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**Authority & Quality Improvement Services (AQIS)**

**Adult & Older Adult Behavioral Health Support Team**

**Notice of Licensure Status and Qualifications**

Your assigned provider, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, is a:

 Provider Name

🞎 Registered Associate Clinical Social Worker (Registration #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

🞎 Registered Associate Marriage and Family Therapist (Registration #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

🞎 Registered Associate Professional Clinical Counselor (Registration #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

🞎 Registered/Waivered Psychologist (Registration #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

🞎 Other Non-Licensed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Registration #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

As an unlicensed clinician, he/she practices under the supervision of a licensed clinical supervisor, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

 Clinical Supervisor Name / Clinical Supervisor License Type & Number

As a member of the care team, your provider will also be consulting with your Psychiatrist/Nurse Practitioner and the rest of the care team as needed to coordinate and provide treatment.

Everything discussed with any team members will be held in strict confidence with exceptions as mandated by law. Please refer to the *Notice of Privacy Practices* provided to you at the time of initial intake appointment for the exceptions to confidentiality.

I have read and understand the above.

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

Client Name Client/Representative Signature Date

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

Provider/Witness Name Provider/Witness Signature Date