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|  | **Saginaw County Community Counseling Directory** **Questionnaire / Application** **2019-2020** |  |

**Please complete every Section**

**Disclaimer: By completing this questionnaire and returning it to Saginaw County Community Mental Health Authority (SCCMHA), you are giving permission to publish in the counseling directory. SCCMHA reserves the right to independently verify any information provided. While SCCMHA intends to be inclusive of all available counseling resources, SCCMHA reserves the right to not publish any provider completing this questionnaire at our own discretion. Any questionnaire received without the certification/disclaimer check box checked and an authorized signature will not be published. This questionnaire must be delivered via US Postal Service, email or fax to the SCCMHA Customer Service Office located at 500 Hancock by October 31, 2018 by 5:00 p.m.**

**Name of Provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: , MI Zip: \_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Director: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Nearest Intersection: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hours of Operation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Weekend Hours: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hours of Psychiatric Service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all applicable License(s)/Certifications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all applicable Accreditations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of Male Therapists: \_\_\_\_\_\_\_\_\_\_ Number of Female Therapists: \_\_\_\_\_\_\_\_\_\_

Therapist willing to do therapy out of office? [ ]  Yes / [ ]  No

Please list your web site address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any bi-cultural staff to provide services? [ ]  Yes / [ ]  No

If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How do you address anyone you serve having Limited English Proficiency? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your agency, you, or any of your staff ever had any Licensing Violations, or other Sanctions? [ ]  Yes / [ ]  No

If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Accessibility** |  | **Availability** |
| Language Assistance |  |  |  | Marriage | [ ]  Yes  | [ ]  No |
|  Spanish Speaking Staff | [ ]  Yes  | [ ]  No |  | Adults:(18 & Up) | [ ]  Yes  | [ ]  No |
| Deaf/Hard of Hearing Interpreter Available | [ ]  Yes  | [ ]  No |  | Children:(6-12 yrs.) | [ ]  Yes  | [ ]  No |
| Other Languages \_\_\_\_\_\_\_\_\_\_\_ | [ ]  Yes  | [ ]  No |  | Adolescent | [ ]  Yes  | [ ]  No |
| Barrier Free/Accessible | [ ]  Yes  | [ ]  No |  | Family | [ ]  Yes  | [ ]  No |
| Near Bus Route | [ ]  Yes  | [ ]  No |  |  |  |  |

If Yes, Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Therapy Focus**

Please list the evidence-based practices (EBPs) you provide and attach proof of training, certification or credentials you have received (in addition to your license and education) to verify your competency in the practice(s). Your signature on this document signifies that you maintain fidelity to the EBPs you have listed. Please spell out any acronyms.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Cultural Diversity**

Please list any specific minority populations you serve and attach proof of your qualifications to provide treatment to those populations: [ ]  Native American Staff; [ ]  African American Staff; [ ]  Hispanic Staff; [ ]  Lesbian, Gay, Bisexual, Transgender, Queer or Questioning (LGBTQ+); [ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Payment/Insurance Information**

Medicaid Accepted: [ ] Yes / [ ] No If yes, please list the names of the Medicaid Health Plans accepted:

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Medicare Type B Accepted; [ ] Yes / [ ] No

Do you accept any commercial insurances? [ ] Yes / [ ] No If yes, which ones?

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Do you have a sliding fee scale? [ ] Yes / [ ] No

[ ]  I have read all information listed on this questionnaire and by signing this questionnaire certify that all information is true and accurate to the best of my knowledge, I certify that I am authorized to sign for the organization listed on this questionnaire, and agree to the terms in the Disclaimer. I also certify that I provide services within the County of Saginaw. This questionnaire must be signed. You will receive confirmation of receipt of your application within 7 days. If you do not receive confirmation please contact Tammy Johnson (contact information below).

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Authorized Signature Date

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Printed Name & Title

 **SEND TO:**

**SCCMHA**

**ATTN: Tammy Johnson Due Date: 10/31/18**

**500 Hancock**

**Saginaw, MI 48602**

***Phone: (989) 797-3436***

***Fax: (989) 797-3595***

**tjohnson@sccmha.org**

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