WISCONSIN COUNCIL ON PROBLEM GAMBLING, INC.
INFORMATION AND REFERRAL SERVICE (HELPLINE)
INDIVIDUAL PROVIDER APPLICATION

Name: ____
Agency Name (If Applicable): ____
Office Address: ____
City: ________________________________ State: ________________ Zip: ________________
Telephone: ________________________________ Fax: __________________________________
E-mail Address: ________________________________ May we contact you by e-mail? __________

Professional Memberships: (please list)
____
____

License/Certification Number: ____________________________Expiration Date: ____________________

Additional licenses/certifications (if any): ____

Number of years in professional practice: _________Please indicate your experience (if any) with evaluating or treating compulsive gambling:
____
____
____

Educational background: ____

Degree held: ____

Fluent in any foreign language (please list): ____

List professional training you have received related to pathological gambling include dates, number of hours, and providers: (documentation required)
____
____
____
____
____
____
____
____

List counties that are accessible to your office____

Please include **legible** copies of documents to support your application:

- College or University degree
- Current state license
- Current state certification
- Current business Card
- Inpatient or Outpatient Facility
- **Proof and number of hours of gambling specific training**

WISCONSIN COUNCIL ON PROBLEM GAMBLING, INC.
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IN-PATIENT OR OUT-PATIENT FACILITY APPLICATION

Facility Name: ____

Address: ____

Phone Number ______________________________ Fax Number ______________________________

________ JCAHO APPROVED FACILITY ________ CARF APPROVED FACILITY

________ MENTAL HEALTH CERTIFICATION ________ AODA CERTIFICATION

Names of trained gambling treatment providers on your staff:

Name:____

Name:____

Name:____

***Please have **each** treatment provider complete an INDIVIDUAL PROVIDER APPLICATION. (See attached)

Do you accept Medical Assistance? ____

Types of Insurance Accepted:

____

____

____

Do you offer Sliding Scale Fee's or Payment Plans? (Please Specify)

____

____

What type of treatment programs do you offer?

Day Programs ____ Individual ____ Family ____ Group ____ Adolescent ____ In patient ____

Other (Please Specify): ____

____

Please write a brief description of your gambling treatment program:

____

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INCLUDE COPIES OF THE FOLLOWING SUPPORT DOCUMENTS:

- Hospital accreditations
- Program certifications
- Current state licenses
- Completed individual provider applications with supportive documentation of their gambling training