



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 7238 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 <input type="checkbox"/>	No <input type="checkbox"/>
Dissociative Disorders?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Dissociative Identity Disorder?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Ritual abuse/Mind control?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Borderline Personality Disorder?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Sleep Disorders?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Depressive Disorders?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Anxiety Disorders?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Eating Disorders?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Self-Injury?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Substance Abuse/Dual Diagnosis?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Sexual Orientation/Identity Issues?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Combat Trauma?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

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: _____

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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: _____

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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: _____

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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: _____

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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 <input type="checkbox"/>	No <input type="checkbox"/>
Family Therapy?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Couples Therapy?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Therapist-Run Support Groups?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Peer-Run Support Groups?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

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 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 <input type="checkbox"/> | No <input type="checkbox"/> |
| Medicare? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| State Assistance? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Payment Plans? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| A Sliding Fee Scale? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Financial Assistance? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

Please specify which insurance plans you accept:
