 Mental Health and Recovery Services

Quality Management Services

**SUD Counselor** Supervision Reporting Form

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| Form Type[ ] NEW [ ]  INFORMATION UPDATE \*Any changes (e.g., name, registration #, supervision status, etc.) must be immediately reported to QMS/MCST. |
| Registered Supervisee Information (select all that apply).[ ] County Employee [ ]  Individual Supervision [ ] CA Consortium of Addiction Programs & Professionals [CCAPP]  or [ ]  Group Supervision [ ] Addiction Counselor Certification Board of CA [ACCBC] [ ] Contract Employee [ ]  Both-2 CSRFs, if different supervisors [ ] CA Association of DUI Treatment Programs [CADTP]Name: Registration Type: Select Registration Type Registration #: Phone:  Email: Program/Clinic: Service Chief/Program Director:  |
| Certified/Licensed Supervisor Information Name: Certified/License Type:Select Certified/License Type Certification/License #: Phone  Email: Program/Clinic:  Service Chief/Program Director:   |
| Supervision Term Start Date:        End Date:

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| If terminating supervision, complete this section: Reason for termination: [ ] Change of Supervisor [ ] Certified [ ] Termination of Employment [ ] Other* If changing supervisor, additionally submit required document(s) for new supervisor
* If certified, date of promotion per HR:
* If terminating employment, date of termination:
* If other, please specify:
 |

SUPERVISOR RECOMMENDATIONS: [ ]  2 SUD CSRFs, if there are multiple supervisors (i.e., group & individual)* Supervisor must be certified or a licensed provider.
* Possess a current and active certification/license.
* Weekly Supervision is recommended until the supervisee is certified.
* Supervisors are to stay current with the CCAAPP, ACCBC and CADTP requirements.
* It is the responsibility of the direct supervisor to ensure the registered staff meets the CCAPP, ACCBC or CADTP requirements.
* Supervision shall be provided and documented for ALL registered/waivered employees, interns, and volunteers. If supervision is not provided the individual is prohibited from providing and billing services.
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| I certify that I understand the responsibilities regarding supervision and that the supervision provided meets the requirements as specified by the certifying organization. I attest that the information submitted on this form is true and correct:Registered Supervisee Signature Date Certified/Licensed Supervisor Signature Date  |

\*Please complete in full and submit to: AQISManagedCare@ochca.com Subject Line: Clinical Supervision. For questions, please contact QMS main line: 714-834-5601.

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 SUD Counselor Supervision Reporting Form

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| SUD Counselor Supervisor InformationName of Primary Counselor Supervisor:Date:   |
| List of All Current Supervisees

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| --- | --- | --- | --- |
|  Name(s) of Current Supervisee(s) |  Type of Supervision |  Program Name | Supervisee Classification |
|  Example: Jane Doe | [x]  Group [ ]  Individual |  SUD: Westminster/ART |  RAC |
|  | [ ]  Group [ ]  Individual |  |  |
|  | [ ]  Group [ ]  Individual |  |  |
|  | [ ]  Group [ ]  Individual |  |  |
|  | [ ]  Group [ ]  Individual |  |  |
|  | [ ]  Group [ ]  Individual |  |  |
|  | [ ]  Group [ ]  Individual |  |  |
|  | [ ]  Group [ ]  Individual |  |  |
|  | [ ]  Group [ ]  Individual |  |  |
|  | [ ]  Group [ ]  Individual |  |  |
|  | [ ]  Group [ ]  Individual |  |  |

**\*\*\* Reminder: If counselor supervision is terminated for any reason, a SUD CSRF with the end date is required.** |
| \*Please complete in full and submit to: AQISManagedCare@ochca.com. For questions, please contact QMS main line: 714-834-5601. |