



# Specialized First Responder Treatment Provider Application

Please fill in all highlighted sections. Online version available at: [www.missouricit.org](http://www.missouricit.org)

## CONTACT/AGENCY INFORMATION

Name		Office Hours:	
Title   Degree		Do you accept?	Do you offer?
License #		<input type="checkbox"/> Cash Payments	<input type="checkbox"/> After Hours Appointments
Business Name		<input type="checkbox"/> Pro-Bono Services	<input type="checkbox"/> Private Entrance
		<input type="checkbox"/> Case by case fee assessment	<input type="checkbox"/> Services to Adults
		<input type="checkbox"/> Insurance - Please list insurances accepted:	<input type="checkbox"/> Services to Children
Phone   Fax			<input type="checkbox"/> Services to Families
E-mail			<input type="checkbox"/> Other (please list):
Registered Business Address			
City, State ZIP Code			

## EDUCATION AND EXPERIENCE

Trauma Specific Education and Treatments Offered:	
Experience working with First Responders:	
Have you ever completed a "ride-along"?	<input type="checkbox"/> Yes <input type="checkbox"/> No If so, when?
Is there anything else you would like us to consider?	

## REFERENCES FROM FIRST RESPONDERS (ATTACH ADDITIONAL FORMS AS NEEDED)

1) Name		Phone	
Address		Fax	
City, State ZIP Code		E-mail	
Type of First Responder			

2) Name		Phone	
Address		Fax	
City, State ZIP Code		E-mail	
Type of First Responder			

### AGREEMENT

1. All First Responder information will be kept strictly confidential and I will agree to treat all First Responder information as especially sensitive.
2. I understand that payment for services will come directly from the First Responder or their payer source and not the Missouri State CIT Council or its affiliates.
3. All additional information you wish to be considered shall be attached to this application.
4. Addition of your name and contact information to the Provider Database is voluntary and can be removed by you or the Missouri State CIT Council at any time.
5. By submitting this application, you authorize the MISSOURI STATE CIT COUNCIL WORKING COMMITTEE to make inquiries into your education and experiential background in working with First Responders.

### SIGNATURES

Signature	
Name and Title	
Date	

Please return this form with any attachment(s):

By Mail: MO Coalition for Community Behavioral Healthcare  
Kimberly Hicks  
221 Metro Drive, Suite A  
Jefferson City, MO 65109

By e-mail: [khicks@mocoalition.org](mailto:khicks@mocoalition.org)

Detective Jason Klaus  
State CIT Coordinator  
[jklaus@mocoalition.org](mailto:jklaus@mocoalition.org)  
(573) 547-4576