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): _________________________________


* 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:
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________