



Provider Information to Receive Referrals from Western Highlands Access Group

(please complete this form thoroughly to assist the Access Group with making a successful referral match)

Agency/Provider Name: _____

Office Address (include city/zip): _____

Mailing Address (if different): _____

Phone Number: _____ Fax Number: _____

Email address: _____

What method do you prefer Access use to confirm scheduled appointments (any combination of phone/email/US mail/fax)? _____

Directions to office for clients: _____

Please list your **permanent assessment appointment slots** for regular referrals (ex. every Tuesday at 2 pm for 1 1/2 hours):

DAY OF WEEK	TIME CLIENTS SHOULD ARRIVE	LENGTH OF APPOINTMENT
_____	_____	_____
_____	_____	_____
_____	_____	_____

What counties are you willing to provide services: (check all that apply)

Buncombe	<input type="checkbox"/>	Madison	<input type="checkbox"/>	Mitchell	<input type="checkbox"/>	Yancey	<input type="checkbox"/>	Rutherford	<input type="checkbox"/>	Polk	<input type="checkbox"/>	Henderson	<input type="checkbox"/>	Transylvania	<input type="checkbox"/>
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Emergency Contact Information (for clients that are in crisis and need to reach you, please list in order of step 1, step 2 etc. names and phone numbers of who to contact in your absence, Please also complete and have on file a "First Responder Plan" with the Access department):

NAME

PHONE NUMBER

- 1. _____
- 2. _____
- 3. _____

Other Specific Emergency Instructions: _____

Do you have a **Purchase of Service Contract** with Western Highlands? YES ___ NO ___

Do you have a **Memorandum of Agreement** with Western Highlands? YES ___ NO ___

Do you accept **Medicaid**? YES ___ NO ___ **Medicare**? YES ___ NO ___ **Sliding Scale**? YES ___ NO ___

Health Choice? YES ___ NO ___

Other Insurances accepted: _____

Please list the name and specialty (psychiatry or general practice) of the **MD** that will provide coverage for your clients:

NAME

SPECIALTY

CHECK IF MD WILL DO PATIENT ASSISTANCE PROGRAM PAPERWORK FOR CLIENTS

_____	_____	_____
_____	_____	_____

Ages of Clients you serve (please check):

____ Preschool ____ Children (ages 5-12) ____ Adolescents ____ Adults ____ Geriatric

Please circle populations you wish to serve and/or areas of specialty (if you serve multiple age groups please indicate whether you serve all those age groups in your specialty area(s)):

- Family Therapy Couple Therapy Play Therapy Depression Anxiety
- Severe and Persistent Mental Illness Mood Disorders PTSD Childhood Trauma
- Developmentally Delayed Domestic Violence Sexually Reactive ADHD
- Sex Offender Substance Abuse Learning Disabilities Eating Disorders
- Anger Management Personality Disorders Oppositional Disorders Conduct Disorders
- DBT Pain Management School Problems OTHER: _____

Anything else you want us to know about you or your practice: _____