# REQUEST FOR LISTING

## **Counseling Agencies** in Marathon, Portage, Lincoln, Oneida and Vilas Counties

### Agency Information

Agency Name: _____

Name and Title of Person in Charge: _____

Street Address: _____

City: _____ State: WI Zip Code: _____

Mailing Address (if different from Street Address): _____

Office phone: _____ Fax: _____

Agency Email: _____

Agency Website: _____

Agency Type:

☐ Non-Profit ☐ For-Profit ☐ Faith Based ☐ Coalition/Group ☐ Government ☐ Tribal

Brief description of your Agency:

### Program Information

Program Name: _____

Street Address: _____

City: _____ State: WI Zip Code: _____

Mailing Address (if different from Street Address): _____

Office Phone: _____ Toll-Free: _____

TTY/TDD: _____ Fax: _____

Program Email: _____

Program Website: _____

**Program Contact Information (public contacts):**

Primary Public Contact Person (Name & Title): _____

Phone: _____ Extension: _____ Email: _____

Alternate Public Contact Persons (Name & Title): _____

Phone: _____ Extension: _____ Email: _____

Counseling Services Offered (Please describe):

Therapy Groups Offered:

| Type of Group | Meeting Days/Times |
|---|---|
| | |
| | |
| | |
| | |

Methods/Therapies (check all that apply):

☐ Biofeedback ☐ Behavior Modification ☐ Hypnosis ☐ EMDR ☐ Group ☐ Family
☐ Individual ☐ Couples ☐ Other: _____

Specialties (check all that apply):

☐ Abuse; specify if applicable (e.g., physical abuse, sexual abuse, etc.) _____

☐ Grief/Mourning ☐ Marriage ☐ Sexuality
☐ Co-Dependency ☐ Parenting ☐ Sexual Addiction
☐ Smoking Cessation ☐ Gender Identity ☐ Farmers' Issues
☐ Stress Management ☐ Religious Issues ☐ Sexual Orentation
☐ Head Trauma ☐ Military/Veterans' Issues ☐ Dual Diagnosis
☐ Hoarding ☐ Other: _____

☐ Alcohol Abuse
Specify treatment services: ☐ Assessment ☐ Counseling ☐ Comprehensive Outpatient Treatment
☐ Day Treatment ☐ Other: _____

☐ Drug Abuse
Specify treatment services: ☐ Assessment ☐ Counseling ☐ Comprehensive Outpatient Treatment
☐ Day Treatment ☐ Other: _____

☐ Psychiatric Disorder Counseling
☐ Psychiatrist on staff

Please specify focus areas:

☐ Anxiety ☐ Reactive Attachment Disorder ☐ Bipolar Disorder
☐ Panic Disorder ☐ Hyperactivity/ADD/ADHD ☐ Schizophrenia
☐ Post-Traumatic Stress Disorder ☐ Learning Disabilities
☐ Depression ☐ Obsessive Compulsive Disorder
☐ Eating Disorders ☐ Multiple Personality Disorder
☐ Other: _____

Clientele: (e.g, ages, special demographic, open to all, etc.)

Intake Procedure:

What to Bring to First Appointment:

Fees:

Reimbursement/Payment Plans:

☐ Sliding Fees ☐ Private Pay ☐ Medicare ☐ Medicaid ☐ Badger Care

☐ Private Insurance Other:

Hours of Operation:

Languages Spoken (or Interpreter Service Available):

Geographic Area Served (e.g., city, county, statewide):

Major Source of Funding:

Driving Directions/Bus Route:

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To improve our service to people in Marathon, Portage, Lincoln, Oneida, and Vilas Counties, United Way's *2-1-1* collects American Disability Act (ADA)-related information about access to local programs. Please provide the following information by checking all those that apply.

**Serving People with Physical Disabilities**

☐ Reserved accessible parking is available
☐ Doorways and hallways are at least 36" wide
☐ Elevators accommodate wheelchairs
☐ Building entrance is free from steps and curbs
☐ Restrooms accommodate wheelchairs
☐ Services on ground floor (no elevator needed)

**Serving People with Speech/Hearing Disabilities**

☐ American Sign Language (ASL) interpreters are available on-site

**Serving People with Visual Disabilities**

☐ Information is available via materials in Braille
☐ Information is available via spoken word recordings
☐ Information is available via Large Print materials
☐ Someone is available on-site to read materials one-on-one

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**Person Responsible for Verifying Program Information**

Name & Title:

Phone: Extension: Email:

Contact information be made confidential (not to be given out to the general public): ☐ Yes ☐ No

**I authorize United Way's 2-1-1 to include this information in their resource database and to share with individuals who contact them for information and referrals.**

**May we include your information in our public online database?** ☐ **Yes** ☐ **No**

**May we include your information in our print publications?** ☐ **Yes** ☐ **No**

Your Name & Title: _____

Email: _____ Phone: _____

Today's Date 9/28/16

Please submit this request via email to mschreiber@unitedwaymc.org, or you can print the pages out and fax them or mail them to :

Print Form

United Way's *2-1-1*
United Way of Marathon County
705 S. 24th Ave, Ste. 400B
Wausau, WI 54401
Fax: (715) 848-2929

If you have questions or need assistance filling out the form, please contqact United Way's 2-1-1 Resource Specialists at (715) 848-2927, Monday - Friday, 8:00 - 5:00 p.m.

**Thank you for providing United Way's 2-1-1 with your program's information.**

**Internal Use Only**

Date of Receipt _____

Meets Inclusion Policies _____ Yes _____ No

Staff Name _____

Rev. 6/24/16