Current Date:_____

NEW LIFE COUNSELOR NETWORK APPLICATION

This application is for professional network membership and verification of provider credentials. Legibly complete all information or mark NA if not applicable. If additional space is needed, use reverse side of each page, numbering your responses to correspond with applicable questions. You may also attach additional sheets as necessary.

**Attach current licensure(s), certification(s), registration(s), malpractice policy, and resume.*

PROVIDER INFORMATION

Last Name:_____First Name:_____MI:_____

Any Other Names Used:_____

Home Address:_____Personal Cell Phone #_____

City:_____State:_____Zip:_____County:_____

Sex: Male ☐ Female ☐ Preferred Email Address:_____

Social Security #:_____Date of Birth:_____Country of Birth:_____

Provider Tax ID #:_____ Years in Practice:_____Marital Status:_____

Languages Spoken Fluently:_____

Race and/or Ethnic Background (optional):_____

How long have you been a Christian?_____Denomination:_____

Practice Name:_____

Primary Office Address:_____

City:_____State:_____Zip:_____County:_____

Office Phone #:_____Fees for Services:_____

What phone number should clients use to contact you?_____

Major Cross Streets:_____Is location handicapped accessible? Yes ☐ No ☐

Website address_____

Other locations where you will be rendering services (if more than 2, attach separate sheet of paper).

Practice Name:_____

Office Address:_____Office Phone #:_____

City:_____State:_____Zip:_____County:_____

Major Cross Streets:_____Is location handicapped accessible? Yes ☐ No ☐

PROFESSIONAL PRACTICE INFORMATION

Saturday appointments	☐ Yes	☐ No	Evening appointments	☐ Yes	☐ No
SCOPE OF PRACTICE					
Abortion	☐ Yes	☐ No	Family: Dysfunctional Families	☐ Yes	☐ No
Abuse: Child	☐ Yes	☐ No	Family: Marital Issues	☐ Yes	☐ No
Abuse: Domestic	☐ Yes	☐ No	Family: Parenting	☐ Yes	☐ No
Abuse: Emotional	☐ Yes	☐ No	Family: Premarital	☐ Yes	☐ No
Abuse: Physical	☐ Yes	☐ No	Financial Management	☐ Yes	☐ No
Abuse: Sexual	☐ Yes	☐ No	Grief/Loss Issues	☐ Yes	☐ No
ACOA	☐ Yes	☐ No	Guilt	☐ Yes	☐ No
Acute Illness	☐ Yes	☐ No	Health Related Issues	☐ Yes	☐ No
ADD/ADHD	☐ Yes	☐ No	Learning Disorders	☐ Yes	☐ No
Addictions: Alcohol	☐ Yes	☐ No	Loneliness	☐ Yes	☐ No
Addictions: Anorexia	☐ Yes	☐ No	Medication management/detox	☐ Yes	☐ No
Addictions: Bulimia	☐ Yes	☐ No	Men's issues	☐ Yes	☐ No
Addictions: Chemical Dependency	☐ Yes	☐ No	Multiple Personality	☐ Yes	☐ No
Addictions: Gambling	☐ Yes	☐ No	Occult Abuse	☐ Yes	☐ No
Addictions: Other	☐ Yes	☐ No	OCD	☐ Yes	☐ No
Addictions: Overeating	☐ Yes	☐ No	Pain Management	☐ Yes	☐ No
Addictions: Sex	☐ Yes	☐ No	Pastoral/Church Relations	☐ Yes	☐ No
Age Group: Adults	☐ Yes	☐ No	Personal Relationships	☐ Yes	☐ No
Age Group: Children 6 and under	☐ Yes	☐ No	Personality Disorders	☐ Yes	☐ No
Age Group: Children 7 and older	☐ Yes	☐ No	Phobias	☐ Yes	☐ No
Age Group: Geriatric	☐ Yes	☐ No	Psychosomatic Illness	☐ Yes	☐ No
Age Group: Teens	☐ Yes	☐ No	Psychotic	☐ Yes	☐ No
Amnesia/Dementia/Alzheimer's	☐ Yes	☐ No	PTSD	☐ Yes	☐ No
Anger/Hostility	☐ Yes	☐ No	Self Esteem	☐ Yes	☐ No
Anxiety Disorder	☐ Yes	☐ No	Self-Mutilation	☐ Yes	☐ No
Asperger's/Autism	☐ Yes	☐ No	Services: ADD Testing	☐ Yes	☐ No
Bipolar/Manic Depressive Disorder	☐ Yes	☐ No	Services: Art/Play Therapy	☐ Yes	☐ No
Boundaries	☐ Yes	☐ No	Services: EMDR	☐ Yes	☐ No
Burnout	☐ Yes	☐ No	Services: Group Therapy	☐ Yes	☐ No
Career	☐ Yes	☐ No	Services: Psychological Testing	☐ Yes	☐ No
Childhood Fear	☐ Yes	☐ No	Severely Emotional	☐ Yes	☐ No
Chronic Illness	☐ Yes	☐ No	Sex Offenders	☐ Yes	☐ No
Codependency	☐ Yes	☐ No	Sexuality: Dysfunction	☐ Yes	☐ No
Conduct Disorders	☐ Yes	☐ No	Sexuality: Homosexuality (Men)	☐ Yes	☐ No
Cultural Diversity	☐ Yes	☐ No	Sexuality: Homosexuality (Women)	☐ Yes	☐ No
Delusional Disorders	☐ Yes	☐ No	Sexuality: Infertility	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Sleep Disorders	☐ Yes	☐ No
Dissociative Disorders	☐ Yes	☐ No	Spiritual Concerns	☐ Yes	☐ No
EMDR	☐ Yes	☐ No	Stress Management	☐ Yes	☐ No
Families	☐ Yes	☐ No	Stroke/Head Trauma	☐ Yes	☐ No
Family: Blended Families	☐ Yes	☐ No	Suicidal Ideation	☐ Yes	☐ No
Family: Dating	☐ Yes	☐ No	Victimization	☐ Yes	☐ No
Family: Divorce/Separation	☐ Yes	☐ No	Women's Issues	☐ Yes	☐ No
Do you use "How We Love" materials by Milan and Kay Yerkovich?				☐ Yes	☐ No

PROFESSIONAL EDUCATION

**List most recent first, attach copies of diplomas/certificates, include additional sheet, if necessary.*

Institution:_____

Dates:_____ Major:_____ Degree:_____

Institution:_____

Dates:_____ Major:_____ Degree:_____

Institution:_____

Dates:_____ Major:_____ Degree:_____

Institution:_____

Dates:_____ Major:_____ Degree:_____

Any specialized clinical training:_____

_____

_____

How many CEU'S are required in your state for your license?_____

Are your continuing education requirements for licensure/certification/registration current?
☐ Yes ☐ No

Describe your continuing education for the last two years: _____

_____

_____

_____

PROFESSIONAL CREDENTIALS/STATUS

**Attach copies of all active and inactive licenses/certifications/registrations from the last 5 years.*

License Type and # (do not use initials)_____

Date Issued:_____

Exp. Date:_____

State:_____

License Type and # (do not use initials)_____

Date Issued:_____

Exp. Date:_____

State:_____

PROFESSIONAL MEMBERSHIPS

**List local, state, and national professional associations and dates.*

_____

_____

_____

Publications, teaching experience, research, conferences and workshops presented:

_____

_____

_____

_____

Do you use Group therapy as part of your practice? ☐ Yes ☐ No

Do you offer Phone Counseling as part of your practice? ☐ Yes ☐ No

Do you offer Internet Counseling (SKYPE) as part of your practice? ☐ Yes ☐ No

How do you integrate biblical principles in your practice? _____

_____

_____

Please describe your practice in 2 sentences: _____

_____

_____

PROFESSIONAL LIABILITY

**The New Life Counselor Network requires each member to maintain a current policy with minimum coverage of $1 million per occurrence/$1 million aggregate. Please provide the information on your current carrier and attach copy of your current policy or certificate of insurance [COI] that names you as a covered insured. (The certificate must list your name.)*

Carrier:_____ Effective Date:_____ Exp. Date:_____

Address:_____ Phone #:_____

Policy #:_____ Coverage Per Incident:_____ Per Aggregate:_____

Name of Policy Holder:_____

Previous Professional Liability Carriers:_____

Have you ever had a malpractice claim filed against you?	☐ Yes	☐ No
Have you ever been denied professional liability insurance?	☐ Yes	☐ No
Has your liability insurance ever been suspended or revoked?	☐ Yes	☐ No
Has liability insurance renewal been refused or have premiums been surcharged because of claims?	☐ Yes	☐ No
Have you or your carrier ever settled malpractice allegations involving your work prior to the filing of a claim or lawsuit?	☐ Yes	☐ No
Do you know of any complaints currently pending against you that may give rise to a future malpractice insurance claim	☐ Yes	☐ No

If yes to any of the above malpractice questions, please attach the following details:

- ✓ Date and details of the incident(s) leading to the complaint, claim or settlement, including your role
- ✓ Professional liability insurer involved
- ✓ Your status in any suit or legal action (primary defendant, co-defendant, other)
- ✓ Subsequent events, including patient outcome, resolution, and amount paid as an out-of-court award
- ✓ Current status of complaint, suit or other legal action

PROFESSIONAL WORK EXPERIENCE/EMPLOYMENT HISTORY

**Include all full-time, part-time and private practice employment for the last 5 years. Please identify periods of unemployment lasting more than three months. Begin with the most recent and current employment; attach a separate sheet, if necessary:*

Dates (From/To):__________________________Employer/Practice:____

Title/Type:________________________________Salary:_____________________Supervisor:________________________

Address:_________________________________City:_______________________State:__________Zip:________________

Phone #:_________________________________Reason for Leaving:____

Responsibilities:____

Dates (From/To):__________________________Employer/Practice:____

Title/Type:________________________________Salary:_____________________Supervisor:________________________

Address:_________________________________City:_______________________State:__________Zip:________________

Phone #:_________________________________Reason for Leaving:____

Responsibilities:____

Dates (From/To):__________________________Employer/Practice:____

Title/Type:________________________________Salary:_____________________Supervisor:________________________

Address:_________________________________City:_______________________State:__________Zip:________________

Phone #:_________________________________Reason for Leaving:____

Responsibilities:____

PHYSICAL AND MENTAL HEALTH

**Indicate current status and disabilities*

Are you ***unable*** to perform any procedures within the scope of privileges and duties as a mental health provider, with or without reasonable accommodations required by the Americans with Disabilities Act, within accepted standards of professional performance, and without posing a direct threat to patients?

☐ Yes ☐ No

If yes, explain:

PROFESSIONAL REFERENCES

**List the names, titles, addresses, and telephone numbers of 3 references with recent experience in observing and working with you:*

Name:

Title:

Email Address:

Phone #:

Name:

Title:

Email Address:

Phone #:

Name:

Title:

Email Address:

Phone #:

PROFESSIONAL QUESTIONS

**Each question must be answered. For each YES response, you must provide a detailed explanation attached to this application.*

1. Has your license, certification, or registration to practice in any jurisdiction, whether completed or still pending, been denied, restricted, limited, suspended, revoked, not renewed; or have you ever been placed under probation, subjected to disciplinary action, or otherwise sanctioned, limited or curtailed; or have you voluntarily relinquished any item in anticipation of any of these actions?	☐ Yes	☐ No
2. Has there ever been any investigation relating to your license, certification, or registration?	☐ Yes	☐ No
3. Has your federal and/or state DEA Registration Certificate ever been denied, suspended, canceled, or not renewed, or subjected to any disciplinary action?	☐ Yes	☐ No
4. Has your status, as a provider, ever been denied, suspended, canceled, sanctioned, or has any disciplinary action ever been taken against you, or are you currently under investigation by any municipal, state, federal, or any other governmental agency, as well as, DHMO, PPO, or other pre-paid health plan (e.g., Medicare, Medicaid)?	☐ Yes	☐ No
5. Are your privileges or memberships at any hospital, institution (including military service), and/or HMO currently under investigation, or have they ever been denied, suspended, reduced, or not renewed; or have any other disciplinary proceedings ever been instituted against you?	☐ Yes	☐ No
6. Have you ever been denied membership, or renewal thereof, or been subjected to disciplinary proceedings for a medical or ethical reason by any professional organization?	☐ Yes	☐ No
7. Do you currently, or did you in the last two years, engage in the unlawful use of drugs, including the improper use of prescription drugs?	☐ Yes	☐ No
8. Do you have any felony or misdemeanor charges pending against you, other than a traffic violation, or have you ever been convicted of, or pleaded “nolo contendere” to, a felony?	☐ Yes	☐ No

PROVIDER CONFIRMATION OF REQUIRED ATTACHMENTS

I have attached:

- ☐ License(s)/certification(s)/registration(s)
- ☐ Curriculum Vitae or Resume
- ☐ Liability Insurance
- ☐ Diplomas/Certificates (highest education)
- ☐ Additional Sheets (as needed to provide further detail as requested in each section, numbered above)
- ☐ Informed Consent/Scope of Practice (as required by your state)

STATEMENT OF THE APPLICANT AND NEW LIFE COUNSELOR NETWORK AGREEMENT

I certify that information in this application is correct and complete. I fully understand and agree that any misstatement in, or omission from, this application constitutes cause for denial or termination of New Life Counselor Network (hereinafter referred to as NLCN) membership. All information submitted by me, in this application, is true to the best of my knowledge and belief. I hereby agree to notify the NLCN of any changes in the above information, including providing a copy of all new, or renewed, licenses, certifications, registrations, and/or malpractice insurance.

I have thoroughly read New Life Ministries' Program Description. As long as I am a member of the NLCN, I agree to the practices as set forth in the program description as they apply to my practice when providing counseling to NLCN clients. To the extent that any of this conflicts with the law, in the state(s) in which I am licensed, I understand that state law and professional ethics will govern. I understand and agree that the NLCN will use these documents and the verifications of credentials as the primary foundations for evaluating my qualifications to enter, and maintain, a good standing with this association.

I hereby authorize New Life Ministries and the NLCN, its representatives, and CompHealth (Credentialing Verification Organization), to contact administrators and members of staffs or other facilities or institutions with which I have been associated, and with any person, organization or others, including malpractice liability insurance carriers and state licensing boards, who may have information bearing on my professional competence, character and ethical qualifications. I hereby further consent to the inspection, by the NLCN and its representatives, of documents, including records at hospitals and other facilities, which may be material to an evaluation of my professional qualifications and competence to become or continue as a member of the NLCN and/or to carry out the clinical services I have listed in this application. I hereby authorize my malpractice carriers, other institutions, or parties, to forward and release malpractice information or history, to New Life Ministries and NLCN, its representatives, and CompHealth.

I understand and agree that I, as an applicant for NLCN membership, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications.

I hereby release from liability all representatives of New Life Ministries, NLCN; including, without limitation, its officers, directors, agents, and employees, for all their acts performed in good faith and without malicious intent in connection with evaluating my application, my credentials and qualifications. I also hereby release from liability any and all individuals and organizations who provide information to the New Life Ministries and the NLCN or its representative in good faith and without malicious intent concerning my professional competence, ethics, character and other qualifications for NLCN membership and hereby consent to the release of such information.

I agree to defend, hold harmless and indemnify New Life Ministries and its agents, employees, officers and directors from and against any and all claims, liabilities, judgments, damages, costs and expenses, including the costs of defending any litigation either threatened or existing as a result of any alleged act of negligence, professional malpractice, unlawful billing and collection, any tortuous act or omission on my part. I agree to indemnify New Life Ministries against any misinformation given by insurance companies, clients, or myself.

I have not requested membership for any procedures for which I am not appropriately licensed, certified, or registered, and have demonstrated competence and expertise. Further, I realize that certification by a board does not necessarily qualify me to perform certain procedures. However, I believe that I am qualified to perform all procedures for which I have requested NLCN membership.

I am committed to honoring God by providing the highest quality of Christian care, with professional and ethical integrity in all my counseling and related ministry work, while striving to avoid negative situations that would embarrass the cause of Christ and reflect poorly on New Life Ministries and the NLCN. If a dispute should arise between me and the New Life Counselor Network, I agree to use a dispute resolution process that: (1) First, attempt direct communication and negotiation, then (2) Mediation with someone acceptable to both parties, then (3) Arbitration or (4) Binding arbitration with someone acceptable to both parties. Litigation, if even justified for any reason (1 Corinthians 6:1-8) will only be used as a last resort, only after a good faith effort at each of the four steps previously noted has failed.

SIGNATURE OF APPLICANT_____ **DATE**_____

PRINTED NAME OF APPLICANT_____

MEMBERSHIP APPLICATION AND CHECKLIST

The New Life Counselor Network is committed to selecting and retaining only qualified Christian professionals to participate as members of the New Life Counselor Network association. To ensure quality care and network integrity, the New Life Counselor Network requires all membership applicants to complete the credentials verification process, which follows NCQA guidelines for credentialing of behavioral health care professionals.

The New Life Counselor Network is contracted with an accredited Credentials Verification Organization, CompHealth, for the credentials verification process. After your application has been returned and submitted for verification, CompHealth may contact you, directly, if they should have any questions regarding information on your application.

Please review the following checklist of required documentation and follow each step for completing the membership application process:

- ☐ Membership Application (complete, signed, and dated).
- ☐ $175 Non-Refundable Application Fee made payable to New Life Ministries. Pay by check or money order; list applicant's name in the check's memo section.
- ☐ Current Resume or Curriculum Vitae *(explaining any gaps greater than 3 months).*
- ☐ Copy of diploma for highest degree of education.
- ☐ Copy of current state license(s), certification(s), and/or registration(s).
- ☐ Copy of current Board Certifications (if applicable).
- ☐ Letter of reference from a pastor (on church letterhead, from a pastor who is familiar enough with your practice or character to confirm that you counsel from a Christian perspective).
- ☐ Copy of current Malpractice Insurance Policy or Certificate of Insurance (showing you as a named insured and listing limits, policy number, and expiration date. This coverage must apply to your professional services rendered in your practice, where clients will be referred, as well as, to any professional services you may render at any New Life Ministries sponsored event. NOTE: The New Life Counselor Network requires that members maintain liability coverage of a *minimum* of $1 million per occurrence and $1 million aggregate).
- ☐ Explanation and copy of court document or statement from attorney for each formal complaint, action, suit, or proceeding made against you (if applicable).

The completed application, application fee, and related documents should be returned to:

New Life Counseling Network
New Life Ministries
PO Box 852347
Richardson, TX 75085-2347

We encourage you to keep copies of all information submitted for membership consideration. If you have any questions about the application process or New Life Counselor Network membership, please feel free to contact Becky Brown, Director of New Life Counselor Network at (949) 494-8383 x8144, or by email at beckyb@newlife.com.