



# MESA MENTAL HEALTH

## CORPORATE HEALTH RESOURCES

PO Box 90607, Albuquerque, NM 87199-0607  
(505) 816-6737 • Fax (505) 816-6744

### PRE-APPLICATION FOR PRACTITIONER PARTICIPATION

Are you applying for a Private Practice Contract or as part of a Group Contract? Check ONE box only:

**Private Practice Contract (i.e., Individual Contract)**

- Private Contract w/in Private Practice (one employee, self-owned)
- Private Contract w/in Group Practice (multiple employees) with Single Applicant – only the applicant will be credentialed to see Mesa Mental Health members.

**Group Contract**

- Group practice with multiple employees and multiple applicants - a Group Application must be submitted along with each individual practitioner's Pre-application packet.

<b>Practitioner's Name:</b> Last	First	MI	License (PhD, LPCC, etc.)
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**Practice Location: (Please indicate if you are associated with a group practice)**

Name of Practice: \_\_\_\_\_

Administrator of Group: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Office Manager: \_\_\_\_\_

Office Hours: \_\_\_\_\_ Evenings? \_\_\_\_\_ Weekends? \_\_\_\_\_

Tax I.D. # \_\_\_\_\_ NPI#: \_\_\_\_\_ E-mail: \_\_\_\_\_

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Type 2 NPI # (business) \_\_\_\_\_ May we contact you by E-mail?  Yes  No

*Mesa Mental Health requires 24-hour on-call coverage at practice location; referring to 911 is unacceptable. Pre-application packets will not be reviewed until coverage is in place.*

Indicate type of coverage:  Cell Phone  Pager, Answering Service

Rotating On-Call  Other \_\_\_\_\_

To whom do you refer when you are ill or unavailable? \_\_\_\_\_

**Mailing Address (if different from Practice Location)**

Name: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_



## PRE-APPLICATION FOR PRACTITIONER PARTICIPATION

- **Must provide documentation of certification or training, i.e., CEUs, certificates, supervision, post graduate training or documented experience.** Name \_\_\_\_\_

### Practitioner Profile

- *Items marked with an asterisk\* require documentation or certification of training.*
- *Please check only those services that you are qualified to provide and diagnoses/issues that you routinely accept in your professional practice.*

- |   |   |
|---|---|
| <input type="checkbox"/> ADHD Testing                             | <input type="checkbox"/> Gay/Lesbian Issues                         |
| <input type="checkbox"/> Anger Management                         | <input type="checkbox"/> Gender Identity Issues                     |
| <input type="checkbox"/> Anxiety                                  | <input type="checkbox"/> Geriatric*                                 |
| <input type="checkbox"/> Bilingual* Specify Language(s):<br>_____ | <input type="checkbox"/> Grief                                      |
| <input type="checkbox"/> Bipolar Disorder                         | <input type="checkbox"/> Family Therapy                             |
| <input type="checkbox"/> Cancer Patients                          | <input type="checkbox"/> HIV/Aids*                                  |
| <input type="checkbox"/> Religious Oriented Counseling            | <input type="checkbox"/> Personality Disorders                      |
| <input type="checkbox"/> Chronic Illness/Pain*                    | <input type="checkbox"/> Play Therapy*                              |
| <input type="checkbox"/> Couples/Marital Counseling               | <input type="checkbox"/> Postpartum Depression                      |
| <input type="checkbox"/> DBT*                                     | <input type="checkbox"/> Process Addiction Please Specify:<br>_____ |
| <input type="checkbox"/> Depression                               | <input type="checkbox"/> PTSD*                                      |
| <input type="checkbox"/> Dissociative Identity Disorder*          | <input type="checkbox"/> Sand Tray*                                 |
| <input type="checkbox"/> Domestic Violence                        | <input type="checkbox"/> Sexual Abuse                               |
| <input type="checkbox"/> Eating Disorder*                         | <input type="checkbox"/> Smoking Cessation                          |
| <input type="checkbox"/> EMDR*                                    | <input type="checkbox"/> Evening Hours _____                        |
| <input type="checkbox"/> Hearing Impaired                         | <input type="checkbox"/> Weekend Hours _____                        |

### Employee Assistance Program Services

- EAP Counseling
- Employee Training
- Department of Transportation/Substance Abuse Professional\* (SAP)
- Critical Incident Stress Management\*

# PRE-APPLICATION FOR PRACTITIONER PARTICIPATION

## *Employee Assistance Program*

***Mesa Mental Health Providers may be called upon to provide needed EAP services as part of being in the MMH network. Since EAP work involves unique activities and abilities, please complete the following information. This will be helpful in the evaluation of your pre-application for our network.***

- I. Please describe your experience working in EAP including assessment, referral, **employer** relations, workplace training, O.D. interventions, and methods of counseling:

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- II. Describe your approach to EAP Counseling:

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- III. Please describe other assessment and referral skills/experience:

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- IV. Please describe your certification and experience in Substance Abuse Assessment. Indicate if you have experience with D.O.T. regulations:

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- V. Please describe your knowledge of community resources and utilization:

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- VI. Please describe your certification and experience in providing Critical Incident Stress Management (CISM):

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- VII. Please describe your certification and experience in mediation:

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**APPLICANTS NEED TO SUBMIT THE FOLLOWING WITH PRE-APPLICATION:**

1. Copy of current License with expiration date; wallet cards will not be accepted.
2. Copy of current Curriculum Vitae or Resume which must include professional or medical school, internships, residencies, fellowships, etc. with dates of attendance month/year.
3. Copy of current malpractice insurance face sheet with expiration date. **Note: Current coverage amounts must meet MMH minimum requirements. The industry for MD is \$1 million/\$3 million, for Ph.D. is \$500,000/\$1 million, for MA is \$200,000/\$600,000.**
4. Copies of documented certifications or trainings related to requested privileges or profile specialties.
5. Copies of current DEA and Controlled Substance Registration with expiration dates for providers with prescription authority.
6. Completed IRS W-9 form
7. Completed Practitioner Profile

*Your application will not be reviewed unless it is submitted in full.*