Network Clinician Application Form
CCGNJ Treatment Services for Gambling Disorder Grant Program

Dear Clinician Applicant:

Please complete this form for CCGNJ to assess your request for consideration for participation in its Gambling Disorder Treatment Provider Network.

If you are self-employed you are likely the **Billing Provider (Payee)** as well as the **Treating Clinician**. Should you work for another person or a group you may be an **Employed Clinician** but not the **Billing Provider** (Payee). Please record your data accordingly below.

I. Billing Provider Information:

Billing Provider (Payee) Name: _____ **EIN:** _____

Billing Provider (Payee) Address: _____

_____

_____

Billing Provider (Payee) Phone #: _____

Billing Provider (Payee) Fax #: _____

Billing Provider (Payee) Email: _____

II. Clinician Information:

Clinician Information (below): (If same as above, record "Same" in all applicable lines below). Otherwise complete a form for **each individual clinician employed/subcontracted** under the Billing Provider's EIN (Payee).

Clinician Name: _____

Employer (list "self" or employer name here→): _____

Address: _____ Ph #:_____

_____ Fax: _____

_____ Email: _____

Days and hours agency (or private practitioner) is open and able to assess and/or treat Gambling Grant clients:

Licenses/Certifications you hold and in which (States): (LCSW, LPC, LMFT, LCADC, LAC, Psychologist, ICGC I or ICGC II, CADC, etc.) 1._____ ( ) 2._____ ( ) 3. _____ ( )

4. _____ ( ) 5. _____ ( )

Within 30 days of the initial application each clinician must submit the required documents to CCGNJ (see enclosed Checklist) to be considered for the Network.

III. In what areas do you specialize? – Circle all that apply:

General MH Problems - Substance Use Disorders – Gambling – Couples – Children – Geriatrics

Other: _____ _____ _____ _____

IV. Please provide complete and verifiable responses to the questions below. **Circle No or Yes as applicable.**

Have you:

1. Treated clients for at least 1-2 years? No Yes
2. Do you have any past sanctions or pending actions against your license? No Yes
   If Yes, explain:
   _____
   _____
   _____

3. Ever been denied clinical privileges at any healthcare facility? No Yes
   If Yes, explain:
   _____
   _____
   _____
   _____
   _____
   _____

4. Have you ever been excluded from a payment program like Medicare or Medicaid? No Yes
   If Yes, explain:
   _____
   _____
   _____

5. Have you ever been involved (or are you currently involved) in any malpractice action against you?
   No Yes
   If Yes, explain:
   _____
   _____
   _____

I, (print your name) _____, attest that the information I have provided to the questions above are, to my knowledge, fully truthful. I understand that I am required to notify the funding source, CCGNJ, immediately in the event any action is taken on my professional license/certification. Action of this nature may be grounds for termination from the Network.

If I am not already an International Certified Gambling Counselor (ICGC-I or II), I understand that I must earn this credential within two (2) years of Network acceptance. I understand that I am required to periodically provide updates to the Council about my status, continued intentions in pursuing this credential and that I will be terminated from the Network should I not earn this credential within two (2) years of Network acceptance.

Clinician/Agency Signature: _____ Date: _____