**Mental Health Services in Primary Care**

**Expression of Interest for provision of contracted psychological services 2020-2021**

***Date of application:***

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| **APPLICANT DETAILS** |
| Given name: |  | Family name: |  |
| Date of birth: |  | Telephone: |  |
| Email address: |  |
| Do you identify as an Aboriginal and/or Torres Strait Islander (please circle) **YES NO** |
| **LOCATION OF SERVICES**  |
| *Please indicate the areas you are able to deliver services:*☐ **Mid Coast** ( ☐ Taree ☐ Forster ☐ Gloucester ) ☐ Dungog ☐ Singleton ☐ Cessnock ☐ Muswellbrook ☐ Upper Hunter (Scone) |
| **PROGRAM AREAS** |
| *Please indicate the program areas you are interested in delivering (details in Summary of Service Types document)*☐ **Psychological Therapy** *If ticked above, please outline the client age groups you be interested/skilled to deliver services to:*☐ Children (Age 0-12) ☐ Adolescent (Age 13-18) ☐ Adults (18-65) ☐ Older Adults (65+)*Please outline the specialised groups you would be interested to deliver services to:*☐ Perinatal women ☐ Aboriginal/ Torres Strait Islander ☐ Culturally and Linguistically Diverse ☐ **Psychological Services in Residential Aged Care Facilities** ☐ **Clinical Care Co-ordination services**  |
| *Please select your professional group:***Psychologist/Clinical Psychologist** ☐Full registration with the Psychology Board of Australia. Registration no: PSY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Additional endorsements (e.g. Clinical Psychologist): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Social Worker** ☐Met AASW accreditation standards for mental health in Social Work: ☐ Yes ☐ NoAt least 2 years’ experience working in mental health: ☐ Yes ☐ No |
| **Occupational Therapist** ☐Hold endorsement as a member of Occupational Therapy Australia (OTA) To provide Better Access to Mental Health care services ☐ Yes ☐ NoAt least 2 years’ experience working in mental health: ☐ Yes ☐ No**Mental Health Nurse** ☐Registered Nurse with AHPRA. Registration no: Credentialed Mental Health Nurse by the ACMHN: ☐ Yes ☐ NoAt least two years’ experience working in mental health: ☐ Yes ☐ No |
| **DETAILS OF PROFESSIONAL PRACTICE FROM WHICH YOU WILL DELIVER SERVICES** |
| Name of practice: |  | Physical address: |  |
| Postal address: |  | Phone: |  |
| Fax: |  | Mobile: |  |
| Email: |  | Website: |
| Is your practice co-located with GP Practice? | ☐ No ☐ Yes |
| If yes, name of GP practice: |  |
| ABN: |  | Medicare provider number: |  |
| Membership of professional body (name): |  |
| Other languages I can provide services in: |  |
| **PRACTICE ACCESSIBILITY** |
| Days available at practice: Monday: ☐ Tuesday: ☐ Wednesday: ☐Thursday: ☐ Friday: ☐ Saturday: ☐ |
| Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |