Sidran Institute
TRAUMATIC STRESS EDUCATION & ADVOCACY

Treatment Center Form for Sidran Resource Database

If you have a treatment center that treats clients who have experienced psychological trauma, childhood abuse, or dissociation, the Sidran Institute would like to list your services. To be included in our Treatment Centers Directory, please complete the questionnaire below. There is no charge for inclusion. Please mail completed form to 7220 Muncaster Mill Rd Suite 376 Derwood, MD 20855, or fax the form to us at 410-825-8888, or email to help@sidran.org. Thank You.

Contact Information: (* required information)

*Institution Name: _____

*Name of Trauma Program:_____

*Website:_____

*Clinical Director: _____

*Intake/Contactor Person: _____

*Street Address: _____

*City:_____*State:_____

*Zip Code: _____ *Country: _____

*Phone Number: _____ Extension: _____

Alternate Phone Number: _____ Extension:_____

Fax Number: _____*Year Program Began:_____

*Email (for Administrative Use Only):_____

Public Email (optional): _____

Do you give Sidran permission to share your public email with potential clients? Yes ___No__

*Have you previously submitted your information? Yes___ No___

*Is this institution/program accredited? Yes_____ No_____

If yes, please give the name of the accrediting agency: _____

*Philosophical Orientation (e.g. Spiritual/Religious): _____

*Populations served: Children?☐ Adolescents?☐ Adult Men?☐ Adult Women?☐

* Is your office accessible to people with physical disabilities? Yes☐ No☐

*Are you fluent in any languages other than English (including ASL for the hearing impaired)? ☐ If so, please specify which ones:_____

*Do you treat:

Post Traumatic Stress Disorder?	Yes ☐	No ☐
Dissociative Disorders?	Yes ☐	No ☐
Dissociative Identity Disorder?	Yes ☐	No ☐
Ritual abuse/Mind control?	Yes ☐	No ☐
Borderline Personality Disorder?	Yes ☐	No ☐
Sleep Disorders?	Yes ☐	No ☐
Depressive Disorders?	Yes ☐	No ☐
Anxiety Disorders?	Yes ☐	No ☐
Eating Disorders?	Yes ☐	No ☐
Self-Injury?	Yes ☐	No ☐
Substance Abuse/Dual Diagnosis?	Yes ☐	No ☐
Sexual Orientation/Identity Issues?	Yes ☐	No ☐
Combat Trauma?	Yes ☐	No ☐

Other Relevant Specialties (Please Describe):_____

_____

_____

_____

Services and Capacity:

Inpatient/Residential: Yes ☐ No ☐

What is the Capacity? _____

What is the ratio of staff to clients? Staff:_____ Clients: _____

Please provide a description, admission criteria, and other information a prospective client would need to know: _____

_____

_

_____

_

Emergency Shelter: Yes ☐ No ☐

What is the Capacity? _____

What is the ratio of staff to clients? Staff:_____ Clients: _____

Please provide a description, admission criteria, and other information a prospective client would need to know: _____

_____

_

_____

_

Extended Care: Yes ☐ No ☐

What is the Capacity? _____

What is the ratio of staff to clients? Staff:_____ Clients: _____

Please provide a description, admission criteria, and other information a prospective client would need to know: _____

_____

_____

Transitional Living: Yes ☐ No ☐

What is the Capacity? _____

What is the ratio of staff to clients? Staff:_____ Clients: _____

Please provide a description, admission criteria, and other information a prospective client would need to know: _____

_____

_____

Halfway House: Yes ☐ No ☐

What is the Capacity? _____

What is the ratio of staff to clients? Staff:_____ Clients: _____

Please provide a description, admission criteria, and other information a prospective client would need to know: _____

_____

_____

Intensive Outpatient: Yes ☐ No ☐

What is the Capacity? _____

What is the ratio of staff to clients? Staff:_____ Clients: _____

Please provide a description, admission criteria, and other information a prospective client would need to know: _____

_____

_____

Outpatient/ Walk-in Counseling/ Therapy: Yes ☐ No ☐

What is the Capacity? _____

What is the ratio of staff to clients? Staff:_____ Clients: _____

Please provide a description, admission criteria, and other information a prospective client would need to know: _____

_____

_____

School-Based Program: Yes ☐ No ☐

What is the Capacity? _____

What is the ratio of staff to clients? Staff:_____ Clients: _____

Please provide a description, admission criteria, and other information a prospective client would need to know: _____

_____

_____

Therapy Services:

Do you provide: Individual Therapy? Yes ☐ No ☐

Group Therapy?	Yes ☐	No ☐
Family Therapy?	Yes ☐	No ☐
Couples Therapy?	Yes ☐	No ☐
Therapist-Run Support Groups?	Yes ☐	No ☐
Peer-Run Support Groups?	Yes ☐	No ☐

If you run therapy groups or sponsor peer-run support groups, please describe:_____

_____

_____

_____

How many therapists are in your program? _____

*What adjunctive therapies does your program offer? _____

_____

_____

_____

*Briefly state your Center's treatment philosophy. What issues does your program focus on and how do you treat them? _____

_____

_____

_____

Describe the medical services available at your facility: _____

_____

_____

* Do your therapists have advanced training in trauma/PTSD? Yes ☐ No ☐

Please specify training: _____

_____

_____

*Please describe more about your program's experience in treating trauma/PTSD:

_____

_____

_____

* Do you your therapists have advanced training dissociative disorders/DID? Yes ☐ No ☐

Please specify training: _____

_____

_____

*Please describe more about your program's experience in treating DID:

_____

_____

_____

Institutional Information:

Is your program affiliated with a hospital or medical center? Yes:____ No: _____

If yes, please name the institution and describe the relationship: _____

_____

_____

_____

*Does your program accept: Private Insurance?

	Yes ☐	No ☐
Medicare?	Yes ☐	No ☐
State Assistance?	Yes ☐	No ☐
Payment Plans?	Yes ☐	No ☐
A Sliding Fee Scale?	Yes ☐	No ☐
Financial Assistance?	Yes ☐	No ☐

Please specify which insurance plans you accept:

_____

_____

_____

_____