Mental Health America of Greater Houston

Date:_____

Pro Bono Counseling Provider Form

Provider's Name: _____

Organization (if applicable): _____

Mailing Address: _____

Physical Address **(if different from mailing address):**_____

Main #: _____ **Appointment #:** _____

Fax#: _____ **E-mail:** _____ **Web:** _____

Provider Credentials:

Academic Degree(s)	License Type(s)	License #(s)	Other Credentials (if applicable)

Ages Served:

☐ All ages ☐ Adolescents ☐ Adults ☐ Children
☐ Seniors ☐ Age Limits (Specify:_____)

Special Focus on Diverse Populations:
*Do you **specialize** in serving any of the populations below? (Accreditations or Experience)*

☐ Adolescents	☐ Men
☐ African American	☐ MR
☐ Asian American	☐ Native American
☐ Children	☐ Seniors/Elderly
☐ Gay/Lesbian/Bisexual/Transgender	☐ Women
☐ Hispanic	☐ Other (specify: _____)

Special Accommodations:

☐ TDD	☐ Wheelchair Accessible
☐ Other (specify: _____)	

Hours of Service:

☐ Business Hours	☐ 24 hr. Emergency
☐ Some Evening Hours	☐ Some Weekend Hours

Languages Spoken: _____

Do you have available translation services? ☐ Yes ☐ No

Service/Treatment Orientation: *Which of the following do you practice?*

☐ Addiction Model	☐ Interpersonal Psychotherapy
☐ Cognitive/Behavioral Therapy (CBT)	☐ Multisystemic Therapy (MST)
☐ Critical Time Intervention (CTI)	☐ Psychodynamic
☐ Crisis Intervention	☐ Spiritual / Faith-Based (religious orientation: _____)
☐ Dialectical Behavioral Therapy (DBT)	☐ 12-Step
☐ Educational	☐ Other (specify: _____)

Areas of Specialization: C*heck those you specialize in addressing (accreditations, supplemental training, and/or extensive experience).*

☐ Abuse Issues (physical and/or sexual)	☐ Mood Disorders
☐ Anxiety Disorders	☐ Personality Disorders
☐ Anger Management	☐ Postpartum Mood Disorders
☐ Bereavement/Grief	☐ Psychosis
☐ Compulsive Behaviors	☐ Stress Management
☐ Developmental Disorders	☐ Substance Abuse
☐ Eating Disorders	☐ Suicide Intervention
☐ Family Issues/Parenting	☐ Trauma
☐ Marriage/Relationship Issues	☐ Other (specify: _____)

Populations Not Served:

☐ Chronic, Severe Mental Illness	☐ People Diagnosed with Substance Abuse
☐ People Diagnosed with Mental Illness	☐ Suicidal Individuals
☐ People Diagnosed with Mental Retardation	☐ Other (specify) _____

Fees Accepted:

☐ All	☐ Medicare
☐ Financing	☐ Private Pay
☐ Insurance – including HMOs, PPOs, Managed Care Contracts, etc.	☐ Sliding Scale Minimum $ _____ Maximum $ _____
☐ Medicaid	☐ Other _____

Is there anything else that you would like us to know about your services, treatment approaches, areas of specialization, or the clients you are most interested in serving? *(This information helps us to match callers with providers.)*

_____

_____

Please provide any information you can about how a client could reach your site using public transportation (for example, bus number, closest bus stop, distance to bus stop, etc.):

_____

Please select one:

____I would like to learn more about the Pro Bono Counseling Program.

____I am very interested in volunteering for the Pro Bono Counseling Program.

- How many clients would you be willing to see per year (6 sessions per client)? _____
- How many clients would you be willing to see concurrently (6 sessions per client)? _____
- When would you be available to start? _____
- Would you be willing to see clients outside of your office? ____YES ____NO

Please fax, mail, or e-mail completed form to:

MHA Pro Bono Counseling Program
E-mail: ddelariva@mhahouston.org
Phone 713-523-8963x235 • Fax: 713-522-0698
Mailing address: 2211 Norfolk, Suite 810, Houston, TX 77098

Thank you for your time!