



The Mental Health Association  
in Suffolk County, Inc.

Bridging the Way Toward Mental Wellness  
www.mhasuffolk.org

199 N. Wellwood Avenue, Lindenhurst, NY 11757  
Phone: 631-226-3900 Fax: 631-225-1708

## PROFESSIONAL MEMBERSHIP FORM

Name \_\_\_\_\_ Title \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Company/Organization (if applicable) \_\_\_\_\_

Phone \_\_\_\_\_ / \_\_\_\_\_ Fax \_\_\_\_\_

E-mail \_\_\_\_\_ Preferred Method of Contact? Yes  No

Additional Offices: Yes  No  *If yes, please attach a list of additional locations.*

### Mental Health Professional Membership (includes website listing) \$90 Annual Fee

#### Mental Health Professional Criterion for Listing on MHAS Website

To be listed as a provider in the Resource Section of our website and to be included in our telephone Information and Referral database, you must meet the following criterion and submit the required documents:

- Be licensed in NYS and in practice a minimum of two years
- Provide MHA with a copy of your NYS Certificate of licensure
- Complete the back page of the membership application

By meeting the above, your name, address and telephone number will appear on our website database under your profession and areas of practice, and be included in our telephone Information and Referral database.

Please make checks payable to The Mental Health Association in Suffolk County, Inc.  
If using a credit card, application may be faxed to 631-225-1708.

AMEX      VISA      MC      DISCOVER

Account #: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Verification #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_ / \_\_\_\_\_

(3 digit code on back of card – For AMEX 4 digit code on front)

Signature: \_\_\_\_\_



newyork.bbb.org

*For Office Use Only:*

DR: \_\_\_\_\_ CK DATE: \_\_\_\_\_

CK#: \_\_\_\_\_ MDB: \_\_\_\_\_ IDB: \_\_\_\_\_

TY: \_\_\_\_\_ SI: \_\_\_\_\_

*The MHA does not share the names of its members with any other organization.*

**Practice Information:** Please provide MHA with any brochures, material or additional information regarding your services.

Profession:

Psychiatrist  Social Worker  MHC  Psychologist  Nurse Practitioner  CASAC  Other

Population(s) Served:

Infants  Children  Adolescents  Adults  Elderly  (Age Range \_\_\_\_\_)

Modality: Individual  Couples  Family  Group  Homebound Services: Yes  No

Therapeutic Approach: \_\_\_\_\_

Expertise with Specific Populations: \_\_\_\_\_

Free Consultation: Yes  No  Evaluations: Yes  No  If yes, please list type \_\_\_\_\_

**Insurance Information:** Sliding Scale: Yes  No  Medicare: Yes  No  Medicaid: Yes  No

Accepted Insurance: \_\_\_\_\_

Check Areas of Practice and Expertise (Limited to Six Categories for website listing)

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Abuse                             | <input type="checkbox"/> Dialectical Behavioral Therapy | <input type="checkbox"/> Obsessive Compulsive Disorder  | <input type="checkbox"/> Sexual Abuse              |
| <input type="checkbox"/> Affect Disorder                   | <input type="checkbox"/> Divorce                        | <input type="checkbox"/> Panic Disorder                 | <input type="checkbox"/> Spanish Speaking Services |
| <input type="checkbox"/> Anger Management                  | <input type="checkbox"/> Domestic Violence              | <input type="checkbox"/> Parenting                      | <input type="checkbox"/> Substance Abuse           |
| <input type="checkbox"/> Anxiety                           | <input type="checkbox"/> Eating Disorders               | <input type="checkbox"/> Personality Disorders          | <input type="checkbox"/> Suicide                   |
| <input type="checkbox"/> Attention Deficit Disorder (ADHD) | <input type="checkbox"/> Emergency Services             | <input type="checkbox"/> Phobias                        | <input type="checkbox"/> Support Groups            |
| <input type="checkbox"/> Autism                            | <input type="checkbox"/> Evaluations                    | <input type="checkbox"/> Post Partum Depression         | <input type="checkbox"/> Other Languages           |
| <input type="checkbox"/> Bereavement/Grief                 | <input type="checkbox"/> Family Therapy                 | <input type="checkbox"/> Post Traumatic Stress Disorder | Please List:                                       |
| <input type="checkbox"/> Bipolar Disorder                  | <input type="checkbox"/> Gay/Bisexual/Transgendered     | <input type="checkbox"/> Schizophrenia                  | _____  |
| <input type="checkbox"/> Borderline Personality Disorder   | <input type="checkbox"/> Mood Disorders                 | <input type="checkbox"/> Self Injurious Behavior        | _____  |
| <input type="checkbox"/> Depression                        |   |   |  |

**Please Help Us Serve You Better**

What areas of need have you identified in our community? \_\_\_\_\_

What mental health issues are important to you? \_\_\_\_\_

Would you like to learn more about any of our programs and services? (check all that apply)

- Consumer Training Program  Support Groups  Speakers Bureau  Volunteer/Internship Opportunities  
 Peer Support & Advocacy  Committees  Fundraising  Other