**L. CONTRACTUAL REQUIREMENTS FOR APPROVAL OF THERAPISTS**

1. To obtain approval of a new therapist complete the CPS Therapist Questionnaire Form and submit with a copy of the therapists resume to:

CPSCollateralReports@Saccounty.net

1. To qualify to provide services under this STC agreement, therapists/counselors/interns must:
2. Be pre-approved via the CPS STC Therapist Questionnaire process.   (See Section M for CPS Therapist Questionnaire Form);
3. Be a Licensed Clinical Social Worker (LCSW); an Associate Clinical Social Worker (ASW); Marriage, Family and
4. Children’s Counselor (MFCC); a Marriage and Family Therapist (MFT); Psychologist; a Registered Psychological Assistant; a Psychological Assistant; or Licensed Professional Clinical Counselor (LPCC);
5. Have demonstrated experience providing brief or STC with a minimum of one year of experience counseling adult clients on issues of physical abuse (perpetrator), neglect/failure to protect, and sexual abuse (perpetrator and non-offending parent);  and
6. Additionally, all therapists (including interns) should be trained in trauma-focused therapy.
7. COUNTY may, at its sole discretion, authorize an intern registered with the Board of Behavioral Sciences or Board of Psychology. Close supervision as defined by the Board of Behavioral Sciences is required for all counseling services provided by interns and intern supervisors must meet the minimum requirements of the Board under which the intern is seeking licensure.
8. Interns must have educational training and counseling experience in the areas of physical, emotional, and/or sexual abuse, neglect or domestic violence.
9. Additionally, COUNTY may, at its sole discretion, authorize use of counselors with a minimum of a Bachelor's Degree and/or equivalent training and experience in anger management or domestic violence for anger management or domestic violence groups. In which case, counselor shall be under the supervision of an LCSW, MFCC, MFT, or Psychologist who must complete the pre- and post-group individual counseling sessions and sign off on all reports.
10. All reports prepared by interns and doctoral students must be reviewed and signed off by the fully-licensed supervising therapist.

 Continue on to Section M, “CPS STC Therapist Questionnaire Form.”

**M. CPS STC THERAPIST QUESTIONNAIRE FORM**

Contractor’s Name: Contractor’s Name. **Date:** Todays Date.

Therapist Name: Therapist Name.

If you are not licensed, please provide the name of your supervising therapist: Supervising Therapist.

ATTACH A COPY OF YOUR RESUME TO THIS FORM.

1. List degrees (including those in progress), date received, and institution:

|  |  |  |
| --- | --- | --- |
| **Degree/Degrees in Progress** | **Date received** | **Institution** |
| Degree | Date Received | Institution Name |
| Degree | Date Received | Institution Name |
| Degree | Date Received | Institution Name |
| Degree | Date Received | Institution Name |

2. List licenses, board certificates, and/or registration number and dates (**Attach a copy of clinical license[s]**):

|  |  |
| --- | --- |
| **License/Board Certificate/Registration Number** | **Date** |
| License/Board Certificate/Registration Number | Enter a Date |
| License/Board Certificate/Registration Number | Enter a Date |
| License/Board Certificate/Registration Number | Enter a Date |
| License/Board Certificate/Registration Number | Enter a Date |

3. Provide a list of completed Continuing Education Unit coursework (recent and/or relevant). Enter Coursework

4. Describe your experience providing counseling for adults and families in each of the following areas:

|  |
| --- |
| **PHYSICAL ABUSE – *PERPETRATOR*** |
| # of years experience: Years of Experience Approx. # of clients served: # of ClientsDescribe: Enter Comments |
| Self Assessment:Level of experience: [ ]  High [ ]  Medium [ ]  Low [ ]  N/A  [ ]  I specialize in this area  |

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|  |
| **PHYSICAL ABUSE – *NON-OFFENDING PARENT*** |
| # of years experience: Years of Experience Approx. # of clients served: # of ClientsDescribe: Enter Comments |
| Self Assessment:Level of experience: ☐ High ☐ Medium ☐ Low ☐ N/A  ☐ I specialize in this area  |

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| **SEXUAL ABUSE – *PERPETRATOR*** |
| # of years experience: Years of Experience Approx. # of clients served: # of ClientsDescribe: Enter Comments |
| Self Assessment:Level of experience: [ ]  High [ ]  Medium [ ]  Low [ ]  N/A  [ ]  I specialize in this area  |
|  |
| **SEXUAL ABUSE – *NON-OFFENDING PARENT*** |
| # of years experience: Years of Experience Approx. # of clients served: # of ClientsDescribe: Enter Comments |
| Self Assessment:Level of experience: [ ]  High [ ]  Medium [ ]  Low [ ]  N/A  [ ]  I specialize in this area  |
|  |
| **NEGLECT/FAILURE TO PROTECT** |
| # of years experience: Years of Experience Approx. # of clients served: # of ClientsDescribe: Enter Comments |
| Self Assessment:Level of experience: [ ]  High [ ]  Medium [ ]  Low [ ]  N/A [ ]  I specialize in this area  |

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| ***FAMILIES DEALING WITH A YOUTH COMING OUT AS LGBTQ AND STRUGGLING WITH ACCEPTANCE*** |
| # of years experience: Years of Experience Approx. # of clients served: # of ClientsDescribe: Enter Comments |
| Self Assessment:Level of experience: [ ]  High [ ]  Medium [ ]  Low [ ]  N/A [ ]  I specialize in this area  |

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| ***FAMILY WHO IS NOT ACCEPTING OF A YOUTH’S LGBTQ IDENTIFY AND WORKING THROUGH GETTING TO ACCEPTANCE AND BECOMING AFFIRMING*** |
| # of years experience: Years of Experience Approx. # of clients served: # of ClientsDescribe: Enter Comments |
| Self Assessment:Level of experience: [ ]  High [ ]  Medium [ ]  Low [ ]  N/A  [ ]  I specialize in this area  |

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| ***FAMILIES DEALING WITH A YOUTH OR FAMILY MEMBER TRANSITIONING***  |
| # of years experience: Years of Experience Approx. # of clients served: # of ClientsDescribe: Enter Comments |
| Self Assessment:Level of experience: [ ]  High [ ]  Medium [ ]  Low [ ]  N/A [ ]  I specialize in this area  |

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| ***ABUSE OR NEGLECT RELATED TO A YOUTH’S LGBTQ IDENTIFY*** |
| # of years experience: Years of Experience Approx. # of clients served: # of ClientsDescribe: Enter Comments |
| Self Assessment:Level of experience: [ ]  High [ ]  Medium [ ]  Low [ ]  N/A [ ]  I specialize in this area  |

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| ***FAMILIES DEALING WITH FAITH BASED ISSUES AND THEIR IMPACT ON LGBTQ YOUTH, IDENTIFY AND ACCEPTANCE*** |
| # of years experience: Years of Experience Approx. # of clients served: # of ClientsDescribe: Enter Comments |
| Self Assessment:Level of experience: [ ]  High [ ]  Medium [ ]  Low [ ]  N/A [ ]  I specialize in this area  |

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| **TRAUMA-*SPECIFIC* *OR TRAUMA-INFORMED* THERAPY** ***AND HOW DO YOU DETERMINE WHETHER THE CLIENT NEEDS TRAUMA-SPECIFIC THERAPY*** |
| # of years experience: Years of Experience Approx. # of clients served: # of ClientsDescribe: Enter Comments |
| Self Assessment:Level of experience: [ ]  High [ ]  Medium [ ]  Low [ ]  N/A [ ]  I specialize in this area  |
|  |
| ***EVIDENCE-BASED MODELS DESIGNED AND TESTED FOR TREATMENT OF TRAUMA-RELATED THERAPY*** |
| # of years experience: Years of Experience Approx. # of clients served: # of ClientsDescribe: Enter Comments |
| Self Assessment:Level of experience: [ ]  High [ ]  Medium [ ]  Low [ ]  N/A [ ]  I specialize in this area  |
|  |
| ***DIALECTICAL BEHAVIORAL THERAPY (DBT)*** |
| # of years experience: Years of Experience Approx. # of clients served: # of ClientsDescribe: Enter Comments |
| Self Assessment:Level of experience: [ ]  High [ ]  Medium [ ]  Low [ ]  N/A [ ]  I specialize in this area  |

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| --- |
| ***BRIEF OR SHORT-TERM MODEL THERAPY (10-12 sessions)*** |
| # of years experience: Years of Experience Approx. # of clients served: # of ClientsDescribe: Enter Comments |
| Self Assessment:Level of experience: [ ]  High [ ]  Medium [ ]  Low [ ]  N/A [ ]  I specialize in this area  |
|  |
| ***FOREIGN LANGUAGE PROFICIENCY*** |
| # of years experience: Years of Experience Approx. # of clients served: # of ClientsDescribe: Enter Comments |
| Self Assessment:Level of experience: [ ]  High [ ]  Medium [ ]  Low [ ]  N/A [ ]  I specialize in this area  |
|  |
| ***CULURAL COMPETENCIES AND HUMILITY*** |
| # of years experience: Years of Experience Approx. # of clients served: # of ClientsDescribe: Enter Comments |
| Self Assessment:Level of experience: [ ]  High [ ]  Medium [ ]  Low [ ]  N/A [ ]  I specialize in this area  |

5. Identify three (3) community-based services that you would, or have recently, transitioned clients into following completion of counseling and why you made the referral. Enter Comments

6. Have you ever been formally disciplined by your credentialing agency or successfully litigated against?

 Yes [ ]  No [ ]  If so, please explain. Enter Comments

7. Have you ever been employed by Sacramento County? Yes [ ]  No [ ]

If currently employed or had been employed by Sacramento County in the past list department(s) and position title(s): Enter Information

 If previously employed by Sacramento County under another name, please identify: Enter Information

8. Have you ever been terminated for cause or released from probation from Sacramento County employment?

 Yes [ ]  No [ ]

9. Do you authorize the County to obtain information regarding your job performance from previous employers?

Yes [ ]  No [ ]  Exceptions: Enter Exceptions

 If yes, please send your employer a letter authorizing release of information and attach a copy to this application.

I certify that the information on this form is accurate to the best of my knowledge.

Applicant’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved by Sacramento County:

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_