

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 from WCPG's Phase 1 & 2 and any other gambling specific training**

**WISCONSIN COUNCIL ON PROBLEM GAMBLING, INC.**  
**INFORMATION AND REFERRAL SERVICE (HELPLINE)**  
**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:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**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