# TCTI DEA Provider Questionnaire

Thank you for your interest in joining the TCTI DEA Provider Network. We take every precaution to properly qualify providers for the network to ensure they meet the growing needs of our clients and that they will have a positive experience working with us.

## QUALIFICATIONS

### In Person Counseling

- Master's Degree
- Fully licensed in the state you provide services
- Malpractice insurance in an amount of not less than one million dollars ($1,000,000) per occurrence and three milliondollars ($3,000,000) per aggregate
- Minimum of three-years' experience in a clinical setting post full licensure

### Video Counseling

- Master's Degree
- Fully licensed in the state you provide services
- Malpractice insurance in an amount of not less than one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) per aggregate
- Minimum of three-years' experience in a clinical setting post full licensure
- HIPPA compliant video counseling platform
- Business Associate Agreement from a platform verifying the platform is HIPAA compliant
- Malpractice insurance that includes video counseling

## CREDENTIALING

Credentialing is the process we use to verify your professional credentials in conjunction with our criteria. Here's what you need to begin. *Additional instructions/forms will be provided after your Clinical Questionnaire is reviewed.

- A copy of your curriculum vitae
- A copy of your license(s)
- A copy of certification(s), if applicable
- A copy of your malpractice insurance
- Practice Information*
- Malpractice Questionnaire*
- Provider Payment Checklist*
- W-9*
- Billing Procedures*
- ACH authorization form*
- Business Associate Agreement*

## WHERE TO SEND

Email: JMartinez@thecounselingteam.com
FAX: 760.636.0437
Mail: The Counseling Team, 41750 Rancho Las Palmas Dr. Ste O-2, Rancho Mirage, CA 92270

Submission of credentials is for consideration only and does not ensure acceptance into the TCTI DEA Provider Network. We will carefully review your application and contact you when the review is completed.

## TCTI DEA Clinical Questionnaire

Date_____

Counselor's Name_____ Credentials_____

Practice/Group Name (dba)_____ National Provider #_____

Practice Mailing Address _____

City _____ State _____ ZIP Code _____

Practice Address _____

City _____ State _____ ZIP Code _____

Additional Practice Address _____

City _____ State _____ ZIP Code _____

Phone Listings: Office _____ Cell _____

Fax _____ Emergencies _____

E-mail _____ Website _____

Please check the presenting problems for which you have unique credentialing or targeted and current training for assessment and treatment.

- ☐ Abuse Issues
- ☐ ACOA
- ☐ ADHD/ADD
- ☐ Adolescent Disorders
- ☐ Adolescents
- ☐ Adoption Issues
- ☐ Adults
- ☐ AIDS/HIV
- ☐ Alternate Lifestyles
- ☐ Anger Management
- ☐ Anxiety Disorders/Panic
- ☐ Autism/Asperger's
- ☐ Behavioral Problems
- ☐ Bipolar Disorders
- ☐ Blended Families
- ☐ Borderline Personality Disorders
- ☐ Career Counseling
- ☐ Child Abuse
- ☐ Childhood Conduct Disorders
- ☐ Children
- ☐ Christian Counselor
- ☐ Codependency
- ☐ Critical Incident Response
- ☐ Depression
- ☐ Development Disorder
- ☐ Disability Management
- ☐ Domestic Violence
- ☐ Eating Disorders
- ☐ Elder Issues
- ☐ Ethnicity/Minority Issues
- ☐ Family Counseling
- ☐ Family of Origin Issues
- ☐ Gambling
- ☐ Gay/Lesbian Issues
- ☐ Grief & Loss
- ☐ Group Therapy
- ☐ Housing/Shelter
- ☐ Impaired Professionals
- ☐ Insomnia
- ☐ Internet Addiction
- ☐ Learning Disabilities
- ☐ Marital/Relationship
- ☐ Mediation
- ☐ Medical Issues
- ☐ Men's Issues
- ☐ OCD
- ☐ Pain Management
- ☐ Parenting Issues
- ☐ Performance Problems
- ☐ Personality Disorders
- ☐ Phobias
- ☐ Physical Abuse
- ☐ Play Therapy
- ☐ PTSD
- ☐ Psychological Evaluation
- ☐ Rape/Sexual Assault
- ☐ Runaways
- ☐ Schizophrenia/Psychosis
- ☐ School Problems
- ☐ Self-Help – Alcohol
- ☐ Self-Help – Cocaine
- ☐ Self-Help – Gambling
- ☐ Self-Help – Mental Health
- ☐ Sex Therapy
- ☐ Sexual Abuse Therapy
- ☐ Sleep Disorders
- ☐ Stress Management
- ☐ Substance Abuse – Alcohol
- ☐ Substance Abuse – Other Drug
- ☐ Suicide
- ☐ Trauma
- ☐ Women's Issues

Of the above list, what would you say are your three (3) main areas of interest?

_____

Is your practice: Adult Only _____ Children Only _____ Both _____ Number of years in clinical practice _____

Do you work with clients who have been referred to EAP due to job performance issues? Yes _____ No _____

Do you work with perpetrators? Yes _____ No _____

Do you provide marriage counseling? Yes _____ No _____

Do you work with sex addiction? Yes _____ No _____

Do you have an interest in becoming a network trainer for TCTI? Yes _____ No _____

Do you have experience working with first responders/law enforcement? Yes _____ No _____

Do you have any of the following special abilities/certifications? Please attach a copy of certificate(s).

Alcohol/Drug Assessment Yes _____ No _____
What substance use screening tool(s) do you use? _____
Do you use ASAM criteria to determine level of care? Yes _____ No _____
Are you able to provide a brief (4 – 5 sessions) curriculum of sobriety maintenance education at the ASAM Early Intervention level of care? Yes _____ No _____
Do you have the ability to drug test clients? Yes _____ No _____
If not, do you refer to another agency for drug tests? If so, who? _____
What treatment facilities have you found to be most helpful? _____
Substance Abuse Professional Yes _____ No _____
Critical Incident Response Yes _____ No _____
Certified Employee Assistance Professional (CEAP) Yes _____ No _____
EAS-C Certification Yes _____ No _____
Speak a second language fluently? Please list _____ Yes _____ No _____
Work with returning military, Guards, Reservists and their families Yes _____ No _____
Work with children? Please list age ranges _____ Yes _____ No _____
Life Coach Yes _____ No _____ Are you a certified Life Coach? Yes _____ No _____
Workplace Coach Yes _____ No _____ Are you a certified Workplace Coach? Yes _____ No _____

Do you provide on-site critical incident response? Yes _____ No _____
Are you affiliated with a national critical incident response group? Yes _____ No _____

If so, which group? _____

Do you participate in a video counseling network? Yes _____ No _____

If so, which network? _____
Is the network HIPAA compliant? Yes _____ No _____

Do you provide a sliding scale or reduced fee schedule if needed? Yes _____ No _____
Are there clinical issues you prefer not working with? Yes _____ No _____

If so, please list _____

Please list treatment orientation(s) _____

_____

How do you prefer authorizations be sent to you? Mail _____ Fax _____ Secure email _____

Do you use a billing service/individual to submit billing? Yes _____ No _____
If so, please list name of service or individual.

_____

Phone _____

The following information assists our assessment staff in completing the referral process by matching clients with resources based on client request/expectation and presenting problem:

Your Gender _____ Your Age _____ Your Ethnicity _____

Is your office handicapped accessible? Yes _____ No _____

Days/Hours available to see clients _____

Insurance Panels (Please list panels you are on.) _____

While we try to minimize paperwork demands on our network providers, our insurance carrier requires we ask you to respond to these questions. Since we are required to keep responses on file, we ask that you return the completed form to TCTI. We appreciate your continuing support and thank you for assisting us in this way.

1. Have you ever been convicted of a crime involving sex-related or child/elder abuse related offenses? Yes _____ No _____

2. Have you ever been convicted of any other crime? (other than minor traffic violations) Yes _____ No _____

3. Do you have any pending misdemeanor or felony charges? Yes _____ No _____

4. In the past three years, has your license to practice in any jurisdiction ever been voluntarily or involuntarily denied, restricted, suspended, challenged, revoked, conditioned or otherwise limited? Yes _____ No _____

5. In the past three years and up to and including the present, have you had any ongoing physical or mental impairment or condition that would make you unable, with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice, or unable to perform those essential functions without a direct threat to the health and safety of others? Yes _____ No _____

6. Considering the essential functions of a practitioner in your area of practice, in the past three years and up to and including the present, have you suffered from any communicable health condition that could pose a significant health and safety risk to your clients? Yes _____ No _____

7. Have you ever had an incident that resulted in an allegation of sexual, child or elder abuse? Yes _____ No _____
   Was a claim made against you? Yes _____ No _____
   **(If yes, please submit details at the end of the document.)**
   Was the case settled? Yes _____ No _____
   Taken to trial? Yes _____ No _____

8. Have you ever been sanctioned for an ethical violation? Yes _____ No _____
   **(If yes, please submit details at the end of the document.)**

   Was a claim made against you? Yes _____ No _____
   **(If yes, please submit details at the end of the document.)**
   Was the case settled? Yes _____ No _____
   Taken to trial? Yes _____ No _____
   Were there any recommendations or restrictions made for you? Yes _____ No _____

9. In the past three years, have you had a history of chemical dependency or substance abuse that might affect your ability to competently and safely perform the essential functions of a practitioner in your area of practice? Yes _____ No _____

10. In the past three years, have you had or do you have any mental or physical condition or do you take any medications that might affect your ability to competently and safely perform the essential functions of a practitioner in your area of practice? Yes _____ No _____

11. In the past three years, has any malpractice carrier ever made an out-of-court settlement or paid a judgment of a medical malpractice claim on your behalf or have you ever been named in a malpractice suit, settled, active or dismissed? Yes _____ No _____

12. In the past three years, has your professional liability insurer placed conditions or restrictions on your coverage of ability to obtain coverage? Yes _____ No _____

13. Are you aware of any potential malpractice suits that may be filed against you? Yes _____ No _____

14. Have you ever been trained in the area of sexual, child and elder abuse in aspects such as how to recognize the signs and what to do if a client/child/aging person reports that someone has abused him or her? Yes _____ No _____

15. Are you supervised on a regular basis to monitor your relationship and professional services with clients/children/aging persons? Yes _____ No _____

16. Do you participate in peer supervision or consult with peers when needed? Yes _____ No _____

17. If you are without supervision resources, do you agree to contact TCTI so that we can work with you to provide peer supervision or to find adequate supervision resources? Yes _____ No _____

18. Do you agree to contact TCTI should you be charged with or convicted or any ethical violation or crime including sex-related or child/elder abuse- related offenses? Yes _____ No _____

19. Do you have malpractice insurance?
**(If yes, please attach evidence thereof and return with this form.)** Yes _____ No _____

Network Provider's Name and Credentials | Signature | Date