Innovative
Health Foundation

Instructions for Completing Provider Application

Thank you for your interest in joining our network of treatment providers for children with developmental disabilities. The Innovative Health Foundation (IHF) provides clinical scholarships to fund direct services for children with special needs such as assessments, medical treatment, education and therapeutic services.

The application is for an individual, not an organization or group.

- If there are a number of professionals providing services within your practice, please have each fill out a separate application.
- If an individual works out of multiple locations, only one application for that person is necessary.

1. Complete this application in its entirety.
2. There is no fee associated with this application.
3. Enclose copies of the following documents for you and your clinical staff:
    a. Insurance Fact Sheet
    b. Current License/Certification
    c. Degree
    d. Resume
4. Submit all documents via email or U.S. Postal mail:
    a. Mail to: 5050 Research Court, Suite 800, Suwanee, GA 30024
    b. Email to: Info@InnovativeHealthFoundation.org
5. You will be notified of your participation in the provider network within one month.
6. You may submit your application along with the completed scholarship application from your client.
7. This is a one-time application. Once you are approved as a provider, any of your clients/patients with financial need, whose required services come under the IHF scholarship guidelines, may apply during an IHF grant cycle. The application is available for download at http://innovativehealthfoundation.org/apply_for_support.

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www.InnovativeHealthFoundation.org | Info@InnovativeHealthFoundation.org

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Provider Application Form

Provider Name _____ Date _____

Practice Name _____

Practice Address _____

City _____ State _____ Zip _____ County _____

Telephone_____ FAX Number _____

License No _____ E-Mail_____

Professional Discipline _____

License/Certifications Held (attach sheet if necessary) _____

Professional Organizations and Member status _____

Type of Practice _____Years in Practice_____

Please Provide (3) Professional References (attach separately). Include Name, Relationship, Address and Telephone

Are you enrolled in any insurance networks? If so, list majors:

_____

MALPRACTICE PROFESSIONAL LIABILITY INSURANCE COVERAGE

Name of Carrier _____

Coverage Limits per Incident _____Aggregate _____

Have you ever had a malpractice claim brought against you? _____
If yes, please attach documentation of final resolution.

Has your professional license ever been limited, revoked or suspended? _____
If yes, please give dates, reasons and attach documentation of final resolution.

Have you ever been disciplined by any professional association, organization, or professional society? _____
If yes, please attach documentation of final resolution.

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PROFESSIONAL CLINICAL CONCENTRATION

Method of Treatment _____

☐ Individual Therapy ☐ Family Therapy ☐ Group Therapy

Services Provided

Please number up to 6 areas in which you have proficiency. (No.1 being most proficient - No. 6 being least proficient.)

( ) Psychological Testing/Treatment
( ) Nutrition/Nutritional Therapy
( ) Developmental Disorders
( ) Occupational Therapy
( ) Speech and Language Therapy
( ) Neurofeedback Assessment/Treatment
( ) Children/Adolescents Age range _____
( ) Behavioral Assessments/Therapy
( ) Vision Therapy
( ) Psychiatry
( ) Physical Therapy
( ) Other (Specify) _____

_____

Days and hours you are willing to see clients? _____

Do you speak a foreign language? _____If yes, Please specify: _____

Can you use sign language? ☐ Yes ☐ No Is your office handicap accessible? ☐ Yes ☐ No

Please describe your office setting:

_____

_____

_____

I authorize Innovative Health Foundation to verify any and all information provided in this application for the purpose of determining my professional competence, character, ethical qualifications and consideration for acceptance.

I also authorize any person or organization named in this application to release relevant information to Innovative Health Foundation for the purposes stated above.

I hereby certify that the information contained in the foregoing application is true and complete to the best of my knowledge and belief.

Applicant Signature _____Date_____

Print Name: _____

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