AGENCY INFORMATION

Please list information on your agency as a whole and return to the address listed below with the necessary documentation.

1) Agency/Group name: ____

2) Main office address: ____

____

3) Main telephone # of practice: ______________________

4) Main fax # of practice: __________________________

5) E-mail: ____

6) How do you prefer to receive referrals? (Fax or Email) _______________________

7) Do you have any clinicians on staff who are trained to do CISD (Critical Incident Stress Defusing/Debriefing) and would be able to assist us in an emergency situation?

❑Yes ❑No

8) Do you have any clinicians on staff who are able to do telephonic or online counseling?

Telephonic: ❑No ❑ Yes

Online: ❑No ❑Yes – What platform/software? ____________________________

9) Please list contact information for your agency if we have any questions or concerns.

Name/Title_______________________________________

Phone________________________Extension___________Email ____________________

10) Please list any additional offices your practice maintains. (Use a separate sheet if necessary.)

Address: ____

Phone (if different):___________________________Fax (if different): ____________________

Address: ____

Phone (if different):___________________________Fax (if different): ____________________

11) If you have more than one location, referrals should be directed to:

❑ Main office number ❑ Individual office where client will be seen

12) Please list all insurances accepted by your practice (use separate sheet if necessary):

____

____

13) Hours available (generally):

❑ Daytimes ____________ ❑ Evenings ____________ ❑ Weekends ____________