

# 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 access to services and your help is crucial. Information on this form will be provided to anyone requesting the Transgender Resource & Referral List.

Name of Individual or Organization \_\_\_\_\_ Geographic 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 trans or gender non-binary 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 |
| <input type="checkbox"/> Psychological evaluation  | (circle: individual / group)                        | electrolysis                                       |
| <input type="checkbox"/> Other (please list) _____ |                                                     |                                                    |

## Surgical Procedures

Which of the following surgical procedures do you provide for your trans or gender non-binary clients?

- Not Applicable
- Genital Reassignment Surgery (GRS) for transfeminine or male to female spectrum persons
- Genital Reassignment Surgery (GRS) for transmasculine or female to male spectrum persons
- Chest surgery for transmasculine or female to male spectrum persons
- Breast augmentation for transfeminine or male to female spectrum persons
- Other 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 Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People.

How long and in what capacity have you worked with trans or gender non-binary community members?

\_\_\_\_\_  
\_\_\_\_\_

How did you receive your training/knowledge of trans or gender non-binary communities?

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How do clients find out about your services?

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What is the biggest obstacle for you in providing care to trans or gender non-binary community members?

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What licenses do you currently hold?

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Do you provide services to trans or gender non-binary youth clients? If so, please list services.

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

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Do you have trans or gender non-binary identified staff? YES  NO

Are gender neutral bathrooms available at your facility? YES  NO

Is there handicap access to your facility? YES  NO

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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

Ted.Heck@vdh.virginia.gov