

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**