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?

☐ Primary care services
☐ Dental services
☐ Psychiatric services
☐ Psychological evaluation
☐ Hormone therapy
☐ Support services
☐ Psychotherapy & Counseling (circle: individual / group)
☐ OB/GYN services
☐ Legal services
☐ Laser hair removal and/or electrolysis
☐ 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?

_____

_____

How do clients find out about your services?

_____

_____

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

_____

_____

What licenses do you currently hold?

_____

Do you provide services to trans or gender non-binary 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 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 ☐

Please provide two references who can vouch for your work with members of trans and gender non-binary communities:

Name	Phone	Email	Relationship to Provider

_____

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