



The Lexington Group, Inc.

PO Box 2014

Burlington, CT06013

AFFILIATE APPLICATION

Name: _____

Company: _____

Street: _____

City, State: _____ Zip Code: _____

Telephone: () _____ Fax: () _____

Email: _____

Languages Spoken: _____

Degree: _____ License Type: _____ License Number: _____

Years in practice? _____

-Please attach: Professional Liability Insurance Policy (Declaration Page)

Resume

License

Participating provider for the following insurance health care plans:

- | | |
|---|---|
| <input type="checkbox"/> Cigna | <input type="checkbox"/> United Health Care |
| <input type="checkbox"/> United Behavioral Health | <input type="checkbox"/> BC/BS |
| <input type="checkbox"/> Aetna | <input type="checkbox"/> Oxford |
| <input type="checkbox"/> Healthnet | <input type="checkbox"/> ConnectiCare |
| <input type="checkbox"/> Managed Health Network | <input type="checkbox"/> Value Options |
| <input type="checkbox"/> Alliance | <input type="checkbox"/> Other: |



The Lexington Group, Inc.

AFFILIATE AGREEMENT

THIS AGREEMENT, made and entered into this ____ day of _____, _____, by and between _____ (hereinafter referred to as “Affiliate”) and The Lexington Group, Inc. (hereinafter referred to as “Lexington”).

WITNESSETH:

WHEREAS, Affiliate is a provider of behavioral health services.

WHEREAS, Lexington is a Employee Assistance Program vendor.

NOW THEREFORE, Affiliate and Lexington are desirous of establishing an affiliate provider relationship, as follows:

1. Affiliate agrees to give prompt and scheduling priority to Employee Assistance clients and professional service to all individuals referred to Affiliate by Lexington. Routine appointments will be seen within 48 hours unless client desires otherwise.
2. Affiliate is responsible for assuring the professional credentials of all clinical personnel servicing needs of clients referred by Lexington.
3. Affiliate agrees that all clinical personnel servicing the needs of clients referred by Lexington will have an appropriate professional degree in a clinically relevant discipline, will be licensed or certified in that discipline by a State or National professional organization, and will have at least one million dollars of professional liability insurance in force during the life of this Agreement.
4. Affiliate further agrees that all clinical personnel servicing the needs of clients referred by Lexington will not be students or individuals being trained by Affiliate.
5. Affiliate agrees to accept the fee of \$_____ (US) per session as payment in full for Lexington referrals and agrees not to bill any additional amounts to the client or their representatives for any reason while acting as a Lexington affiliate.
6. Affiliate agrees that approval for additional sessions must be obtained prior to initiation of sessions.
7. Affiliate agrees to comply with all accepted rules and norms of clinical practice, including but not limited to, the maintenance of client confidentiality under Federal Regulation 42 CFR, Part 2, and HIPAA Protected Health Information in accordance with 45 CFR 164.

8. Affiliate agrees not to contact the employer of the client for any reason without prior approval from The Lexington Group, Inc.
9. Affiliate agrees that in all cases where subsequent referrals for services are deemed necessary, such referrals will be made only to licensed practitioners, accredited community resources or other accredited treatment facilities and that client financial capability and insurance will be considered in the selection of these services.
10. Affiliate agrees that it will not solicit, bid or contract for employee assistance program services with any entity that has contracted with Lexington.
11. This agreement shall not be construed as establishing a condition of employment or agent relationship between Lexington and Affiliate, and Lexington holds Affiliate harmless in all matters arising as a result of the acts or omissions of Lexington, and Affiliate holds Lexington harmless in all matters arising as a result of Affiliate's acts or omissions.
12. This agreement may be terminated by either party, with thirty (30) days written notice of such termination, and such termination, regardless of cause, shall be construed as having been done without prejudice.
13. Lexington agrees to pay only for services rendered and not for missed appointments on the part of the client or telephone contact time with the client or Lexington staff.
14. The relationship between Lexington and Affiliate shall be governed and controlled solely by and exclusively by the provisions of this agreement and that no other provisions, verbal or written, shall be empowered unless formally set down in an addendum to this agreement.

Dated at _____, _____, this _____ day of _____, _____.

AFFILIATE

THE LEXINGTON GROUP, INC.

PO Box 2014
Burlington, CT 06013

(affiliate signature)

James Vincent
Vice President of Clinical Services

(typed or printed name)

(Address/City/State)



The Lexington Group, Inc.

PO Box 2014

Burlington, CT06013

REFERRAL PROCESS

1. The individual client establishes contact with The Lexington Group, Inc. via our 800 number, and our counselor makes a clinical assessment as to which affiliate would best meet the identified needs.
2. Our office will give you a “heads up” call indicating that The Lexington Group is making a referral. The client will be given your name and number to make contact with you.
3. In the event that the referral is a crisis, it is expected that the client will be seen immediately. Clinical and/or medical crises are to be managed according to the appropriate clinical, ethical and legal standards, laws and norms. Routine appointments will be seen within 48 hours unless client desires otherwise. Appointments should not be made beyond four days unless requested by the client.
4. Three sessions will initially be authorized to assess the problem, and initiate appropriate intervention. For Assessment and Referral models cases requiring more than 3 sessions are referred to a provider covered by the client’s insurance plan. For Short Term Counseling (STC) models, **clinician should call and request additional EAP sessions based on clinical presentation, or if longer term care is needed, assist in a referral to an appropriate provider.**
5. All clinicians must contact the Lexington Group, at 1-800-571-0197, before making any contact with client’s employer.
6. A complete clinician chart should be prepared and maintained for each client with entries made for each contact. Include a signed release of information. The Lexington Group reserves the right to conduct clinical and administrative audits of affiliate records. You will be notified well in advance of these audits.
7. **The Referral Authorization and a Client Satisfaction Survey will be sent to you. Please give the Survey to the client so it can be filled out and return client satisfaction survey with invoice.**
8. The Lexington Group is always available to help facilitate referrals or answer questions by calling the business office at 1-800-571-0197.