**REDWOOD CHILDREN’S CENTER (RCC) APPLICATION**

**to provide RCC Evidence-Based Therapy Services**

**Agency/Individual Name**:

**Contact Name:**       **Email:**

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

**Phone**:       **Fax**:

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

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1. **Does agency/individual 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:**

1. **Does agency/individual accept Medi-Cal? Yes** [ ]  **No** [ ]
2. **List Evidence Based interventions used by Agency/Individual.**

1. **Client Focus: Adults** [ ]  **Teens** [ ]  **Preteen** [ ]  **Children 6-10** [ ]  **Children 0-5** [ ]

**Family Therapy** [ ]  **Couples** [ ]  **Individuals [ ]  Group [ ]**

1. **Are there therapists who speak, read, and write Spanish at a professionally fluent level?**

 **Yes** [ ]  **No** [ ]  How many staff are proficient Spanish speakers?

1. **Days and Hours of availability for therapy appointments**

**Weekdays: Days and Hours**

**Weekend: Days and Hours**

1. **List License & License # of staff who will be used to deliver RCC therapy services:**

***Would agency/individual like this application to be used to apply to other therapeutic services as described in this Request for Applications?*** Yes [ ]  No [ ]

***If yes, indicate what other services agency can offer.***

[ ]  Psychotherapy

[ ]  Psychological Evaluation [ ]  Neuropsychological Evaluation

[ ]  Domestic Violence Services [ ]  Batterer Intervention Services

[ ]  Specialized Therapeutic Services \*\* [ ]  Alternative Therapeutic Services\*\*

*\*\* Describe Specialized Therapy Services or Alternative Therapeutic Services under Supplemental Question 5*

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**Conditions for Contracting with the County**

In order to contract with the County, an agency or individual 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, including cyber liability, as described in the Sample Contract.
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 application 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 & Title:*

**Please include the following with agency Application:**

1. Signed Application (all pages of this document)
2. Answers to the supplemental questions 1-6
3. Copy of Supervising Clinician’s License or Individual Therapist License
4. Proof of Agency Insurance – must be current (if already not on file with Human Services Department)

**Send all materials by email to** fyctherapyinfo@schsd.org

**Supplemental Questions – Please respond to questions 1 – 6 as a separate attachment (6-page maximum including the table).**

Responses to these questions will be shared with FY&C social workers for the purposes of matching client therapeutic needs with a therapy provider.

1. Please provide a summary of Supervising Clinician qualifications, a description of the oversight structure, and agency experience in providing therapy services to families. If applying as an individual therapist, please provide a current resume.
2. Explain in detail Agency/individual experience with providing culturally relevant services to BIPOC and Sexual Orientation and Gender Identity/Expression (SOGIE) clients.
3. Please provide a description of the following:
	1. General approach to treatment including how relationships are built with clients.
	2. The types of clinical needs and personality characteristics Agency/individual has had success in working with and why.
	3. How Agency/individual assesses client readiness for and engagement in treatment.
	4. How Agency/individual has used treatment plans in their work.
4. Please describe the following:
	1. Experience working with CPS families (if any).
	2. Perspective on the challenges that are particular to families involved in the child welfare system.
	3. Strategies for repairing alliance ruptures.
	4. Perspective on what are the keys to success to working with this population.
5. **This question is only for those applying to provide Batterer Intervention Services**. Please describe your experience in providing Batterer Intervention services 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 6.*

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 (Culturally relevant services for BIPOC communities, Group Therapy, Bilingual/Bicultural Spanish speaking, therapeutic services for victims of sexual abuse, therapeutic services for youth with high risk behaviors, Attachment Therapy for families going through the adoption process, evidenced based therapeutic practices, therapeutic services for youth on the autism spectrum, therapeutic services in outlying areas of the County..

Please be sure to describe the model of treatment, e.g. CBT, and the format, e.g. group. 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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