PRO BONO COUNSELING PROVIDER PARTICIPATION FORM

INSTRUCTIONS: Form to be completed by pro bono counseling provider and faxed to Anchorage Project Access (APA) at (907) 646-0542 or email to SRichardson@AnchorageProjectAccess.org

NAME OF PROVIDER:_____

PRACTICE/OFFICE NAME: _____

SCOPE OF COUNSELING PRACTICE OR SPECIALTY: _____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP: _____

PHONE:_____ FAX:_____ EMAIL: _____

CONTACT PERSON'S NAME:_____ TITLE: _____

CONTACT PHONE:_____ FAX:_____ EMAIL: _____

HOW DID YOU HEAR ABOUT US: ☐ TV ☐ Radio ☐ Provider ☐ Patient ☐ Meeting, please list _____
☐ Other _____

YES, I will help APA Pro Bono Counseling Partnership provide this valuable service to qualified patients.

- Prior to you seeing a patient, each applicant receives an initial screening including the individual's ability to respond to talk therapy and verifying the absence of need for urgent stabilization (i.e., high imminent risk of suicide, homicide, or grave disability). APA will send you an **Appointment Request, accompanied by a copy of the initial screening,** for an eligible patient. You agree to respond to the request within 72 hours. Each patient will be re-evaluated by APA for program participation eligibility every six months.
- I can provide care to ____ (number of) patients per month. Please check areas of specialty:

☐ Depression ☐ OCD ☐ ADHD ☐ Disordered Eating ☐ Couples ☐ Family ☐ Teens
☐ Anxiety ☐ PTSD ☐ Grief ☐ Bipolar ☐ Relationship Challenges ☐ Children ☐ Other

- Would you be willing to see more than one APA patient at a given time? Yes☐ No☐
- Languages spoken in office?_____
- Do you have interpreter services? ☐ Yes ☐ No

APA staff will call/text the patient prior to each appointment. Patients referred by APA agree to keep 100% of scheduled appointments as part of their enrollment process.

I understand that the treatment I provide is free of charge to the patient, and always based on my best clinical judgement. The provided assessment and treatment request is a guideline provided by APAPBC.

_____ _____
Provider's Signature Date

Internal Use Only:
☐ Licensed Verified # _____
☐ TrackVia-Provider
☐ TrackVia-Group
☐ TrackVia-Notes
☐ Added Provider List
☐ Ltr Sent
☐ Scanned

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