ORGANIZATIONAL PROFILE

Name of Organization or Practice: _____

Mailing Address: _____

Phone Number: _____ Website: _____

CEO/Owner: _____ Clinical Director: _____

Name of Person completing this form: _____ Title: _____

Phone Number: _____ Email: _____

Organizational Information:

Please choose one: For-Profit If Non-Profit, are you a registered 501c3? Yes

Accredited: Yes If yes, accrediting body and last date of accreditation: _____

Licensed: Yes If yes, please list license type: _____ Expiration Date: _____

Organizational staff (please indicate how many of each):

_____ LMSW ____ LCSW _____LCSW-C _____ LGPC _____ LCPC _____ LCMFT

_____ Psy.D ____PNP _____ NP _____ MD _____ Other licensed clinicians

Payment accepted (please circle all that apply):

Does not accept insurance | Medicaid | Medicare | Commercial Insurance | Tricare | Sliding Scale

Locations in Maryland (please provide addresses in which services are provided):

Location Name	Street	City	State	Zip

Please describe how your organization embraces a trauma-informed culture:

Please describe how you ensure staff are adequately trained to meet the needs of their clients:

Please describe how clinical supervision or consultation is provided:

Completed by: _____ Title: _____ Date: _____

Signature of Owner/CEO/Clinical Director (please circle): _____ Date: _____