**AGENCY APPLICATION**

**TO PROVIDE CHILD WELFARE THERAPEUTIC SERVICES**

Only one statement of qualifications per agency is required, even if multiple areas are being applied for. Please identify in which of the following area(s) you are applying to provide services:

Practice Areas:

Psychotherapy

Psychological Evaluation  Neuropsychological Evaluation

Domestic Violence Services  Batterer Intervention Services

Specialized Therapeutic Services \*\*  Alternative Therapeutic Services\*\*

*\*\* Describe Specialized Therapeutic Services or Alternative Therapeutic Services under Supplemental Question 6*

**Agency Name**:

**Contact Name:**       **Email:**      

**Service Address/City/Zip**:

**Phone**:       **Fax**:

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

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1. **Does agency 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 have therapists who speak, read, and write Spanish at a professionally fluent level?**

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

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

**Family Therapy**  **Couples**  **Individuals  Group**

1. **Does Agency accept Medi-Cal? Yes**  **No**
2. **Days and Hours of Operation for therapy appointments:**

**Weekdays: Days and Hours**

**Weekend: Days and Hours**

1. **If applying to provide Batterer Intervention Services, are you certified to provide these services?**

**Yes**  **No**  **If certified, by which agency?**      

1. **List Staff, License & License numbers (include interns):**

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**Conditions for Contracting with the County**

In order to contract with the County, an individual or agency 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 at 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, including all pages of this document
2. Answers to the supplemental questions 1-6
3. Copy of Supervising Clinician’s 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](mailto: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 FYC 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.
2. Explain in detail Agency 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. Agency’s general approach to treatment including how relationships are built with clients.
   2. The types of clinical needs and personality characteristics Agency has had success in working with and why.
   3. How Agency assesses client readiness for and engagement in treatment.
   4. How Agency 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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