Sexual Dysfunction	_____ Chemical Dependency
_____ Adolescents	_____ Infertility	_____ Obsessive Compulsive
_____ Children (Latency)	_____ Rape	_____ Organic Mental Disorders
_____ Children (Preschool)	_____ Sexual Abuse	_____ Schizophrenic Disorders
_____ Family	_____ Physical Abuse	_____ Learning Disability
_____ Couples	_____ Trauma	_____ Somatoform Disorders
_____ Geriatric	_____ Chronic Pain	_____ Eating Disorders
_____ Gay/Lesbian	_____ AIDS	_____ Phobias
_____ Police	_____ Medical Stress	_____ Sleep Disorders
_____ Physically Impaired	_____ Domestic Violence	_____ Attn. Deficit Disorders
_____ Hearing Impaired	_____ Financial Stress	_____ Mood Disorders
_____ Developmental Disability	_____ Grief	_____ Anxiety Disorders
_____ Airline Personnel	_____ Post Traumatic Stress	_____ Personality Disorders
_____ Emergency Svcs Personnel	_____ Other:	_____ Compulsive Gambling
_____ Sex Offenders		Other:
_____ Other:		

Specialty Areas:

- \_\_\_\_\_ Critical Incident Debriefing
- \_\_\_\_\_ Group Therapy
- \_\_\_\_\_ Psychological Testing
- \_\_\_\_\_ Mandatory Referrals
- \_\_\_\_\_ EMDR
- \_\_\_\_\_ Hypnosis \*\*
- \_\_\_\_\_ EAP \*\*

Do you self-identify as:

- Certified Pastoral Counselor \*\* Yes \_\_\_\_\_ No \_\_\_\_\_
- Ordained Clergy Yes \_\_\_\_\_ No \_\_\_\_\_
- Christian Counselor Yes \_\_\_\_\_ No \_\_\_\_\_
- Gay/Lesbian Yes \_\_\_\_\_ No \_\_\_\_\_
- Bi-Cultural Yes \_\_\_\_\_ No \_\_\_\_\_
- Hearing Impaired Yes \_\_\_\_\_ No \_\_\_\_\_
- Specify: Yes \_\_\_\_\_ No \_\_\_\_\_

**\*\* You must include proof of Certification**



Languages (other than English) in which you conduct treatment: \_\_\_\_\_

Your ethnicity (optional) \_\_\_\_\_

(Note: For clients who request clinicians of the same ethnic group)

**Managed Care Experience**

A. What insurances do you accept? Please list.

\_\_\_\_\_  
\_\_\_\_\_

**Clinical Experience**

1. Please summarize the major characteristics of your practice population (age, sex, diagnosis, etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. How many patients are in your current clinical caseload?

Number of Patients

Outpatient psychotherapy

\_\_\_\_\_

Other (specify)

\_\_\_\_\_

\_\_\_\_\_

1. Please list training, education or supervision sessions (for yourself) which you regularly attend.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Liability Information**

Professional liability / malpractice insurance:

\_\_\_\_\_

Carrier

\_\_\_\_\_

Expiration Date

Coverage limits (per incident and aggregate):

\_\_\_\_\_

Per incident

\_\_\_\_\_

Per aggregate



Please respond to each of the following questions.

If you answer yes to any of these questions, please explain clinical details on a separate sheet.

1. Has your clinical license ever been revoked, suspended or limited?  
Is there an action pending?  Yes  No  
 Yes  No
2. Within the past five years, have you ever been subject to disciplinary review by any of the following?  
State Licensing Board  Yes  No  
State \_\_\_\_\_ Date \_\_\_\_\_  
County, State or Professional Society  Yes  No  
State \_\_\_\_\_ Date \_\_\_\_\_  
Hospital Medical or Clinical Staff  Yes  No  
Hospital \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_
3. Within the past five years, have you ever been denied hospital privileges?  
 Yes  No  
— —
4. Within the past five years, have you ever been denied professional liability insurance, has your insurance ever been cancelled, has renewal been refused, or have premiums been surcharged because of claims?  
During the past five years, have you been a party to malpractice suits which went to the final disposition and resulted in payment to the Plaintiff?  
 Yes  No  
 Yes  No  
If the answer is yes, please complete the following:  
Year    Number of Suits    Total of Payment(s)    Nature of Suit  
\_\_\_\_\_  
\_\_\_\_\_
5. Presently, do you have any malpractice suits pending against you?  
If answer is yes, you MUST attach an explanation of the (1) nature of the suit; (2) the clinical events leading up to the suit.  
 Yes  No  
— —
6. Within the past five years, have you ever resigned from the staff of any hospital or professional organization because of problems regarding privileges or credentials?  
 Yes  No  
 Yes  No
7. Have you ever had any licensing board or professional ethics body ever require you to surrender your license or found you guilty of violation of ethics codes, professional misconduct, unprofessional conduct, incompetence or negligence in any state or country? If yes, please give full particulars.
8. Within the past five years, have you ever been convicted or pleaded guilty to a felony?  
 Yes  No  
— —
9. Do you suffer from any physical or mental condition which impairs your ability to practice?  
 Yes  No  
— —
10. Within the last five years, have you had any chemical dependency, alcohol or other substance condition?  
 Yes  No  
— —

IF YOU HAVE ANSWERED YES TO ANY OF THE PREVIOUS QUESTIONS, PLEASE SUBMIT MATERIAL OF EXPLANATION. YOUR APPLICATION WILL BE RETURNED INCOMPLETE IF MATERIALS ARE EXCLUDED.

## Instructions

PLEASE ATTACH THE FOLLOWING INFORMATION TO THIS APPLICATION:

1. Photocopy of *state license* and certificates) with an expiration date.
  - State License
  - Criminal Clearance Certificates - State & FBI
  - Child Abuse Clearance Certificate
  - Critical Incident Certificate (ICISF, Red Cross), if applicable
  - CAC (Certified Addiction Counselor), if applicable
  - SAP (Substance Abuse Professional), if applicable
  - DOT SAP (DOT Substance Abuse Professional), if applicable
2. Board Certification Certificate.
3. Proof of professional *liability coverage* indicating limits of coverage and expiration date (photocopy of face sheet).
4. *Curriculum vitae (resume)* which includes dates and locations of education, post-graduate training, professional experience, credentials and professional memberships. For each setting in which you have worked or trained, PLEASE DESCRIBE IN DETAIL the populations, problems and disorders treated as well as the theoretical orientation of your work.
5. List of *continuing education* programs attended over the last 24 months and credits received, including Annual professional Society certification when possible.
6. Completed W-9 form.

## Certification

I, the undersigned, hereby attest that the information given in or attached to this Application is accurate, complete and fairly represents the current level of my training, experience, capability, and competence to practice at the level requested. I specifically authorize you and your authorized representatives to consult with any third party which may have information bearing on the subject matter addressed by this Application and to inspect or obtain any reports, records, recommendations, or other documents or disclosures of third parties that may be material to the questions in this Application. I also specifically authorize any third parties to release information to you and/or your authorized representatives upon request. I hereby release you and/or your authorized representatives, and any third parties, from any liability for any reports, records, recommendations, or other documents or disclosures involving me that are made, requested, or received by you and/or your authorized representatives to, from, or by any third parties, including otherwise privileged or confidential information, made or given in good faith and relating to the subject matter addressed by this Application.

I warrant that I have authority to sign this Application, on my own behalf, and on behalf of any entity or organization for which I am signing in a representative capacity. I understand that if this Application is accepted by Life Management Associates, I will be bound by the terms of the Life Management Associates Provider Agreement, of which this Application is a part. I have read and understand the terms of the Life Management Associates Provider Agreement, and agree to be bound by them, and accept the published rates for my level of licensure.

ANY INFORMATION ENTERED INTO THIS APPLICATION WHICH SUBSEQUENTLY IS FOUND TO BE FALSE COULD RESULT IN OUR REFUSAL TO ENTER INTO A CONTRACT WITH YOU OR TERMINATION OF ANY CONTRACT WITH YOU.

YOUR SIGNATURE IS REQUIRED TO COMPLETE THIS APPLICATION.  
STAMPED SIGNATURES ARE NOT ACCEPTABLE.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Please Print Name \_\_\_\_\_

