

The Sexual Assault Center of Pierce County
Provider Referral Application

We appreciate your willingness to take the time to fill out this application. We are often asked for referrals not only for counseling related to sexual assault issues, but also many other issues which we do not treat, such as substance abuse, sex therapy, anger management, offender treatment, and medication monitoring. It is helpful for us, and in turn our clients, to have a comprehensive list of service providers from which to draw.

If you are filling out this application to be listed as a private practitioner, please list information about yourself. If you are filling out the application as a representative of an agency, please list the minimum requirements required for staff. Please use additional paper if necessary.

If you have questions regarding this application, please contact Stephanie Sacks, Clinical Director of Therapy Services, at (253) 597-6424 ext. 14.

Name of Agency or Private Practitioner _____

Business Address _____

Mailing Address (if different) _____

Offices in Other Locations _____

Telephone Number (yours) _____

Fax Number _____ **E-mail Address** _____

Professional Degree(s) _____

Certification/Licensure _____

Type of Treatment/Services Provided

Please circle the types of therapy you provide:

Individual Couples Family Group Other _____

Area(s) of Expertise _____

Would you be willing to provide occasional consultation? _____

Describe your experience, training and approach to treating victims of sexual abuse/assault. _____

What ages do you treat? _____

Are there any types of clients or issues you routinely refer out? _____
If so, please describe _____

Please describe your experience treating individuals from various cultural groups. _____

What are your fees for services? _____

Do you accept: _____Medical Coupons _____CVC _____Private Insurance

Do you offer a sliding fee scale? _____ If so, what is the lowest fee? _____

Would you be willing to provide pro bono work? _____

Do you offer counseling in any languages other than English? _____
If so, which ones? _____

Is your office accessible by public transportation? _____

Have you ever been brought up on ethics or assault charges?_____
If so, please explain:_____

Please list two colleagues (including phone numbers) who can speak to your professional work:_____

Would you like to discuss positive or negative feedback the Sexual Assault Center of Pierce County may receive regarding referrals to your practice? _____ If so, whom may we contact?

Would you be willing to speak with our Clinical Director regarding this application? _____ If so, whom may we contact?

Please attach a resume/CV/data sheet.

I certify that the facts contained in this application are true and complete to the best of my knowledge.

Signature

Date

Thank you for taking the time to fill out this application. Please return it to:

**Stephanie Sacks
Sexual Assault Center of Pierce County
633 North Mildred Street, Suite J
Tacoma, Washington 98406-1725
(253) 597-6424
Fax (253) 597-6443
e-mail: stephanie@sexualassaultcenter.com**