RIPCPC Behavioral Health Affiliate Collaboration Questionnaire

Name:_____

As a behavioral health affiliate of the Rhode Island Primary Care Physicians Corporation (RIPCPC), you have indicated your willingness to identify the populations you serve and the services you provide (that are "appropriate").This sheet allows you to do so by checking all the boxes below that apply:

Please indicate the populations you serve:

Populations you are able to serve:	***Check all that apply:***
Geriatric	
Adults	
Teens (13-18)	
Children (3-12)	
Infants & Toddlers (0-2)	
Other (Special)	

Please indicate the services you offer and the services you identify to be your specialties. Your training, experience and supervision for services you offer must meet the standards of your profession. You should only identify as "specialties" services you provide where your training, experience and supervision extend beyond the standards of your profession. These may be areas in which you meet your profession's criteria for specialty guidelines, where you have advanced board certification; or training, experience and supervision that clearly exceeds the expectations of your profession.

Services:	***Services I provide:***	***Specialties***
Agency Consultation		
Behavioral Medicine		
Case Management		
Cognitive Behavioral Therapy		
Consultation		
Dialectical behavior therapy		
Eye movement desensitization and reprocessing		
Family Therapy		
Forensic Practice		
Group therapy		
Home-based services		
Individual Psychotherapy		
Medication Management		
Psychodynamic Psychotherapy		
Psychological Evaluations ➢ Psychological Testing ➢ Neuropsychological Testing		
School Consultation		
Other Services(please identify		

Name:_____

Please indicate the issues you treat in your practice.

Behavioral & Mental Health Concerns:	***Issues I treat:***	***Specialties:***
ADHD		
Adjustment Disorder		
Anger Management		
Anxiety		
Bipolar Disorders		
Chronic Pain		
Depression		
Developmental Disabilities		
Eating Disorders		
Exercise Coaching		
Forensic Psychology		
Gambling		
GLBT		
Grief		
Medication/Treatment Compliance		
Men's Health		
OCD		
Panic Disorder		
Phobias		
PTSD		
Relationships		
Relaxation Training		
School Support		
Sex Therapy		
Sleep Disorders		
Smoking Cessation		
Social Phobia		
Stress Management		
Substance Use Disorders (including Alcohol)		
Traumatic Experiences		
Weight Management and Diet		
Family Issues		
Women's Health		
Other:		

Name:_____

Languages in addition to English in which you practice:

Do you practice under supervision? Yes No

Is your supervisor a RIPCPC member? Yes No

Supervisor's name, address phone and email?

If there is anything else about your practice that you have not been able to express in this questionnaire please attach a note.

I attest that I will provide supporting information regarding the areas of practice and specialties I have endorsed above if requested (under penalty of exclusion from the RIPCPC behavioral health affiliate network):

_____
Print Name

_____
Signature

_____
Date