**INDIVIDUAL APPLICATION**

**TO PROVIDE THERAPY SERVICES**

Only one statement of qualifications per individual is required, even if multiple areas are being applied for. Please identify in which of the following area(s) you are applying to provide services:

Practice Areas:

Psychotherapy

Psychological Evaluation  Neuropsychological Evaluation

Domestic Violence Services  Batterer Intervention Services

Specialized Therapy Services \*\*  Alternative Therapeutic Services\*\*

*\*\* Describe Specialized Therapy Services or Alternative Therapeutic Services under Supplemental Question 5*

**Name**:       **Email:**      

**Location of Services Address/City/Zip**:

**Phone**:       **Fax**:

**Billing Address/City/Zip (if different than above)**:

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1. **Are you licensed? Yes**  **No** *If not licensed, are you an intern?* Yes  No

**If an intern, please indicate the name and license information of your Clinical Supervisor:**

**Supervisor Name:**       **Phone:**

**Supervisor E-Mail:**

**Supervisor License:**       **License Number:**

*NOTE: If you are an intern, your Clinical Supervisor is the person with whom Sonoma County Human Services Department will contract and s/he must submit all billing invoices and receive payment from County.*

1. **Do you speak, read, and write Spanish at a professionally fluent level? Yes**  **No**
2. **Client Focus: Adults**  **Teens**  **Preteen**  **Children 6-10**  **Children 0-5**

**Family Therapy**  **Couples**  **Individuals  Group**

1. **Do you accept Medi-Cal? Yes**  **No**
2. **Days and Hours of Operation for therapy appointments:**

**Weekdays: Days and Hours**

**Weekend: Days and Hours**

1. **If applying to provide Batterer Intervention Services, are you certified to provide these services?**

**Yes**  **No**  **If certified, by which agency?**      

**Education: List License & License Number**

Psychiatrist

Psychologist

LCSW

MFT

LPCC

Intern

Batterer Intervention Specialist

Other (explain)

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**Conditions for Contracting with the County**

In order to contract with the County, an individual or agency must meet the following criteria and agree to the criteria by initialing each criteria below.

1. Be legally capable and willing to contract with the County based on Sample Contract.
2. Be able to provide current insurance documents, including cyber liability, as described in the Sample Contract.
3. Be willing to maintain routine communication with referring social workers and testify at court hearings when required.

**Certification**

*To the best of my knowledge and belief, all information in this application is true and correct. The Respondent will comply with all of the requirements of the application process and the subsequent contract with the County.*

*Signature:* *Date:*

*Printed Name:*      

**Please include the following with your Application:**

1. Signed Application including all pages of this document
2. Answers to the supplemental questions 1-5
3. Current Resume (limit of 4 pages)
4. Copy of current License or Certification
5. Proof of Insurance (if not already on file with Human Services Department)

**Send application and all materials to:**

Family, Youth & Children’s Services Division

Attn: Sabrina Johnson

1202 Apollo Way

Santa Rosa, CA 95407

OR Email to: [fyctherapyinfo@schsd.org](mailto:fyctherapyinfo@schsd.org)

**Supplemental Questions – Please respond to questions 1 – 5 on a separate attachment (4 page maximum including the table).**

Responses to these questions will be shared with FYC social workers for the purposes of matching client therapy needs with a therapy provider.

1. Explain in detail experience with providing culturally relevant services to BIPOC and Sexual Orientation and Gender Identity/Expression (SOGIE) clients.
2. Please provide a description of the following:
   1. Your general approach to treatment including how you build relationships with clients.
   2. The types of clinical needs and personality characteristics you have had success in working with and why.
   3. How you assess client readiness for and engagement in treatment.
   4. How you have used treatment plans in your work.
3. Please describe the following:
   1. Experience working with CPS families (if any).
   2. Perspective on the challenges that are particular to families involved with child welfare.
   3. Strategies for repairing alliance ruptures.
   4. Perspective on what are the keys to success to working with this population.
4. **This question is only for those applying to provide Batterer Intervention Services**. Please describe your experience in providing Batterer Intervention services to clients including number of years you have provided the service, specifically what services you have provided, and from which sources you have been provided referrals. If you are not applying to provide Batterer Intervention Services, please indicate with ‘N/A’.

*Please see next page for Question 5.*

1. Please summarize your therapeutic experience providing services in specific Practices in the table below. Please list the service model, years of experience in this Practice Area, examples of types of service provided and any other information you feel is relevant. Please list your experience in any of the Priority Practice Areas (Group Therapy, Bilingual/Bicultural Spanish speaking, Attachment Therapy for families going through the adoption process, therapy services in outlying areas of County, therapy services for youth on the autism spectrum) first.

Please be sure to describe the model of treatment, e.g. CBT, and the format, e.g. group. Strong consideration will be given to evidence-based treatment modalities. Please cite the evidence-base for your proposed model.

| **Practice Area**  (list experience in any of the Priority Practice Areas first) | **Format  (**Individual, Couple, Family and/or Group­) | **Training Received/Certification** | **Years of Experience** | **Is the Modality Evidence-Based or Evidence-Informed**  (if not, please write N/A) | **Client population that is best match**  (Children, Adults, DV survivors, etc.) |
| --- | --- | --- | --- | --- | --- |
| ***e.g.*** *Functional Family Therapy* | *Individual, Couple, Family and/or Group* | *Trained and certified*  *by NIMH* | *4* | *Evidence-based* | *Families with children 5-18* |
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