

***Connecting adoptive families, adoption professionals, and all those interested in adoption***

***to form a strong, supportive and resourceful adoption community.***

**Provider Application for Inclusion in the Adoption Community Network’s Directory of Therapy Providers.**

**(Boxes will expand as you type)**

|  |  |
| --- | --- |
| Name |  |
| Practice Name |  |
| Practice Address |  |
| Mailing Address (if different) |  |
| Telephone Number |  |
| Fax Number |  |
| Email Address |  |
| Website |  |

|  |  |
| --- | --- |
| Degrees, Licenses, Certifications & Credentials |  |
| Professional Affiliations & Memberships |  |
| Ages Served |  |
| Languages spoken |  |
| Handicapped Accessibility |  |
| Do you accept Husky? |  |
| If no, are you willing to become a Husky provider? |  |
| Other insurances accepted |  |
| Hourly Rate |  |
| Are there different rates to attend PPTs, etc.? Please describe. |  |
| Sliding scale? Please describe. |  |
| Available appointment dates & times |  |
| How long have you been practicing? |  |
| How long has your practice included work with adoptive/foster families? |  |
| On average, how many adoptive families have been treated in your practice over the past 2 years? |  |
| Do you have practice partners that provide co-therapy if needed? Please elaborate. |  |

|  |  |  |
| --- | --- | --- |
| **Do you:** | **Yes or No** | **If yes, please elaborate here** |
| Provide treatment in a family’s home? |  |  |
| Provide crisis management? |  |  |
| Attend school meetings? |  |  |
| Participate in treatment meetings? |  |  |
| Offer support groups? |  |  |
| Refer for additional assessments? |  |  |
| Have an affiliation with a psychiatrist or other medical professional who can prescribe medications if necessary? |  |  |
| Other? |  |  |

|  |  |
| --- | --- |
| **Please describe your training and experience specific to:** | |
| Adoption |  |
| Attachment |  |
| Birth Family and/or Open Adoption Issues |  |
| Early childhood development/impact of early history |  |
| Family Therapy |  |
| Foster Care |  |
| Grief and Loss |  |
| Multi-racial Families |  |
| Sensory Integration |  |
| Trauma |  |

|  |
| --- |
| **Please write a 3-4 sentence description of your practice that you would like to appear on the web page:** |

*I certify that the above information is true and correct. I hereby authorize UConn Health’s Adoption Assistance Program/Adoption Community Network to release any or all of the above to third parties seeking referrals to or information about mental health service providers and to publish any or all of such information on the ACN website,*[***www.ctadoption.org***](http://www.ctadoption.org)*. In consideration for being listed as a provider, I hereby agree to indemnify and hold harmless* *the State of Connecticut, the University of Connecticut, UConn Health and their trustees, officers, directors, agents and employees from all liability arising as a result of my inclusion on the website. I understand that UConn Health is not endorsing or evaluating any therapist or kind of treatment. UConn Health is not responsible for any misrepresentation or misuse of this information or for any typographical errors in its reproduction. It is my responsibility to notify the AAP/ACN of any changes to the information provided above.*