Dear Prospective Employee Assistance Program (EAP) Provider,

Kepro is a global provider of EAP services serving over 200 customer accounts throughout the United States. We are currently looking to expand our availability of independently licensed mental health providers to administer Employee Assistance services to the employees, dependents, and household members of our customer accounts. If this is of interest to you, please submit all the documents outlined below in the credentialling application checklist.

By submitting your documents in one complete package, this allows our credentialing department to process your application quickly. Any documents omitted create delays in our ability to credential you as a provider in good standing in our network and refer Kepro EAP clients to you. Credentialing documents should be sent via e-mail to EAPCredentialing@kepro.com. If you do not have the ability to send via email, documents can be faxed to us at 866-480-8341.

**CREDENTIALING CHECKLIST**

- ☐ CAQH Application (Council for Affordable Quality Healthcare, Inc.)
- ☐ Data Protection Survey
- ☐ EAP Provider Acknowledgement
- ☐ Kepro EAP Provider Telemental Health Services Acknowledgment
  - ☐ Business Associate Agreement w/Technology provider (if NOT using ZOOM)
- ☐ Copy of License(s) - **Please provide ALL licenses in all states**
- ☐ Copy of Malpractice Insurance
- ☐ **Groups:** name and email address for Administrative/Credentialing Point of Contact
- ☐ **Optional information**: any languages you speak, for example: ASL, Spanish, Portuguese, etc.

Once all documents above have been received and you have been approved as an EAP Provider, the following documents will be sent via DocuSign and must be completed to finalize the credentialing process:

- ☐ Kepro Employee Assistance Program (EAP) Service Provider Agreement
- ☐ W9

**CAQH Application**

- Download your CAQH application and mail to EAPCredentialing@kepro.com
- If you **do not participate with CAQH,** please register using this link: https://proview.caqh.org/PR/Registration
- If you prefer to email a paper application, you may download the application from this link: https://www.caqh.org/sites/default/files/solutions/proview/paper-application.pdf?token=enguSSk2
- **Optional:** If not included in the CAQH application, please list additional language information for example: ASL, Spanish, Portuguese, etc.

**Data Protection Survey**

- **Administrative Point of Contact (Name & Email)**
  - If provider(s) are part of a Group, please provide the **Administrative/Credentialing Point of Contact** who can process the Kepro EAP Service Provider Agreement & W9 for signatures.

- Please complete and sign the attached Data Protection Survey
  - **Question 3b**: indicate the system you use to back-up your client data files (e.g., cloud backup, etc.); or if you use paper charts, indicate how you keep your paper charts safe (e.g., locked in file cabinet, etc.).

**Telemental Health** (Virtual Sessions)

- Review all Kepro policies and acknowledge your review and acceptance.
- **Copy of Business Associate Agreement with Technology Provider -** Only required if using a Telehealth platform that is NOT Zoom.
- If you intend on using a platform other than Zoom for Telemental health sessions, you are required to submit you/your practice's copy of the Business Associate Agreement (BAA) you have with your technology provider. If you do not have a BAA, please consider using Zoom as you will not be credentialed.

**Copy of License**

- If there are multiple licenses and/or you are licensed in multiple states, please provide copies of all active licenses.

Visit our website for more information:
http://eap.kepro.com/

If you have any questions, do not hesitate to contact us at EAPCredentialing@kepro.com. Thank you and we look forward to working with you as part of our Kepro EAP Network.

Kepro's EAP Credentialing Team
**Kepro.com**
**Connect with Kepro**: LinkedIn | Facebook | Twitter

# Kepro Employee Assistance Program (EAP) Provider Application

Clinician's Name: _____

**Please indicate the Practice Setting:**

- ❑ Private Practice (Solo)
- ❑ Group (Single)
- ❑ Group (Multiple Providers)

Group/Practice Name: _____

**If provider(s) are part of a Group, please provide the name and email address of the Administrative/ Credentialing Point of Contact who can process the Kepro EAP Service Provider Agreement & W9 for signatures:**

Administrative/Credentialing Point of Contact:_____

Email:_____

## Data Protection Survey

| DATA ACCESS PROTECTION | | |
|---|---|---|
| **1.** | Do you have physical safeguards (i.e., locked rooms, locked file cabinets, alarms, etc.) in place to prevent inappropriate use or disclosure of personal/medical information across all applicable media? | ❑ Yes ❑ No |
| **2.** | Do you have administrative safeguards (i.e., restricted, limited, monitored access) in place to prevent inappropriate use or disclosure of personal/medical information across all applicable media? | ❑ Yes ❑ No |
| **3a.** | Do you backup all professionally relevant information and data across all applicable media demonstrating implementation of technology controls to satisfy HIPAA Security Rules? | ❑ Yes ❑ No |
| **3b.** | If so, identify which systems do you use to backup this information? | |

**DISCLOSURE**

Please answer the following questions relative to your professional history within the last five (5) years. For all "Yes" responses, please complete and follow the additional instructions: You are REQUIRED to provide:

(1) a detailed explanation of your involvement;
(2) the date the action was initiated;
(3) the current status, including any final outcome;
(4) amount of judgment/settlement or adverse decision; **AND**
(5) a copy of any court order, consent order and findings, and settlement agreement or other documentation regarding the current status or final resolution matter.

If a matter is pending, include a letter from your attorney providing detailed information regarding current status of the matter and any related documentation such as an indictment, statement of charges, summons, complaints, answers, etc.

| | | |
|---|---|---|
| **1.** | Do you currently have any charges or sanctions filed against you in a criminal, civil, or administrative proceeding; or do you have reason to believe that such charges or sanctions will be filed? If yes, please explain below. | ❑ Yes ❑ No |

| | | |
|---|---|---|
| **2.** | Have you ever been convicted of a misdemeanor related to your professional functions? | ❑ Yes ❑ No |
| **3.** | Do you have pending charges of a felony in any state? | ❑ Yes ❑ No |
| **4.** | Have you ever been investigated by any professional or licensure board, professional association, private payor, state or federal regulatory agency, or other authority? | ❑ Yes ❑ No |
| **5.** | Has your clinical license, certification, DEA, CDS, or ability to practice in any jurisdiction ever been stipulated, denied, restricted, suspended, reduced, revoked, not renewed, placed on probation, or otherwise limited in any way by a licensing agency or other regulatory bodies? | ❑ Yes ❑ No |
| **6.** | Have you ever voluntarily relinquished your professional license, certification, or other authority to practice for any reason, including as an alternative to disciplinary action? | ❑ Yes ❑ No |
| **7.** | Are you aware of any formal disciplinary or criminal charges pending against you? | ❑ Yes ❑ No |
| **8.** | Are there any current complaints against you filed with any licensing, certification, or other regulatory body? | ❑ Yes ❑ No |
| **9.** | Has it ever been determined that you have operated outside the recognized boundaries of your professional competencies? | ❑ Yes ❑ No |
| **10.** | Has your employment, hospital privileges, managed care organization or EAP participation, or other privileges or participation status ever been denied, restricted, suspended, reduced, revoked, not renewed, placed on probation, or otherwise limited in any way? | ❑ Yes ❑ No |
| **11.** | Have you ever been involuntarily terminated from professional employment or a hospital staff, or terminated by a managed care organization, EAP or any other organization that granted you privileges or participation status? | ❑ Yes ❑ No |
| **12.** | Have you ever resigned with knowledge of an investigation about you by a professional employer, hospital staff, managed care organization, EAP or any other organization that granted you privileges or participation status? | ❑ Yes ❑ No |
| **13.** | Are you aware of any disciplinary actions that have been initiated against you by a professional employer, hospital staff, managed care organization, EAP or any other organization that granted you privileges or participation status? | ❑ Yes ❑ No |
| **14.** | Are you aware of any complaints against you filed with a professional employer, hospital staff, managed care organization, EAP or any other organization that granted you privileges or participation status? | ❑ Yes ❑ No |
| **15.** | Has a professional liability carrier ever denied, limited, not renewed, or canceled your coverage? | ❑ Yes ❑ No |
| **16.** | Are you now or have you ever been sanctioned or excluded from federal, state, or local government programs? | ❑ Yes ❑ No |
| **17.** | Have any malpractice suits, professional liability suits, arbitration, or other proceedings ever been instituted against you? | ❑ Yes ❑ No |
| **ABILITY TO PERFORM ESSENTIAL FUNCTIONS** | | |
| **1.** | Are you unable to perform the essential functions of a provider in your area of practice? | ❑Yes ❑ No |
| **2.** | Do you require accommodations in order to perform the essential functions of a provider in your area of practice? | ❑ Yes ❑ No |
| **3.** | Have you ever entered a plea of guilty or nolo contendere where the offense involved the use or delivery of a controlled substance? If your conviction has been expunged, please answer "No." | ❑ Yes ❑ No |
| **4.** | Do you have any reason to believe that you would pose a risk to the safety or wellbeing of your patients? | ❑Yes ❑ No |

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| PLEASE USE THE SPACE BELOW TO EXPLAIN 'YES' ANSWERS TO ANY QUESTIONS IN ABOVE SECTIONS | | |
|---|---|---|
| **Question Number:** | **Explanation:** | **Document Attached?** |
| | | ❑ Yes ❑ No |
| | | ❑ Yes ❑ No |
| | | ❑ Yes ❑ No |

# EAP Provider Acknowledgement

I hereby give permission to Keystone Peer Review Organization, Inc. ("Kepro") and its employees, contracted entities, agents, and representatives or its authorized designee thereof (collectively, "Representatives") to obtain information about my professional education, training, licensing, competence, ethics, character, and other qualifications. I consent to the release of such information, whether in the form of transcripts, records, tapes, letters, photocopies/duplications of any of the forgoing, or verbal statements by hospital administrators, chiefs of clinical departments of hospitals in which I have served on staff, state licensing boards or regulatory bodies (by whatever name known in their respective jurisdictions), physicians, clinics or other individuals or organizations who or which possess information about me. Such information may be released to Kepro and its affiliates or Representatives.

I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, and the Federation of State Medical Boards to release to Kepro and/or its Representatives, information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for participation in, or with, Kepro.

I authorize my current and past professional liability carrier(s) to release the past five (5) years of my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Acknowledgement.

I hereby release from liability and agree to hold harmless any person or entity who or which provides the above-described information as authorized herein.

I hereby release from liability and agree to hold harmless Kepro and its affiliates and Representatives for their acts performed and statements made in connection with obtaining, reviewing, and evaluating my credentials and qualifications. I further acknowledge my cooperation by consenting to the production of such information about me as a provider of services to their insurers and enrollees. The determination of whether I am qualified to serve as a provider of services is the reason such information is needed for the review and evaluation by Kepro and its Representatives.

This application shall not be considered complete until Kepro completes a sanction query and primary source verification.

In the event I am accepted for participation by Kepro, I hereby consent to the inspection of my patient records by Kepro relating to covered members as necessary for its peer review, utilization review, quality management and quality improvement processes and agree to be bound by the Kepro Employee Assistance Program (EAP) Service Provider Agreement.

I acknowledge that all information provided in this application and disclosure is true, correct, and complete to the best of my knowledge and belief. I will notify Kepro within three (3) business days of any material changes to the application. I understand and agree that any material misstatement or omission in this application may constitute grounds for denial or revocation of participation. I acknowledge that I have read the foregoing EAP Provider Acknowledgement.

I further agree that a photocopy of this document will serve as a duplicate original. Facsimile signatures or signatures imprinted in an electronic medium, such as .pdf format, shall be deemed to be original signatures.

Clinician Name (Print)

Date

Signature

# Kepro EAP Provider
# Telemental Health Services Acknowledgment

I, _____ acknowledge the completion of and continued compliance to the following (Please check each of the boxes below):
*(First and Last Name)*

- ❑ Kepro Policy EAPTELE.001 – Telemental Health: Standard Operating Procedures
- ❑ Kepro Policy EAPTELE.002– Telemental Health: Licensure, Credentialing and Scope of Practice
- ❑ Kepro Policy EAPTELE.003 – Telemental Health: Telemental Health: Confidentiality and Informed Consent
- ❑ Kepro Policy EAPTELE.004 – Standard Operating Procedures– Standard Operating Procedures
- ❑ Kepro Telemental Health Office Setting and Service Delivery Guidelines (Included Below)
- ❑ I understand that any use of a Telemental Health platform may be subject to periodic audits by Kepro for compliance with contractual and regulatory requirements.

I further understand that ZOOM is the preferred Telemental Health platform for Kepro.

- ❑ I acknowledge that I will use the ZOOM platform for all Telemental Health EAP sessions, OR
- ❑ I elect to use _____to provide Telemental Health EAP sessions. I acknowledge this platform is fully compliant with all HIPAA requirements; AND
  - ❑ I have attached the Business Associate Agreement (BAA) I have with my technology provider.

**If you do not wish to participate in Telemental Health EAP sessions, indicate below.**

- ❑ I elect not to participate in Telemental Health EAP sessions for clients participating in Kepro's EAP program.

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_____ _____

Clinician Name (Print) Date

_____

Signature

**Please submit the requested documents via email to EAPCredentialing@kepro.com.**

# Telemental Health Sessions: Physical Environment Expectations

Telemental Health sessions should mirror those of in-person sessions; both locations (clinician and client) are treatment rooms and should provide the same professional specifications as those of a standard in-person clinical service room. Clinicians should make every attempt to adhere to the following expectations:

- **Privacy**: The clinician should make every effort to ensure privacy so that the clinical discussion cannot be heard outside of the rooms where the services are being provided. If there are other people present, either in or in or near the service room), both will be made aware of these individuals and agree to their presence.
- **Noise Level**: Both the clinicians and clients rooms should be free of noises that could distract from the clinical sessions. This includes but is not limited to door bells, televisions, radios, children, animals, and other conversations.

- **Physical Environment**: The physical environment of the room (i.e. seating, lighting, and ambiance) should allow for the maximum comfort of the clinician and client. To maximize clarity and visibility, the provider and client's cameras should be placed at the same elevation as the eyes.

- **Visual Distractions**: The clinician's background should be free of visual clutter. KEPRO recommends a neutral colored wall to minimize distractions.

- **Clothing**: Clinicians are expected to dress professionally for their telemental health sessions. Clothing that could be distracting from the clients sessions should not be worn.

- **Eye Contact**: Maintaining good eye contact during telemental health sessions is imperative. Clinicians should avoid doing other work, looking at other computer screens or engaging in any activity that prevents them from maintaining good eye contact with the client.