Michigan Health & Wellness 4 x 4 Plan

Worksite Wellness Provider Application

The purpose of this application is to compile a list of worksite wellness providers that organizations can refer to when looking for outside assistance for their employee wellness programs.

Only worksite wellness providers who are able to document that they have delivered services to multiple worksites over the past two years using their own staff the majority of the time will appear on the provider list.

The worksite wellness provider list is only a resource. **Appearing on the provider list does not constitute endorsement or recommendation by the Michigan Department of Community Health (MDCH)**. Worksites will be encouraged to evaluate and chose the provider best suited for their wellness needs.

Email the completed application to Christi Demitz at demitzc@michigan.gov or fax to 517.335.9056.

Provider Name: _____

Street Address: _____

_____

City/State/Zip: _____

Provider Website: _____

Your Name & Title: _____

Your Phone: _____ Your Email: _____

Which best describes your service area? ☐ Local ☐ Statewide ☐ National ☐ International

1. In 100 words or less describe your organization's philosophy and approach when providing worksite wellness services.

2. Which of the following best describes the wellness services you provide to worksites? Choose all that apply.

- ☐ Clinical Screenings/Services *(biometric measures such as blood pressure, weight, etc.)*
- ☐ Health Assessments *(self-reported health status)*
- ☐ Health Coaching
- ☐ Health Education Resources
- ☐ Wellness Classes *(nutrition, exercise, smoking cessation, etc.)*
- ☐ Employee Assistance Program
- ☐ Nutrition Counseling
- ☐ Cultural/Environmental Audits *(organizational support of health)*
- ☐ Fitness/Exercise Counseling
- ☐ Other _____

3. How are your worksite wellness services provided? Choose all that apply.

☐ Onsite ☐ Telephonic ☐ Online ☐ Software/Applications

4. What percentage of wellness services are provided by your staff and what percentage is provided by outside contractors? Total must equal 100%.

Percentage of wellness services provided by your staff: _____

Percentage of wellness services you provide through outside contractors: _____

TOTAL 100%

5. What certifications do your employees possess that qualify them to provide these services? Choose all that apply. *NOTE: This is not a comprehensive list. Please choose "Other" and describe if needed.*

- ☐ Wellness Practitioner (CWP/CWWS)
- ☐ Registered Dietician (RD)
- ☐ Personal Trainer (ACSM, ACE, NSCA)
- ☐ Health Coach (CHC)
- ☐ Health Educator (CHES)
- ☐ MD or DO
- ☐ Counselor (LPC, MSW)
- ☐ Nurse Practitioner or Registered Nurse
- ☐ Physician Assistant
- ☐ PhD in a Health-related Field
- ☐ Graduate Degree in Health-related Field
- ☐ Bachelor Degree in a Health Field
- ☐ Other _____

6. How many years has your company been providing wellness services to worksites? _____

7. How many worksites has your company provided wellness services to over the past 2 years? _____

8. What percentages of your clients are: *(total percentages must equal 100%)*

Fully insured _____

Self-funded _____

Uninsured _____

Unknown _____

TOTAL 100%

9. What metrics do you use to measure the outcomes of the wellness services you provide? Choose all that apply.

- ☐ Employee Participation
- ☐ Medical Costs
- ☐ Employee Satisfaction
- ☐ Workers' Compensation
- ☐ Health Status/Risk Factors (*smoking, blood pressure, etc.*)
- ☐ Behavior Change
- ☐ Absenteeism
- ☐ Disability
- ☐ Other _____

10. How are your wellness services tailored to meet employees' needs? Choose all that apply.

- ☐ Reading Levels
- ☐ Cultural Diversity (*language, preferences*)
- ☐ Shift Work
- ☐ Health Status
- ☐ Disabilities
- ☐ Needs Assessment
- ☐ Other _____

11. Please list two references of worksites you have provided wellness services for in the past two years.

Reference 1

Company: _____
Street Address: _____
City/State/Zip: _____
Contact Person/Title: _____
Phone: _____ Email: _____

Reference 2

Company: _____
Street Address: _____
City/State/Zip: _____
Contact Person/Title: _____
Phone: _____ Email: _____

IMPORTANT: *To ensure accuracy of the information contained in this application, MDCH reserves the right to contact senior leadership and the references provided.*

I hereby attest, as a member of the senior leadership of this organization, that the information provided above is true, accurate and complete to the best of my knowledge. I understand that an organization may contact the references I have provided for the purpose of identifying an appropriate worksite wellness provider for its employee population.

_____

Signature of Senior Leadership *(electronic signature accepted)* **Date**

Print Name: _____
Title: _____
Phone: _____
Email: _____