Connecticut Association for Marriage and Family Therapy
Toll-Free Telephone Referral Service
CAMFT Participating Clinical Member Application

Name: ____ **Degree:**_________________

License Type and Number: ____

Office Address: ____

Town:_______________________________ **State:** ____________ **Zip:** __________________

County: _______________________ **Office Telephone Number:** ________________________

Professional Information:

The following information will be used to help the CAMFT Toll Free Telephone Referral Service best match persons who call in for a CAMFT clinical member referral. Please complete the following:

Availability: ☐ Early Mornings ☐ Evenings ☐ Weekends ☐ Other ________________________

Fees: Would you accept clients on a sliding fee scale? Yes ☐ No ☐

Insurance Coverage: Yes ☐ No ☐

Age Group Seen: ☐ Children, ages __________ ☐ Adults
☐ Adolescents, ages _______ ☐ Geriatric

Special Services: ☐ Wheelchair access ☐ Foreign Language _______________________________
☐ Home visits ☐ Court evaluations
☐ Other____

Experience: Number of years in professional practice? _____________________________________

Employment: Please list any employment in addition to private practice: ________________________

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Optional Information:

Sometimes persons who call ask for therapists with specific personal qualities. Please list any personal characteristics you wish to have identified should a caller ask.

☐ Male ☐ Female Date of Birth ____

Veteran: Yes ☐ No ☐ Disabled ____

Ethnic Background ___________________ Sexual Orientation ____

Language Spoken other than English: ____

Religious Orientation ____

Other ____

Name

____

Treatment Specialty Areas:

Please check areas in which you want referrals using the following codes for level of training and experience:

Specialty = 3 Good ability and prefer = 2 Some ability, can do = 1
Won't do = 0

The Subcategories of specialty areas (within the parentheses) reflects the breadth of consumer inquiries and CAMFT's desire to match these inquiries with the best fit provider.

Please use no more than <u>THREE</u> #3 specialties that you would like to have accompanying your listing.

1. ____ABUSE (DOMESTIC, EMOTIONAL, PHYSICAL, SEXUAL, CRISIS INTERVENTION, etc.)
2. ___ ADDICTIONS (ACOA, ALCOHOL DEPENDENCY, CHEMICAL DEPENDENCY, COMPULSIVE BEHAVIORS, EATING DISORDERS, GAMBLING, etc.)
3. ____ FAMILY ISSUES (ADOLESCENT, ADOPTION, PARENTING, ATTENTION DEFICIT DISORDER, BLENDED FAMILIES, CHILD PROBLEMS, SCHOOL PROBLEMS, LEARNING DISABILITIES, DEVELOPMENTAL DISORDERS, etc.)
4. ____ INDIVIDUAL ISSUES (ANXIETY/PHOBIA, DEPRESSION, ANGER MANAGEMENT, ASSERTIVENESS TRAINING, POST-TRAUMATIC STRESS, SLEEP DISORDERS, STRESS MANAGEMENT, LIFE TRANSITIONS, WOMEN'S ISSUES, MEN'S ISSUES, CAREER PLANNING, etc.)
5. ____COUPLES ISSUES (PRE-MARITAL PLANNING, SEXUAL AND INTIMACY ISSUES, INFERTILITY, GAY/LESBIAN/BISEXUAL ISSUES, DIVORCE THERAPY, MEDIATION, etc.)

6. ____ AGING/LOSS (RETIREMENT, ADULT CHILDREN OF AGING PARENTS, GRIEF AND BEREAVEMENT, etc.)
7. ____ MEDICAL-RELATED (AIDS/HIV, CHRONIC ILLNESS, PSYCHOSOMATIC DISORDERS, PAIN MANAGEMENT, WEIGHT CONTROL, PHYSICAL DISABILITIES, MEDICAL MANAGEMENT, SEVERE CLINICAL ISSUES SUCH AS SCHIZOPHRENIA, MANIC-DEPRESSIVE, MULTIPLE PERSONALITY DISORDER, SUICIDE RISK, etc.)
8. ____LEGAL (SEXUAL HARASSMENT, DRUG TESTING, Child Custody, Treatment for Legal Offenders, MENTAL COMPETENCE, Criminal Evaluation, etc.)
9. ____OTHER SERVICES (Professional Training, Psychological Testing, NEURO-PSYCHOLOGICAL TESTING, ORGANIZATIONAL CONSULTING AND TRAINING, RELIGIOUS COUNSELING, BIOFEEDBACK, etc.)

Name ____

Client Base:

Group Type	**Group Meets**	
	Day of Week	**Time of Day**
_____ Women's	___________	___________
_____ Men's	___________	___________
_____ Mixed	___________	___________
_____ Couples	___________	___________
_____ Other _____________	___________	___________

Private Practice Description:

Please write a brief description of your practice (the first 75 words will be used—no brochures accepted). Please type or print. Please include anything unique about your practice. It will be entered into the database along with your name as the person who provides this service.

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