ANCHORAGE PROJECT ACCESS
CONNECTING TO CARE

MENTAL HEALTH COUNSELING PROVIDER PARTICIPATION FORM

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 the APA Mental Health Counseling Program provide this valuable service to eligible clients.

- Prior to seeing a client, 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 a **Referral Request, accompanied by a copy of the initial mental health screening,** for an eligible client. Please respond to the request in a timely manner.
- I can provide care to ___ (number of) clients. Please indicate areas of specialty:

  ☐ Depression ☐ Anxiety ☐ Adjustment Disorder ☐ Grief ☐ ADHD
  ☐ OCD ☐ PTSD ☐ Trauma ☐ Parenting ☐ Relationship Challenges
  ☐ Other: _____

- I see ☐ Adults ☐ Teens ☐ Children ☐ Couples ☐ Families
- Would you be willing to see more than one APA client at a given time? ☐ Yes ☐ No
- I offer ☐ In person appointments ☐Telehealth appointments ☐ Both
- Languages spoken in office: _____
- Do you have interpreter services? ☐ Yes ☐ No Are you willing to use an interpreter? ☐ Yes ☐ No
- While there is no reimbursement for services provided to APA clients, it is vital that we are able to track the amount of donated services rendered. Please provide your standard in-office rates for uninsured clients.

  Initial Intake: $_____ per intake Counseling Appointments: $_____ per session

Clients referred by APA agree to keep all scheduled appointments, unless otherwise arranged with the provider, as part of their enrollment process.

I understand that the treatment I provide is free of charge to the client and always based on my best clinical judgement.

_____ _____
Provider's Signature Date

Internal Use Only:
__ Licensed Verified #
__ TrackVia-Provider
__ TrackVia-Group
__ TrackVia-Notes
__ Added Provider List
__ Scanned

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