

Transgender Resource and Referral List Information Form

Please use this form to add or update your organization's information to the Transgender Resource and Referral List. We want to provide our clients with the best possible services and your help is crucial. Information on this form will be provided to anyone requesting the Transgender Resource & Referral.

Name of Individual or Organization _____ Area Served _____

Address _____ City/County, State, Zip _____

Telephone _____ Fax _____ Hotline if applicable _____

Days and hours of operation _____ E-mail address and/or website _____

Do you accept walk-ins? YES NO

Is there a waiting list for services? YES NO If Yes, how long? _____

Services

Which of the following services do you provide for your transgender clients?

- | | | |
|--|---|---|
| <input type="checkbox"/> Primary care services | <input type="checkbox"/> Hormone therapy | <input type="checkbox"/> OB/GYN services |
| <input type="checkbox"/> Dental services | <input type="checkbox"/> Support services | <input type="checkbox"/> Legal services |
| <input type="checkbox"/> Psychiatric services | <input type="checkbox"/> Psychotherapy & Counseling | <input type="checkbox"/> Laser hair removal and/or electrolysis |
| <input type="checkbox"/> Psychological evaluation | (circle: individual / group) | |
| <input type="checkbox"/> Other (please list) _____ | | |

Surgical Procedures

Which of the following surgical procedures do you provide for your transgender clients?

- Genital Reassignment Surgery (GRS) for Male to Female (MTF) transsexuals
- Genital Reassignment Surgery (GRS) for Female to Male (FTM) transsexuals
- Chest surgery for FTMs
- Breast augmentation for MTFs
- Other cosmetic procedures (please list) _____

Payment

Is there a sliding fee scale available? YES NO

Is full fee required at time of services? YES NO

Do you accept Medicaid? YES NO

Do you accept Medicare? YES NO If yes, are there any restrictions? (please list) _____

What insurance plans, if any, does your facility accept? _____

Please check the statements below that are true for you and/or your agency:

- I am currently licensed in the jurisdiction in which I offer service(s).
- I am willing to provide services pro bono to a number of clients that I specify.
- I am cognizant of the Ethical Principles and Standards for my profession.
- I am familiar with the World Professional Association for Transgender Health (formerly the Harry Benjamin International Gender Dysphoria Association) Standards of Care for Gender Identity Disorders.

How long and in what capacity have you worked with the transgender population?

How did you receive your training/knowledge of the transgender population?

How do clients find out about your services?

What is the biggest obstacle for you in providing care to transgender individuals?

What licenses do you currently hold?

Do you provide services to transgender youth clients? If so, please list services.

Do you have persons on site who speak languages other than English? If yes, please list languages.

Do you have transgender staff? YES NO

Do you have handicap access to your facility? YES NO

Name and title of contact person

Telephone

Please return this form to:

Virginia Department of Health, Division of Disease Prevention
ATTN: Ted Heck
Transgender Resource and Referral List
P.O. Box 2448, Room 326
Richmond, VA 23218-2448
Contact Number: 804-864-8012
Fax: 804-864-8053