**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 ☐ No  At 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 ☐ No  At 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 ☐ No  At 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |