

Survey for Directory of Physical Health Services Providers

Adoption Community of New England, Inc.

45 Lyman Street #2, Westborough, MA 01581

508.366.6812 • FAX: 508.366.6813 • info@AdoptionCommunityofNE.org • 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

___ Physical Health Services ___ Evening Hours ___ Home Visits
___ Saturday Hours ___ School Visits Other _____

Geographical Area Served: _____

Languages used in addition to English: _____

Professional Designation

___ MD/DO ___ DDS/DMD ___ Psychiatrist ___ Physical Therapist ___ Occupational Therapist
___ Speech/Language Therapist ___ Massage Therapist Other, specifically _____

License Number(s): _____

Degree, school and year: _____

Internship(s)/Residency/Fellowship(s): _____

Primary Specialty: _____ Secondary Specialty: _____

Professional affiliations: _____

Professional Experience

I have worked with (Check all that apply):

- | | | |
|---|---|--|
| <input type="checkbox"/> Children who have been adopted | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Language disabilities |
| <input type="checkbox"/> Adopted internationally | <input type="checkbox"/> Addiction problems | <input type="checkbox"/> Learning disabilities |
| <input type="checkbox"/> Reading pre-placement profiles | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Post-institutionalization |
| <input type="checkbox"/> Adopted U.S. infant | <input type="checkbox"/> Autism | <input type="checkbox"/> Post-traumatic stress |
| <input type="checkbox"/> Adopted U.S. older/waiting | <input type="checkbox"/> Depression | <input type="checkbox"/> Ritualistic abuse |
| <input type="checkbox"/> Children in foster care | <input type="checkbox"/> Developmental delays | <input type="checkbox"/> Sensory integration |
| <input type="checkbox"/> Children post foster care | <input type="checkbox"/> Eating disorders | <input type="checkbox"/> Sexual abuse |
| <input type="checkbox"/> Kinship/Guardianship families | <input type="checkbox"/> FAE/FAS | <input type="checkbox"/> Substance abuse |
| | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Tactile defensiveness |
| | <input type="checkbox"/> Other _____ | |

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: _____ | | |

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 physical health service providers and to publish any or all of such information in The Physical Health Services Directory.

In consideration for ACONE listing me in The Physical 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 professionals or methods 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: Adoption Community of New England, Inc.
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