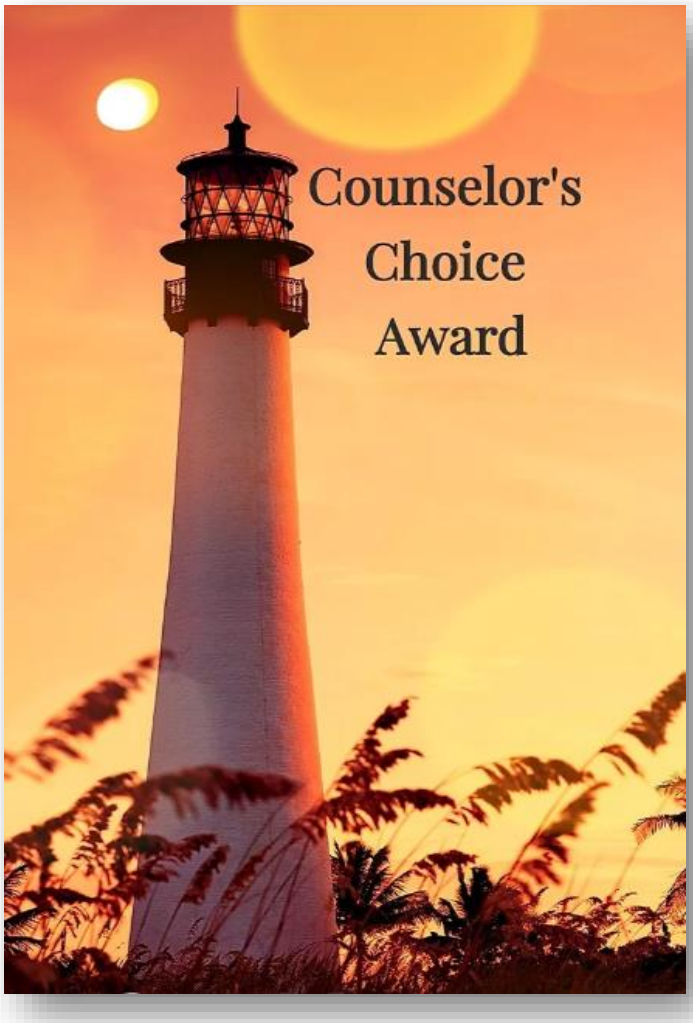

FACILITY OR SERVICE APPLICATION PACKET

www.CounselorsChoiceAward.com

INSTRUCTIONS:

After completing this application, email as an attachment it to LeoDeBroeck@counselorschoiceaward.com

Be sure to submit your payment with the application through the website CounselorsChoiceAward.com

Your application will be reviewed and you will receive and email back confirming your application.

Once your application is reviewed and accepted. Your application will then be distributed to reviewers. This process may take up to 2-6 weeks for the licensed mental health therapists to review your application. If they have any further questions before being accepted for the award, you may be contacted. Once a decision has reached, you will be contacted asking to confirm final information.

If accepted, your facility/service will be given a 100-year license for the Counselor's Choice Award seal and Mark of Distinction. Your facility will be posted on our listings of awarded facilities, a two paper certificates will be sent to you with your facility listed, a digital PDF of the certificate will also be sent to you, you will be given a PNG and JPEG of our Mark of Distinction trademarked logo for use on your business cards, website, social media, retail page, and email signatures.

Primary Contact Information:

First Name: _____ Last Name: _____ Middle Initial: ____

Email address: _____

Telephone:_____ Work ☐ Cell ☐ Other ☐

2nd Telephone:_____ Work ☐ Cell ☐ Other ☐

If applicable:

Title of Profession: _____ Role at Facility: _____

Education: _____ Credentials: _____

Country of Licensure: _____ State of Licensure: _____ License Number: _____

Facility Contact Information:

Facility/Company name: _____

Website URL or Blog: _____

Primary Mailing Address: _____

City: _____

State/Providence: _____

ZipCode/PostalCode: _____

Country: _____

I have submitted payment already to the Counselor's Choice Award for reviewing the facility/service:

Yes ☐ No ☐

I have read and agree to the Counselor's Choice Award Code of Ethics, Privacy Policy, Legal Notices, and accept all responsibilities for the facility/service:

Yes ☐ No ☐

I understand that I am not reimbursed for any time or money spent on research journals/articles purchased.

Yes ☐ No ☐

Are you willing to allow one of Counselor's Choice Award Reviewers who are licensed mental health therapists, tour your facility while supervised? (your facility may not be selected to be reviewed in person)

Yes ☐ No ☐

Does the facility/service contain any material that would be inappropriate for those under the age of 18, chronologically or developmentally?

Yes ☐ No ☐

Is your facility currently or ever been in the past accredited by the Joint Commission?

Yes ☐ No ☐

For publicity and marketing purposes, which status do you prefer as the primary contributor?

☐To remain anonymous

☐To be listed as the contributor.

☐To be added to our Top Contributors page on our website

If chosen, Please include a 200-600 word bio about yourself for the website as a Top Contributor

Describe your facility in one sentence for the website posting:

Describe your facility in one paragraph for the website posting:

Facility/service category (Group practice, private practice, life coach, online smoking cessation or weight loss group etc.): _____

For the following questions, write NA for those that do not apply to your facility/service.

Describe the facility's theoretical model for the treatment of mental health disorders.

Describe the facility's services (e.g. 1:1 counseling, IQ testing, marriage or couple counseling, group therapy, intensive outpatient, EMDR, weekly meetings online or in person, self-help guide or more?)

Does the facility use standardized questionnaires (such as the BDI-II or PHQ-9) or intake interview (such as the SCID) for use with new intakes? If so, which ones:

If any, what kind of peer consultation and/or supervision is available to the clinician(s) on a regular basis?

Does the facility maintain its own crisis line or have any crisis care available?

What are the facility's current hours of operation for clients to be seen?

How many state licensed clinicians are currently practicing at this facility(s): _____

Are there front desk/reception/administration staff available? If so, how many administrative staff are there in total, approximately? _____

On average, approximately how long, in months, and number of sessions do clients stay engaged in services before completing their therapy goals? Months: ____ Session number: _____

As applicable, how many clinicians have joined this facility in the past 12 months: _____

As applicable, how many clinicians have left this facility in the in the past 12 months: _____

What is the policy for the continuation of care for clients when a clinician leaves the facility?

What is the policy for the continuation of care for clients, especially those at high risk, when a clinician takes extended leave from the facility (e.g. Time-off, family emergency, or long term illness)?

What is the average number of clients or sessions a clinician will see or have in an average 40-hour week?

Is there an age range of clients served at this facility? (e.g. Do you serve geriatric or children populations?) If so, what special trainings or accreditations does this facility or staff have to serve that population?

Does this facility serve special populations, including developmentally delayed or those on the autism spectrum? If so, what special trainings or accreditations does this facility or staff have to serve that population?

What is your process for handling intakes for new clients who call in requesting services?

Does your facility accept all referrals, including court ordered clients, violent offenders, sex offenders, children, and hospital discharges at high risk? If, not what is the process for filtering referrals?

How long, in weeks, out does the facility schedule new clients engaging with services? (e.g. if a client calls on January 1st are they seen for their first appointment by February 1st? 4 weeks?): _____

What is the facility's "No Show" policy for the clients it serves? Including payment policy cancellation fee for No-Shows as well as the allowed timeframe to call to change an appointment before a cancellation fee is charged.

Does this facility accept clients who use their state/government insurance to pay for services? If so, approximately what percentage of their caseload currently uses state/government insurance to pay for services?

Do you see clients who are unable to pay? (pro bono) If so, how many hours per week do you see clients unable to pay?

What is the policy for those unable to pay for past services? (e.g. Are they sent to collection services? Do they have to pay their owed debt before being seen again?)

Please include the facility pricing chart for out-of-pocket or cash payment: _____

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