Aurora Employer Solutions
Employee Assistance Program

Aurora Health Care®

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: _____

    _____

13. In routine situations, are staff available to see Clients within two (2) working days: ☐ Yes ☐ No
14. In urgent situations, are staff available to see Clients within twenty-four (24) hours: ☐ Yes ☐ No
15. In emergencies, are staff available to see Clients on a same-day basis: ☐ Yes ☐ No

16. Please list regular clinic hours:

Monday:_____   Saturday:_____

Tuesday:_____   Sunday:_____

Wednesday:_____

Thursday:_____

Friday:_____

17. Are staff ever available outside of these regular hours?   ☐ Yes ☐ No

If yes, list when exceptions are made:_____

18. Describe after hours back-up and telephone coverage.

_____

_____

_____

19. Please add anything else that you feel is important to know about your EAP services or staff.

_____

_____

_____

_____

_____

_____

_____

☐ I have received and read the Affiliate Manual (*www.aurora.org/eapaffiliates)* and understand the procedures the Affiliate must comply with. I agree that the Clinic's activities as an Affiliate shall be bound by, and shall comply with, the Affiliate Manual.

Signed:_____

Title:_____   Date:_____

Please send completed applications to:
EAP Network Coordination
Aurora Employee Assistance Program
4067 N. 92nd Street
Wauwatosa, WI 53222
Phone 888-389-3299
Fax 414-760-5418