

COMMUNITY AGENCY QUESTIONNAIRE
NC State Counseling Center – Triangle Area, North Carolina

All information on this questionnaire will be entered into the Community Agency Data Base and made available to prospective referrals Please note that our Data Base is part of a growing statewide network of agencies that share community referral information. Any information that you provide may be released to other individuals or agencies.

AGENCY INFORMATION

Agency Name: _____

Phone Number: _____

Address: _____

SERVICE INFORMATION

Description of Services: _____

Eligibility (brief description of clients who are eligible for services):

Fees (be specific; indicate range of sliding scale, if available; payment requirements, etc.):

Hours: _____

Disability Access: _____

Services offered: From the following list, please check the services that are offered by your agency:

- | | |
|--|---|
| <input type="checkbox"/> Abuse Investigation | <input type="checkbox"/> Mediation |
| <input type="checkbox"/> Assessment & Referral | <input type="checkbox"/> Out-of-area Referrals |
| <input type="checkbox"/> Day / Partial Treatment | <input type="checkbox"/> Pastoral Counseling |
| <input type="checkbox"/> Detoxification | <input type="checkbox"/> Psychological Testing |
| <input type="checkbox"/> Educational Programming | <input type="checkbox"/> Psychotherapy (Outpt.) |
| <input type="checkbox"/> Emergency Services | <input type="checkbox"/> Spanish-Speaking |
| <input type="checkbox"/> Group: Psychotherapy | <input type="checkbox"/> Telephone Hotline |
| <input type="checkbox"/> Group: Support | <input type="checkbox"/> 12-Step Program |
| <input type="checkbox"/> Inpatient Hospitalization | <input type="checkbox"/> Other (specify): |
| <input type="checkbox"/> Legal Services | |

Specialty Issues: From the following list, please identify the specialized issues that pertain to your agency:

- | | |
|---|--|
| <input type="checkbox"/> General Mental Health | <input type="checkbox"/> Learning Disabilities |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Men's Issues |
| <input type="checkbox"/> AIDS / HIV | <input type="checkbox"/> Pain Management |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Panic Disorders |
| <input type="checkbox"/> Catastrophic Illness | <input type="checkbox"/> Physical Disabilities |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Sexual Abuse |
| <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Sleep Disorders |
| <input type="checkbox"/> Ethnic Minority Issues | <input type="checkbox"/> Violence |
| <input type="checkbox"/> Gay / Lesbian Issues | <input type="checkbox"/> Women's Issues |
| <input type="checkbox"/> Grief & Loss | <input type="checkbox"/> Other (specify): |

Populations: Please indicate the populations served by your agency:

- | | |
|------------------------------------|---|
| <input type="checkbox"/> Adult | <input type="checkbox"/> Families |
| <input type="checkbox"/> Child | <input type="checkbox"/> Couples |
| <input type="checkbox"/> Geriatric | <input type="checkbox"/> Other (specify): |

Please include any addition information that you believe would be useful to us:

Name of contact person: _____

Thank you for your assistance. Please feel free to send us any brochures or other information that describes your agency.

Return this questionnaire to: Jonna Tobin, Ph.D. (919) 515-2423
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