

## **THE NEW YORK COALITION FOR ASIAN AMERICAN MENTAL HEALTH**

Dear Colleague,

The New York Coalition for Asian American Mental Health is in the process of updating our Mental Health Resource Directory. In order to provide accurate information regarding your organization and services, please take a few moments to fill out the information requested on the enclosed sheet. Please fax the signed and completed form to my attention or mail it to the address listed below:

We would also like to give you the option of including this information in our new online directory so that it will be easily accessible via the Internet.

If you have any questions, please feel free to contact me. Thank you for your information and your cooperation.

Sincerely,

Tricia Leung, CSW, Director  
The New York Coalition for Asian American Mental Health  
8710 Fifth Avenue  
Brooklyn, NY 11209  
(718) 680-0006  
(718) 492-7518 [fax]

## ORGANIZATION INFORMATION SHEET

**Organization Name:** \_\_\_\_\_

**Contact Person (Title):** \_\_\_\_\_

**\*If you are a private practitioner - Practitioner Name & Hospital Affiliation:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Email:** \_\_\_\_\_ **Website:** \_\_\_\_\_

**Office Hours:** \_\_\_\_\_

**Type of Service:** (Please check all that apply)

Outpatient  Inpatient  Day Treatment

Other: \_\_\_\_\_

**Services Provided:** (Please check all that apply)

Individual therapy  Group therapy

Other: \_\_\_\_\_

**Area of Expertise:**

Mental Health  Substance abuse  Family therapy

Couple therapy  Play therapy with children

Other: \_\_\_\_\_

**Ethnic communities served:**

East Asian (please specify): \_\_\_\_\_

South Asian (please specify): \_\_\_\_\_

Southeast Asian (please specify): \_\_\_\_\_

Other (please specify): \_\_\_\_\_

**Age groups served:**  Children  Adolescent  Adult  Geriatric

**Languages:** (please list all that apply): \_\_\_\_\_

**Insurances accepted:**  Medicaid  Medicare  Other (please specify): \_\_\_\_\_

**Standard Fee:** how much per visit? \$\_\_\_\_\_  sliding fee scale provided

**NYS licensed service providers:**  MD  CSW  RN  Psychologist  Other (please specify): \_\_\_\_\_

**Pharmacy onsite:**  Yes  No

**Client eligibility criteria:** \_\_\_\_\_

**Catchment area:** \_\_\_\_\_

**Additional information:** \_\_\_\_\_

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### Consent Agreement

Please check off one of the following:

Yes. I agree to give the Coalition permission to reproduce and post the information listed above in both the Mental Health Resource Directory and the Coalition's Internet directory.

Please include my information in the Mental Health Resource Directory. Please do not include this information in the Coalition's Internet directory at this time.

Signature: \_\_\_\_\_

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Organization: \_\_\_\_\_

Date: \_\_\_\_\_