

CG021 CAREinMIND™ Mental Health Provider

Application Checklist\*

**Mental Health Practitioner Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |
| --- | --- |
|  | **Please tick** |
| **Application Form** |  |
| **Registered for GST – Yes - No** |  |
| **Public Liability/Professional Insurance** |  |
| **Professional registration certificate** |  |
| **National Police check** |  |
| **Working with Children check (Child Mental Health Service)** |  |
| **Resume** |  |
| **No Claim Liability** |  |
| **Mental Health Specialties Form** |  |
| **Evidence of continuing professional development** |  |
| **Evidence of Clinical Supervision** |  |
| **Certificates of Completion of specialised ATAPS online modules – e.g. Suicide Prevention, Child Mental Health, Tele-CBT** |  |
| **Supplier Details Form (for banking purposes)** |  |

**\*Please complete this checklist, and attach as front cover to requested documentation.**

We acknowledge the peoples of the Kulin nation as the Traditional Owners of the land on which our work in the community takes place.

We pay our respects to their Elders past and present.

**Application Form–CAREinMIND Mental Health Professional**

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| --- | --- | --- | --- |
| **Personal Details** | | | |
| **Legal Entity Name & ABN Number** |  | | |
| **Legal Entity Contact Name:** |  | | |
| **Telephone number/ fax number:** |  | | |
| **Email:** |  | | |
| **Postal address for correspondence:** |  | | |
| **Practice address(es):**  **Hours of operation:** |  | | |
| **Profession:** |  | | |
| **Are you fluent in another language for counselling purposes? If yes, please indicate language(s)** |  | | |
| **Are you trained in the use of interpreters?** |  | | |
| **Medicare Provider No (where relevant)** |  | | |
| **Practice Information** | | | **Previously Delivered** |
| **Application to deliver mental health services to the following groups:**  (please tick the relevant service/s you are seeking to provide and **indicate completion of mandatory APS training for– Child Mental Health; Suicide Prevention; ATSI (Cultural Competency); Tele CBT.** | | **General Counselling** |  |
| **Child Mental Health (under 12 yrs age)** |  |
| **Suicide Prevention Service** |  |
| **Aboriginal and Torres Strait Islander** |  |
| **Homeless** |  |
| **Peri-Natal Depression** |  |
| **GLBTIQ** |  |
| **Refugee & Asylum Seekers** |  |
| **Tele CBT/Video counselling** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **I have attached a resume and statement of relevant skills training/professional development** | | **Yes** | **No** |
| **I am registered for GST, for taxation purposes** | | **Yes** | **No** |
| **I am registered as a:**  **(please attach certification)** | | **Trust** | **Association** |
| **Sole Trader** | **Partnership** |
| **Company** |  |
| **I am registered with AHPRA or AASW (attach certification)** | | **Yes** | **No** |
| **I have the required public liability and professional indemnity insurance (attach certifications)** | | **Yes** | **No** |
| **I am aware that I am unable to charge a payment for any client seen under the CAREinMIND mental health programs (including client Did Not Attend)** | | **Yes** | **No** |
| **I have a current National Police Check (attach certifications)** | | **Yes** | **No** |
| **I have a current Working with Children Check – (if applicable if working with young people under 18 yo)- attach certification)** | | **Yes** | **No** |
| **I understand that my business/practice is not reliant on CAREinMIND clients** | | **Yes** | **No** |
|  | | **Yes** | **No** |
|  |  | **For office use:** |  |