## Network Provider Information Sheet

HDC Human Development Company

Date: _____

Counselor's Name: _____ Credentials: _____

Practice/Group Name (dba): _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Practice Address: _____

City: _____ State: _____ Zip: _____

Contact Information: Office: _____ Cell: _____ Provide to Client? Yes ___ No ___

Fax: _____ Emergency Contact: _____

E-Mail:_____ Website: _____

Is your office handicapped accessible? Yes __ No __ Days/Hours available to see clients: _____

**Please check the presenting problems for which you have unique credentialing or targeted and current training for assessment and treatment.**

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|---|---|---|---|---|---|---|---|---|---|
| Abuse Issues | ☐ | Bipolar Disorder | ☐ | Family Counseling | ☐ | PTSD | ☐ | | |
| ACOA | ☐ | Blended Families | ☐ | Gambling | ☐ | Psychological Evaluation | ☐ | | |
| ADHD/ADD | ☐ | Child Abuse | ☐ | Grief & Loss | ☐ | Rape/Sexual Assault | ☐ | | |
| Adolescents | ☐ | Children | ☐ | Impaired Professional | ☐ | Schizophrenia/Psychosis | ☐ | | |
| Adoption Issues | ☐ | Christian Counseling | ☐ | Internet Addiction | ☐ | Sex Addiction | ☐ | | |
| Adults | ☐ | Codependency | ☐ | Marital/Relationship | ☐ | Sexual Abuse Therapy | ☐ | | |
| AIDS/HIV | ☐ | Critical Incident Response | ☐ | Mediation | ☐ | Sleep Disorders | ☐ | | |
| Alternate Lifestyles | ☐ | Depression | ☐ | Men's Issues | ☐ | Stress Management | ☐ | | |
| Anger Management | ☐ | Domestic Violence | ☐ | OCD | ☐ | Substance Abuse – Alcohol | ☐ | | |
| Anxiety Disorders/Panic | ☐ | Eating Disorders | ☐ | Personality Disorders | ☐ | Substance Abuse – Drug | ☐ | | |
| Autism/ Asperger's | ☐ | Elder Issues | ☐ | Phobias | ☐ | Trauma | ☐ | | |
| Behavioral Problems | ☐ | Ethnicity/Minority Issues | ☐ | Physical Abuse | ☐ | Women's Issues | ☐ | | |

What would you say are your three (3) main areas of interest? _____

Are there any specific clinical issues you prefer not working with? Yes ___ No ___

If so, which issues? _____

Is your practice: Adult Only___ Children Only___ Both___ Number of years in clinical practice_____

Do you provide on-site Critical Incident Response? Yes ___ No___

Are you affiliated with a national critical incident response group(s)? Yes ___ No ___

If so, which group(s)? _____

Do you work with clients who have been referred due to job performance issues (Formal Referrals)? Yes___ No___

Does your organization have contracts with employers and/or unions to provide EAP services? Yes___ No___