

NATIONAL COALITION FOR THE PROTECTION OF CHILDREN & FAMILIES

Questionnaire for Counseling Organizations
to be included in the HelpLine Referral Network
HelpLine (1-800-583-2964)

Date _____

Name of Agency/Therapist: _____

Please attach any brochure/flyer(s) from your agency.

Street Address _____

City _____ State _____ Zip Code _____

Business Phone _____ Fax Number _____

Charges for Services:

- Basic Fee \$ _____
 Sliding scale
 Insurance (Please specify) _____
 Willing to offer assistance to those in need

Therapist's Name _____

Email Address _____

Highest Level of Education _____

If practicing under supervision, please list name and phone number of supervisor: _____

Professional Affiliation _____ (i.e. AACC, APA, ACA)

Professional Position:

- Social Worker Psychologist Marriage/Family Counselor
 Psychiatrist Other _____

Are you licensed or certified in your state? yes no

License number or certification number & expiration date:

Do you have malpractice insurance? yes no

Have any disciplinary actions been taken as a result of a claim/suit against you? yes no

If answered yes, what were the results of the findings? _____

Please complete both pages of questionnaire.

Therapist or Agency Information, continued:

Counseling Preferences:

Children Individuals Consultation
 Adolescents Marriage/Family Training
 Adults Group

Counseling Specialties: (Please check all that apply)

AIDS/HIV Forensic Female sexual addiction
 Child Sexual Abuse Homosexual Issues Sexual assault
 Codependency Obsessive/Compulsive Sex offenders
 Court referred Pastors Spouses of sex addicts
 Depression Personality Disorders Spousal/Partner Abuse
 Family Violence Male sexual addiction Trauma/PTSD

Groups: (Please specify type of group)

12-step group _____
 Mutual Support groups _____

Counseling Techniques:

Behavior Modification Gestalt Reality Therapy
 Brief Therapy (Solution Based) Insight Oriented Scripture
 Cognitive Psychodynamic Prayer

If you have indicated the use of prayer and scripture, please give brief summary of how you integrate matters of faith into your therapy process. _____

Counseling References: Please provide the names of two licensed accredited professionals in the field of counseling who are familiar with your work and/or the name of your immediate supervisor.

Please print legibly and include all information requested.

(1) Name _____ Phone _____

Street Address _____

City _____ State _____ Zip _____

Email address: _____

Fax number: _____

(2) Name _____ Phone _____

Street Address _____

City _____ State _____ Zip _____

Email address: _____

Fax number: _____