**AGENCY APPLICATION**

**TO PROVIDE THERAPY SERVICES**

Only one statement of qualifications per agency 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

[ ]  Redwood Children’s Center Therapeutic Services

**Agency Name**:

**Contact Name:**       **Email:**

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

**Phone**:       **Fax**:

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

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**Do you use interns? Yes** [ ]  **No** [ ]

**If yes, please indicate the name and license information of your clinical supervisor:**

**Supervisor Name:**       **Phone:**

**Supervisor E-Mail:**       **License Type:**

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

**Do you accept Medi-Cal? Yes** [ ]  **No** [ ]

**Do you speak, read, and write Spanish at a professionally fluent level. Yes** [ ]  **No** [ ]

**Days and Hours Availability:**

**Weekdays and Day Time Hours**

**Weekdays after 5:00pm**

**Weekend Days and Hours**

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

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

 **List Staff Licenses & License numbers (include interns):**

**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 as described.
3. Be willing to maintain routine communication with referring social workers and testify in court hearings when required.

**Certification**

*To the best of my knowledge and belief, all information in this proposal is true and correct. The Respondent and/or Cosigner 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 (all pages of this document)
2. Answers to the supplemental questions 1-4
3. Copies of Supervising Clinician’s License
4. Proof of Agency Insurance (if already not on file with Human Services Department)

**Send all materials to:**

Attn: Emile Smith

Email: FYCTherapyInfo@schsd.org Or Fax to: 707 565-4399

**Supplemental Questions – Please respond to questions 1 – 4 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 therapeutic needs with a therapy provider.**

1. Please provide a description of your general approach to treatment including how you build relationships; the types of clinical needs and personality characteristics you have had success in working with and why; how you assess client readiness for and engagement in treatment; your language and cultural competency; and how you have used treatment plans in your work.
2. What is your knowledge of/experience with families involved with the Child Welfare System? Please describe the following: your previous work with CPS families (if any); your perspective on the challenges that are particular to families involved with child welfare; your approach to adapting your service design to this population; your strategies for repairing alliance ruptures; and your perspective on what are the keys to success to working with this population.
3. **Batterer Intervention Services Only**: If you are applying to provide Batterer Intervention Services, please describe your experience in providing this service 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 to complete the Table for Question 4.*

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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