

## MENTAL HEALTH TECHNICAL ASSISTANCE REQUEST FORM

To aid us in developing the best support for your request please fill in the information below to the best of your ability. What you don't know now, NPCT can aid you in identifying later.

Date:

Department (if applic	abie):		
Contact Person's Ema	nil:		
Organization Mailing	Address 1:		
Address 2:			
City:	State:	Zip:	
Country:			
country.			
Phone Number:	int person for communication	between NPCT and agency. Contact Per	son is expected to

## **TOPICS OF INTEREST**

**Organization Name** 

Please describe your training need in as much detail as possible:

AGENCY'S MENTAL HEALTH EXPERTISE LEVEL: Please describe how long your agency has been providing mental health services, if at all, and how the services are structured (what is provided in-house vs. referred, what types of services or therapies are offered, etc.)
Local Agency Partnership/Network – please identify any mental health referral agencies your agency works with to provide services to your refugee clients.
IN-HOUSE SERVICES PROVIDED: Check all that apply:  R&P Services  Employment Services  Mental Health Screening  Support Groups  Mental Health Treatment  Refugee Medical Health  Referrals  Other  Other
INTERPRETATION - DOES YOUR AGENCY USE:  In-house face-to-face interpretation  Phone Interpretation line  Other:  Are Interpreters trained in refugee issues?
Yes No

## **FUNDING SOURCE(S):**

Check all that apply

Local Grants

Private Funding

Federal
State

Thank you for your submission. Please do not hesitate to add additional information. NPCT will be in touch with you shortly and aid in addressing your request.