perinatal outreach
& encouragement

p(for moms)em

A Program of Mental Health America of Franklin County

Provider Questionnaire

Please submit responses via fax, (614) 221-1491 or email to tfulwider@mhafc.org.
If this is an update to an existing listing, only any changes need to be submitted.

1. Do you/your agency provide specialized treatment for **pregnant or parenting women** with mental health complications?

2. Please indicate the type of services and treatment that you/your agency provides for **pregnant or parenting women**. *(Please check all that apply):*
   - ☐ Psychotherapy/Counseling
   - ☐ Medication Management
   - ☐ Other_____
     _____
     _____

3. Do you or your agency clinicians have **specialized training** in maternal mental health complications?
   - ☐ Yes
   - ☐ No

   If yes, what training program did you complete? _____

4. What is your treatment approach for these disorders? *(Please check all that apply)*
   - ☐ Cognitive Behavioral Therapy
   - ☐ Interpersonal Therapy
   - ☐ Group
   - ☐ Other
     _____
     _____
     _____

5. Do you or your agency clinicians have **specialized training or experience** in working with women with perinatal loss?
   - ☐ Yes
   - ☐ No

6. Does your agency have any eligibility requirements to qualify for your services? ☐ Yes ☐ No

   If, yes, please indicate:

7. What payment types do you accept**?
   - ☐ Medicaid (please list accepted plans)_____
   - ☐ Private Insurance (please list accepted plans)_____
     _____
   - ☐ Sliding Scale Fee
   - ☐ Other_____

8. What is your average wait time for scheduling and for an initial appointment? *(Providers with wait times longer than 2 weeks may not be included, unless there are extenuating circumstances.)*

9. Do you refer to other agencies/providers if you are unable to see a client with a maternal mental health complication for any reason? Do you refer for medication management? If so, to whom do you refer?

To what community or educational resources do you refer?

_____

_____

10. What is the best way for patients/clients to access your services?
(Please check all that apply)

☐ Located on the bus line
☐ Available Parking
(Please Circle) Free or Pay

☐ Have weekend/evening hours
If, yes, please indicate:
_____
_____

11. Does your agency provide services in other languages or interpreter services? □ Yes □ No

If, yes, please indicate which languages.

12. **If your request is approved, please complete your contact information to receive referrals:**

Provider Name: _____
Address: _____
_____
Preferred Contact #: _____
Website and email_____

**Providers in Franklin, Delaware and Fairfield counties listed in this directory are strongly encouraged to participate in MHAFC's Pro Bono Counseling Program (PBCP). The minimum participation requirement is 1 client per year, for up 10-15 weeks for session completion. Program participants also receive discounted CEU opportunities. Are you willing to receive additional information about the PBCP? □ Yes □ No (This does not indicate a commitment to participate, nor is it a condition of inclusion in POEM's referral program)

Your listing may also be made available online through mhafc.org. Please consider supporting this service through a donation to the POEM program or a MHAFC professional membership.