Application for Inclusion in Connections 2019

Please use this form to submit information about your agency or program,
or to make any changes to your current listing.
Photocopy this form as needed, if you wish to submit information on multiple programs.
We reserve the right to exclude any listing or to edit information.

PLEASE PRINT CLEARLY

Agency Name:
_____

Agency Address:
_____

Agency Phone:_____ Agency Fax: _____

Agency Website:
_____

Program Name:
_____

Brief Description:
_____
_____
_____
_____

Hours of Operation:
_____

Where are you services provided? ☐ Broward ☐ Miami-Dade ☐ In-Home Broward ☐ In-Home Miami-Dade

Is your agency a 501c3 not-for-profit or governmental? ☐ Yes ☐ No

Are there fees for your services? ☐ Yes ☐ No

Do you accept? ☐ Medicare ☐ Medicaid ☐ Insurance ☐ Private Pay Only ☐ Sliding Scale

TDD/TYY (Telephone for Hearing Impaired? ☐ Yes ☐ No TTD/TYY Phone #: _____

Multilingual Services Available? ☐ Spanish ☐ French ☐ Creole ☐ American Sign Language ☐ Other_____

Your Name _____ Your Title _____

Your Contact Phone: _____ Your Email: _____

Mail Application to:

MENTAL HEALTH ASSOCIATION OF SOUTHEAST FLORIDA
Attn: Connections 2019
7145 W. Oakland Park Blvd.
Lauderhill, FL 33313-1012

Or Fax to: (954) 746-6373
Questions? Call (954) 746-2055 ext#106