Please download the form before filling it up.

Clinician Membership Agreement

Mission

A Home Within seeks to heal the trauma of chronic loss experienced by foster children and to improve the foster care system by building positive lasting relationships and continuous connections through direct services, professional training, public awareness, and advocacy.

Vision

A Home Within will be successful when decision-makers in the foster care system recognize the need for- and ensure that foster children have- continuous connections, stable placements, and positive lasting relationships with clinicians, family, other caring adults, and peers.

Operating Principles

- The trauma of chronic loss impedes all aspects of human development.
- Positive and lasting relationships and the ability to trust others are essential for overcoming the adverse effects of chronic loss.
- Communities of supportive peers and mentors provide vital opportunities for personal growth and education for both foster care youth and individuals working with children and families in the system.
- The foster care system benefits from community support that promotes positive interactions to help children build the bonds that are fundamental to the development of secure, emotionally healthy, productive adults.
- Non-government organizations can facilitate systematic change in foster care through model programs, educational outreach and academic research that documents the impact of continuous connections and lasting relationships.
- To ensure the long-term sustainability of A Home Within and to achieve our vision, we must undertake projects and programs that directly relate to our mission and implement them in a fiscally efficient manner with the highest possible impact.

I support the mission of A Home Within. A Home Within or I may revoke this agreement with written notice. In the event that my association with A Home Within comes to an end I agree that the needs of the children and families served by A Home Within will be given highest priority during the transition.

Please fill this form up using Adobe Acrobat Reader or preview mode and send it back by email to rfay@ahomewithin.org

☐ I am in good standing as a licensed in the state of
license # , date first issued / / .

Our insurance requires that all of our clinicians have a criminal background check. If you have not had one, we will run one at no cost to you.

☐ I have had a criminal background check.

☐ I am working under the license of
See attached verification.

☐ My professional liability carrier is , effective through / /

☐ I agree to notify A Home Within in the event that my license is suspended or revoked and/or of a lapse in my professional liability insurance.

Signature Date / /
Your name

☐ By checking this box I acknowledge that I'm signing an agreement.

☐ By signing this form I agree that all of the above statements are true and accurate.

Contact Information/Referral Preferences Form

Name

Address (including city, state, zip):

Telephone Email

Date / /

Please indicate any preferences you have for AHW referrals

Areas of expertise:

☐ Child ☐ Adolescent
☐ Individual ☐ Family
☐ Testing ☐ Other

Age Groups Preferred

☐ 0-3 ☐ 11-18
☐ 3-6 ☐ 18 +
☐ 6-11

Languages Spoken

Areas of professional interest:

Session Availability

Please include days and times you are available to see an A Home Within client.

How did you hear about A Home Within

- ☐ Friend/Colleague
- ☐ Workshop/Presentation
- ☐ Email
- ☐ Other
- ☐ Mailing
- ☐ Professional Journal
- ☐ Website

Please attach a copy of your license, and malpractice insurance.

Please send a copy of your CV, LinkedIn profile OR fill up the information below.

LinkedIn profile

Name

Highest Degree Earned

Date Received / /

Institution

Areas of Specialization

Professional Experience

Date / / Agency/Organization

Population Served Position

Date / / Agency/Organization

Population Served Position

Date / / Agency/Organization

Population Served Position

Date / / Agency/Organization

Population Served Position

Professional References

Name Telephone

Agency

Name Telephone

Agency

Name Telephone

Agency

Name Telephone

Agency

For Psychological Assistants Only (to be complete by Supervisor)

Clinical Agreement - Clinical Assistant's Supervisor

I understand that _____ who is working under my license, will be
Your name

participating in The Local Chapters of A Home Within, the primary clinical program of A Home Within. This will involve him/her seeing one child or adolescent in weekly therapy and participating in a consultation group. I understand that A Home Within does not provide supervision and that I am legally responsible for all of his/her clinical work, including that done as part of A Home Within.

Name License #

Signature Date / /
Your name

☐ By checking this box I acknowledge that I'm signing an agreement.

☐ By signing this form I agree that all of the above statements are true and accurate.

Please attach a copy of your CV, license, and malpractice insurance.

Once you have filled the form save it and send it
by email to rfay@ahomewithin.org.
Please remember to attach all the files requested.