



Mental Health Association of Southeast Florida

7145 W. Oakland Park Boulevard ♦ Lauderdale, Florida 33313-1012

Phone: 954-746-2055 ♦ Fax: 954-746-6373

www.mhasefl.org ♦ Email: education@mhabroward.org

JOIN US

Joining the Mental Health Association of Broward County
is a



Professional Membership for Licensed Behavioral Health Providers

Professional Membership in MHASEFL (*formerly MHA of Broward County*) will qualify you for a complimentary listing in the **13th Edition** of the **DIRECTORY OF PROFESSIONAL MEMBERS** - a community resource that includes comprehensive information on State of Florida Department of Health-Division of Medical Quality Assurance licensed professionals providing behavioral health services.

Psychiatrists, Psychologists, Social Workers, Marriage & Family Therapists, Mental Health Counselors and Psychiatric Nurses are listed alphabetically with information regarding areas of interest, specialties, fee structures, populations served, etc. The directory also provides cross-referenced appendices by discipline, areas of interest, location, etc. for easy use by the MHA Staff, other organizations and case managers who make referrals and the general population who consult it as a guide to access mental health care. The directory has a distribution of more than **12,000 copies** plus thousands of website downloads, and it is the basis for the MHASEFL referral database when responding to the many daily requests throughout South Florida.

As a Professional Member, you are supporting your Mental Health Association and will receive:

- ☒ A complimentary spiral-bound copy of the "Directory of Professional Members"
- ☒ A complimentary listing on MHASEFL's website (www.mhasefl.org)
- ☒ A complimentary copy of "Connections", MHASEFL's comprehensive guide to mental health resources in the community
- ☒ A Membership Card to access current and future member services and discounts
- ☒ A Certificate of Membership suitable for framing and display in your office
- ☒ A discount certificate toward matting and framing at MHA's 9Muses Art Center & Frame Shop
- ☒ A discount certificate for participation in MHA sponsored Continuing Education (CEU) Programming (CEU credit included)
- ☒ The Mental Health Association of Southeast Florida's newsletter
- ☒ The MHASEFL's Professional Membership newsletter including research updates, networking opportunities and more
- ☒ Periodic mailing about programs, services and special events including professional networking and advocacy alerts
- ☒ Invitations to "member only" events and activities and discounts on selected special events
- ☒ Discounted use of the MHA conference room and classrooms (subject to availability)
- ☒ Access to multiple copies of NIMH science-based mental health literature for your office and educational activities
- ☒ Opportunities to work with our children's programs and speaker's bureau
- ☒ Connections and Collaborations for personal and professional development

JOIN US as a Professional Member of this nation's oldest advocacy organization working in support of mental health/mental illness issues. We're making a difference, and you can too!

Professional Membership Application with payment and a copy of your Current State of Florida DOH-MQA License and Certifications (if applicable) **must be received by March 15, 2013** in order to be included in the printed Directory of Professional Members.

An Affiliate of Mental Health America, the Mental Health Associations in Florida and the World Federation for Mental Health

PLEASE TYPE OR PRINT ALL INFORMATION CLEARLY AND LEGIBLY

Your Signature Is Required On Back Page

LAST NAME _____ First Name/Initial _____

Primary Office Street Address _____

City _____ County _____ Zip _____

Primary Ofc. Phone # () _____ Alternate Phone # () _____

Additional Office Location _____

Website Address (if available) <http://www.> _____

**** Fax & E-Mail will NOT be published ****

** Fax # () _____ ** E-Mail Address _____ @ _____

Current License(s) # (include prefix) _____

**PLEASE BE SURE TO ATTACH A COPY OF YOUR CURRENT LICENSE
(State of Florida, Dept. of Health-Division of Medical Quality Assurance)**

EDUCATION SUMMARY:

Highest Degree Earned _____ Date Degree Awarded _____ Institution _____

Other Graduate Degree(s), Date(s), Institution(s) _____

Undergraduate Degree, Date, Institution _____

THEORETICAL ORIENTATION _____

LANGUAGE PROFICIENCY - What languages other than English do you speak fluently? _____

FEE STRUCTURE:

Initial Consultation Fee \$ _____

Ongoing Treatment Fee \$ _____

Do you Accept:

Medicare Yes ☐ No ☐

Medicaid Yes ☐ No ☐

Fee Adjustment Yes ☐ No ☐

Fee Adjustment Base (if yes) \$ _____

Do you provide:

☐ Home Visits ☐ Professional Clinical Supervision for Licensure

FLORIDA CERTIFICATION BOARD:

(Must include documentation of certification in order to be included in the directory)

☐ CAP ☐ CAS ☐ CAC ☐ CBHT ☐ CRPS ☐ CRPS-A ☐ CRPS-F
☐ CRPS-V ☐ CRSS ☐ CTTS ☐ CCJAS ☐ CCJAC ☐ CCJAP ☐ CET
☐ CGAC ☐ CMHP ☐ CPP ☐ CPS ☐ SAP

Are there any services that you provide not already listed within this application?

POPULATIONS SERVED: (Check as appropriate)

☐

Adult

☐

Child

☐

Adolescent

☐

Geriatric

AREAS OF INTEREST: Mark your top three categories of interest or specialty as #1, #2, #3

In addition, you may mark up to 12 other categories of interest or specialty.

NOTE: Due to space limitations, we can include no more than 15 total categories. Please select carefully.

- | | |
|-----------------------------------------------------------------------------|---------------------------------------------------------------------------------|
| <input type="checkbox"/> Abused Clients by Former Therapists | <input type="checkbox"/> Learning Issues |
| <input type="checkbox"/> Adopted Children & Families | <input type="checkbox"/> Marriage & Family Issues |
| <input type="checkbox"/> Aging Issues | <input type="checkbox"/> Mediation |
| <input type="checkbox"/> Agoraphobia | <input type="checkbox"/> Medical Psychotherapy |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Men's Issues |
| <input type="checkbox"/> Alzheimer's & Related Disorders | <input type="checkbox"/> Neuropsychology, Neuropsychiatry |
| <input type="checkbox"/> Attention Deficit Disorder/ADHD | <input type="checkbox"/> Non-Substance Addictions (ie: internet, sex, shopping) |
| <input type="checkbox"/> Autism Spectrum Disorders | <input type="checkbox"/> Obsessive/Compulsive |
| <input type="checkbox"/> Batterers | <input type="checkbox"/> Pain Management |
| <input type="checkbox"/> Bipolar Disorder (Manic-Depression) | <input type="checkbox"/> Panic/Anxiety |
| <input type="checkbox"/> Caregiver Issues | <input type="checkbox"/> Parenting |
| <input type="checkbox"/> Child Abuse Perpetrators | <input type="checkbox"/> Personality Disorders |
| <input type="checkbox"/> Child Abuse Victims | <input type="checkbox"/> Phobias |
| <input type="checkbox"/> Co-Dependency | <input type="checkbox"/> Post Traumatic Stress Disorder |
| <input type="checkbox"/> Conduct/Behavior Disorders | <input type="checkbox"/> Postpartum Depression |
| <input type="checkbox"/> Court Testimony/Competency | <input type="checkbox"/> Psychological Testing |
| <input type="checkbox"/> Criminal Behavior | <input type="checkbox"/> Psychopharmacology |
| <input type="checkbox"/> Crisis Intervention | <input type="checkbox"/> Relationships |
| <input type="checkbox"/> Critical Incident Stress Debriefing (CISD) | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Cultural Issues | <input type="checkbox"/> School Issues |
| <input type="checkbox"/> Custody Determination | <input type="checkbox"/> Self-Esteem |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Sexual Abuse |
| <input type="checkbox"/> Disabilities/Rehabilitation | <input type="checkbox"/> Sexuality |
| <input type="checkbox"/> Dissociative Disorders | <input type="checkbox"/> Sleep Disorders |
| <input type="checkbox"/> Divorce | <input type="checkbox"/> Spirituality, Religious Issues |
| <input type="checkbox"/> Dual Diagnosis/Co-Occurring-Developmental Disorder | <input type="checkbox"/> Step Families |
| <input type="checkbox"/> Dual Diagnosis/Co-Occurring-Substance Abuse | <input type="checkbox"/> Stress Reduction |
| <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Substance Abuse (Alcohol and/or Drug) |
| <input type="checkbox"/> Fertility Issues | <input type="checkbox"/> Suicide |
| <input type="checkbox"/> Forensics | <input type="checkbox"/> Trauma |
| <input type="checkbox"/> Gambling | <input type="checkbox"/> Veterans |
| <input type="checkbox"/> Grief/Bereavement | <input type="checkbox"/> Violence/Perpetrators |
| <input type="checkbox"/> Head Trauma | <input type="checkbox"/> Violence/Victims of Violence |
| <input type="checkbox"/> Homosexual/Bi-Sexual/Transgender (GLBT) | <input type="checkbox"/> Vocational/Occupational Issues |
| <input type="checkbox"/> Incest | <input type="checkbox"/> Women's Issues |
| | <input type="checkbox"/> Workers' Compensation |

Other: _____

The following information is intended for internal use only and will not be published in the Directory

Other Certifications not regulated by the Florida Certification Board: _____

Practice Affiliation (if working under titled group practice) _____

The Mental Health Association of Broward County provides free prevention and support services in addition to its information and referral service. Please indicate your interest in supporting these services as a volunteer.

- ☐ I am interested in serving as a speaker at community events and/or Continuing Education for professionals

TOPIC(S) _____

- ☐ I am interested in volunteering to provide consultations at National Screening Day events:

☐ Depression ☐ Anxiety ☐ Eating Disorders ☐ Alcohol ☐ Gambling

- ☐ I am willing to serve as a Professional Advisor to the LISTEN TO CHILDREN program

Requires orientation (1 hour) and one hour per month IN YOUR OWN OFFICE to meet with Listener volunteers in a group

- ☐ I would like to become actively involved in the MHA/Broward committee for

☐ Special Events/Fundraising ☐ Public Policy ☐ Professional Education ☐ Membership Development

What recommendations or suggestions can you make for services or resources that are not currently or adequately available that would meet the needs of your clients?

The Mental Health Association of Broward County is a provider of Continuing Education Units (CEU) for State of Florida, DOH-MQA licensed mental health professionals. Please indicate any topics that you would like to see offered in the Professional Education Series.

Return to:

MENTAL HEALTH ASSOCIATION OF SOUTHEAST FLORIDA
7145 W. Oakland Park Boulevard; Lauderdale, FL 33313-1012

ANY QUESTIONS?
Call (954) 746-2055

DEADLINE: Mar. 15, 2013

Enclosed is payment for my individual PROFESSIONAL MEMBERSHIP in the Mental Health Association of Broward County for 2013-2014 membership and inclusion of a listing in the **2013-2014 MENTAL HEALTH ASSOCIATION DIRECTORY OF PROFESSIONAL MEMBERS** publication. I understand that I have an additional option of including a business card advertisement for an additional cost. I understand that inclusion of my name in this Directory in no way denotes endorsement or competency, nor guarantees referrals.

OPTION TO INCLUDE A BUSINESS CARD IN THE MHA DIRECTORY OF PROFESSIONAL MEMBERS 2013-2014

*Members may include a business card advertisement using the name of their practice but not including any other practitioner other than the individual member. The fee for inclusion of a black & white business card submitted camera ready in an electronic format is **\$35.00**. Additional charges apply to prepare artwork not camera ready in electronic form.*

- ☐ Enclosed is my check in the amount of **\$85.00** or **\$120.00 (circle one)** made payable to MHA/Broward

- ☐ I wish to charge **\$85.00** or **\$120.00 (circle one)** to my MC, Visa or American Express account listed below:

Card # _____ Expiration Date _____ Security Code _____

Signature _____ Billing Zip Code _____

Signature Required Here Only For Memberships Paid For By Charge Card

By signing and completing this application and paying the Annual Professional Member Fee, I agree to be included in MHA's Directory of Professional Members (unless otherwise indicated), a copy of which will be provided to me upon publication. In completing this application, I have provided information which is accurate and complete to the best of my ability. As a criteria for Professional Membership, I will send to MHASEFL a copy of my most current license from the State of Florida, Department of Health-Division of Medical Quality Assurance by 03/15/13.

- ☐ I wish to become a member of the MHA, but do not wish to be included in the Directory of Professional Members.

Date _____ Signature _____

BE SURE TO SIGN YOUR APPLICATION HERE