Provider Survey
for the ACONE Mental Health Services Directory

Adoption Community of New England, Inc.
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www.AdoptionCommunityofNE.org

Contact Information

First Name ______________________	Last Name ______________________
Agency/Clinic affiliation if applicable ______________________	Second Agency/Clinic affiliation ______________________
Street ______________________	Street ______________________
City, State, Zip Code ______________________	City, State, Zip Code ______________________
Is this site handicapped accessible? Yes ☐ No ☐	Is this site handicapped accessible? Yes ☐ No ☐
Primary Phone Number (___) ________________	Primary Phone Number (___) ________________
Secondary Number (___) ________________	Secondary Number (___) ________________
FAX Number (___) ________________	FAX Number (___) ________________
Hotline/Emergency (___) ________________	Hotline/Emergency (___) ________________
TDD (___) ________________	TDD (___) ________________
Email address ____________________________	Email address ____________________________

Services Provided

___ Mental Health Services	___ Evening Hours	___ Home Visits
___ Respite Services	___ Saturday Hours	___ School Visits
___ Refer to Respite	___ Residential Treatment	Other ________________________

Geographical Area Served:
____

Languages used in addition to English: ____

Professional Designation and Areas of Expertise

S.W. ___ Ph.D. ___ Ed.D ___ M.D. ___ Psychiatrist ___ Psychologist ___
Mental Health Counselor ___ Other, specifically ____

License Number(s) ____

Degree, school and year: ____

Internship(s) ____

Years as a therapist: ____ Years in adoption: ___

On the back of this page, list relevant professional memberships.

For what areas of expertise do you provide Mental Health services?
To be considered an area of expertise, write a description of your training and/or experience for each individual area which you have checked. Feel free to attach a separate sheet.

__ Abandonment	__ Eating disorders	__ Pre-adopt
__ ADD/ADHD	__ Emotional abuse	__ Pre-school age
__ Addiction problems	__ FAE/FAS	__ Post-traumatic stress
__ Adolescence	__ Grief	__ Relative adoptions
__ Adoption	__ HIV/AIDS	__ Ritualistic abuse
__ Adoption disruption	__ Holding therapy	__ Search/reunion
__ Adult adoptee	__ Identity issues	__ Separation and loss
__ Anxiety	__ Infertility issues	__ Sexual abuse
__ Attachment	__ Kinship families	__ Substance abuse
__ Behavior disorders	__ Latency age	__ Suicide prevention
__ Birth parent	__ Learning disabilities	__ Transracial/transcultural
__ Depression	__ Physical abuse	__ Other (please describe) ____________________

Expertise with perpetrators of: ____

Preferred treatment modalities: ____

List current training, particularly in the adoption field, with dates and/or other pertinent information.

Do you work with: % of current caseload
__ Children who have been adopted? ________
__ Adoptive families? ________
__ Birthparents? ________
__ Adult adoptees? ________
__ Foster children? ________
__ Foster parents? ________
__ Children with a history of foster care? ________
__ Kinship or guardianship families? ________

Describe your current caseload in percentages:
_____% adults only _____% Children only _____% Families
Do you provide potential patients/families with references? ______________

Optional Personal Information

Are you an adoptee? YES NO No Response
Do you have adoptive siblings? YES NO No Response
Are you an adoptive parent? YES NO No Response
Are you a birthparent of an adoptee? YES NO No Response
Ethnic background ________________________

Fees/Insurance Information

Do you give free initial interviews? YES NO
Fees for Services? YES NO
Are clients ever accepted without charge? YES NO
Are clients accepted on a sliding scale fee basis? YES NO
Do you accept Mass Health? YES NO
HMOs and/or Private/public Insurance accepted: ________________________________

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I certify that the above information is true and correct. I hereby authorize ACONE to release any or all of the above information to third parties seeking referrals to or information about mental health service providers and to publish any or all of such information in The Mental Health Services Directory.
In consideration for ACONE listing me in The Mental Health Services Directory, I hereby agree to indemnify and hold harmless ACONE from all liability arising as a result of my inclusion in The Directory or referral of any patients or person(s) to me.
I understand that ACONE is not endorsing or evaluating any therapist or kind of treatment. ACONE is not responsible for any misrepresentation or misuse of this information or for any typographical errors in its reproduction.

____ __________________
Signature Date

Mail to: **MHS Survey Adoption Community of New England, Inc.**
45 Lyman Street #2
Westborough, MA 01581