 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:   |  | | --- | | 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. |
| 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](mailto:AQISManagedCare@ochca.com) Subject Line: Clinical Supervision. For questions, please contact QMS main line: 714-834-5601.

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| SUD Counselor Supervisor Information  Name of Primary Counselor Supervisor:  Date: |
| List of **All** Current Supervisees   |  |  |  |  | | --- | --- | --- | --- | | Name(s) of Current Supervisee(s) | Type of Supervision | Program Name | Supervisee Classification | | Example: Jane Doe | 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.](mailto:AQISManagedCare@ochca.com) For questions, please contact QMS main line: 714-834-5601. |