MaMHCA

Massachusetts Mental Health Counselors Association

17 Cocasset Street, Foxboro, MA 02035

Phone: 508-698-0010; Fax: 508-698-1711

www.MaMHCA.org

COMING THIS FALL:
MaMHCA's Sixth Edition of *Referral Network Directory*
Listing application due to MaMHCA by January 30, 2019

MaMHCA has created a statewide LMHC network that is easily accessible to consumers and contains comprehensive and complete information about LMHC practices and skills, through the **MaMHCA *Referral Network Directory.***

We use the Directory as a basis for making referrals when MaMHCA receives calls requesting counseling and approved supervisor resources. MaMHCA will continue to distribute the Directory for referral purposes to clinics, agencies, hospitals, schools, graduate programs, LMHCs, mental health practitioners and other appropriate recipients. MaMHCA also makes the Directory available on our web site in PDF format.

The Referral Network Directory offers two ways to share your information. The Standard Listing includes: Contact information, populations served and a very brief description of treatment specialties and modalities. The Expanded Listing includes all the Standard Listing information, plus more space to provide more details about your practice and theoretical orientation. Note: all advertising fees help cover the cost of production, advertising, and distribution.

Inclusion in this directory requires:
- A Massachusetts Licensed Mental Health Counselor in good standing
- A MaMHCA member in good standing
- Professional liability insurance

Please return this form ***on or Before January 30th, 2019*** **to:**
MaMHCA – RND, 17 Cocasset Street, Foxboro, MA 02035

Please Enclose:
- ❑ Standard Listing $65 (renewed listing); $85 (new listing)
- ❑ Expanded Listing $75 (renewed listing); $100 (new listing) Optional 2"x2" Passport-sized Photo
- ❑ Completed information form – neatly typed or printed please
- ❑ Copy of your Massachusetts LMHC license
- ❑ Copy of your Professional Liability policy showing coverage amount
- ❑ **Note: Applications received after 1/30/19 cannot be guaranteed publication in this edition.**

Please fill out the questionnaire as completely as possible. **All questions in the section entitled "Please Answer the Following" must be answered.** If you need to enclose additional information, please attach a separate piece of paper to the form and mail them together with your name printed clearly on the attachment. If you have any specific questions that need to be answered, please call: 508-698-0010

And Remember,
Just One Referral Covers the Cost of Your Listing.

Referral Network Directory Questionnaire – due 1/30/19 or earlier

STANDARD LISTING

Name: ____Degree:__________

Address (Office):____

____

Phone (Office):__________________License #:__________

Which populations apply to your practice:

- ❑ Children
- ❑ Adolescents
- ❑ Adults
- ❑ Seniors
- ❑ Individuals
- ❑ Couples/Families
- ❑ Groups
- ❑ Other ___________

Specialty Treatment Areas and/or Modalities: Please list no more than 3

1- ____.

2- ____.

3- ____.

Treatment Specialty Certifications:

- ☐ Clinical Supervision
- ☐ CISD
- ☐ CBT
- ☐ Hypnosis
- ☐ DBT
- ☐ EMDR
- ☐ Biofeedback
- ☐ Expressive Techniques
- ☐ Other ________________

Theoretical Orientation and Approach: Please provide a brief 1-2 sentence overview of your underlying theoretical orientation and approach to treatment. (Please limit your response to 35 words)

____

____

____.

EXPANDED LISTING [with optional photo]: this may include additional special populations, treatment areas or modalities or certifications not mentioned above, and any other information regarding your theoretical orientation and approach you believe will be helpful. (Please limit your response to 100 words or less. Thank you.).

Please Answer the Following: (all questions must be answered)

1- Do you provide services to any non-English speaking language populations?

- ☐ Yes ☐ No

Please specify which language group:_______________________________

2- Do you offer qualified (LMHC with 3 yrs. Post License) Supervision?

- ☐ Yes ☐ No

3- Are you a MaMHCA Certified Supervisor? ☐ Yes ☐ No MaCCS # ______

4- Are you enrolled in MaMHCA's Certified Supervisor Program? ☐ Yes ☐ No

5- Do you want to list a professional web-site? ☐ Yes ☐ No

- Please supply: URL: _________________________

6- Do you want to list your professional, encrypted-HIPAA certified e-mail address? ☐ Yes ☐ No

- Please supply: E-Mail: _________________________

7- Do you have appropriate 24-hour coverage for emergencies, vacations or other absences? ☐ Yes ☐ No

8- Do you have psychiatric psychopharmacology referral resources available?

- ☐ Yes ☐ No

9- Have you ever had your license suspended, revoked or had disciplinary action taken against you?

☐ Yes ☐ No

If yes, please attach an explanation including conditions/resolution.

I agree to abide by the Ethical Standards as set forth by the
American Counseling Association
and the
American Mental Health Counselors Association

____

Signature Date

Mandatory

10- Optional opportunities to promote your practice:

Advertise Your Practice with a Display Ad in the MaMHCA Referral Network Directory

Display Ad

Size	Dimensions	Cost
Full Page	7 x 9 inches	$300.00
Half Page (horizontal)	7 x 4.5 inches	$150.00
Quarter Page	3.5 x 4.5 inches	$80.00
Business card	2 x 3 ½ inches	$45.00

- **Ads must be transmitted digitally. Please email to: josborne@mamhca.org**
- **Hard copy of ad should be included with Directory application to MaMHCA office.**
- **Accompanied by your check or credit card authorization (see below)**

Please reserve my advertising space: (please circle)

Full Page **Half Page** **Quarter Page** **Business Card**

Name: ____

Address: ____

City:________________________ **State:**__________ **Zip:**__________

Phone: ____

Method of Payment

- ❑ Standard Listing $65 (renewed listing); $85 (new listing) $ ________.
- ❑ Expanded Listing $75 (renewed listing); $100 (new listing) $ ________.
- ❑ Display ad as indicated above $ ________.

Total Due $ ________.

☐ Check #_____ made out to MaMHCA

☐ Credit Card Payment

M/C or VISA please circle one

Acct #: ________________________________Exp. Date:______________

Signature: ______________________________3 Digit Code:____________

Check List:

☐ Completed questionnaire

☐ Copy of current license

☐ Copy of current professional liability policy

☐ *Passport sized [2x2"] head shot photo for Expanded Listing Only*

☐ Copy of ad for display

☐ Payment (Check or Credit Card Information

Due on or before 1/30/19. Anything received after this date will be held until the next publication.

Mail To: MaMHCA - RND

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Foxboro, MA 02035