

Directory of Mental Health Service Providers • Entry Form
A community mental health directory provided by
Mental Health America of Tippecanoe County and NAMI West Central Indiana
www.mhdirectory.info

Last Name _____ First Name _____

Credentials _____ (Ph.D., LCSW, MSW, etc.)

Clinic or Business Name _____

Address _____

City _____ State _____ Zip _____ County _____

Phone _____ Email _____ Website _____
(email addresses will be kept confidential)

Would you like to receive monthly email updates from MHA and NAMI? Yes No

Sliding Fee Scale? Yes No
 Faith-based Services? Yes No

Medicaid Accepted? Yes No
 Medicare Accepted? Yes No

Please check clientele you serve: Children Adolescents Adults Geriatric

Please check the mental health needs and services you currently provide:

- | | |
|--|--|
| <input type="checkbox"/> Addiction | <input type="checkbox"/> Parenting |
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Personality Disorders |
| <input type="checkbox"/> Anger Management | <input type="checkbox"/> Phobias |
| <input type="checkbox"/> Anxiety Disorders | <input type="checkbox"/> Physical Abuse |
| <input type="checkbox"/> Attention Deficit Disorder (ADD) | <input type="checkbox"/> Play Therapy |
| <input type="checkbox"/> Autistic Spectrum Disorders | <input type="checkbox"/> Post Traumatic Stress Disorder (PTSD) |
| <input type="checkbox"/> Behavior Problems | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Psychological Assessment |
| <input type="checkbox"/> Borderline Personality Disorder | <input type="checkbox"/> Psychotherapy |
| <input type="checkbox"/> Codependency | <input type="checkbox"/> Relationship Issues |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Schizophrenia & Schizoaffective Disorders |
| <input type="checkbox"/> Dissociative Disorders | <input type="checkbox"/> School Problems |
| <input type="checkbox"/> Divorce Recovery | <input type="checkbox"/> Self-Esteem |
| <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Self-Injury |
| <input type="checkbox"/> Family Therapy | <input type="checkbox"/> Sexual Abuse |
| <input type="checkbox"/> Grief and Loss | <input type="checkbox"/> Sexual Issues |
| <input type="checkbox"/> Marriage Counseling | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Men's Issues | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Obsessive Compulsive Disorder (OCD) | <input type="checkbox"/> Trauma |
| <input type="checkbox"/> Oppositional Defiant Disorder | <input type="checkbox"/> Women's Issues |
| <input type="checkbox"/> Panic Disorder | |

Does your clinic provide case management? _____

Does your clinic provide free support groups? _____

Signature _____ Today's Date _____

Please complete entire form, sign and mail to Mental Health America, 914 South Street, Lafayette, IN 47901.