



Behavioral Health Services: Quality Management Services Clinical Supervision Reporting Form

STATUS UPDATE:

NEW

INFORMATION UPDATE *Any changes (e.g., name, registration #, supervision status, etc.)

County Employee

Individual Supervision

Adult and Older Adult [AOA]

Group Supervision

Children and Youth Services [CYS]

Contract Employee

Both- 2 CSRFs, if 2 different supervisors

Drug Medi-Cal Organized Delivery System [DMC-ODS]

ClinicalTrainee: *An unlicensed individual who is enrolled in a post-secondary educational degree program that is required for the individual to obtain licensure as a Licensed Mental Health Professional or Licensed Practitioner of the Healing Arts; is participating in a practicum, clerkship or internship approved by the individual's program; and meets all relevant requirements of the program and /or applicable licensing board to participate in the practicum, clerkship or internship and provides rehabilitative mental health services or substance use disorder treatment services, including, but not limited to, all coursework and supervised practice requirements.*

SUPERVISEE INFORMATION:

NPI #:

Supervisee Name:

Phone:

Registration Type:

Registration #:
(if applicable)

Other:

Email:

Program:

Service Chief/Program Director:

CLINICAL SUPERVISOR INFORMATION:

Name:

NPI #:

License Type:

License #:

Phone:

Email:

Program:

Service Chief/ Program Director:

SUPERVISION TERM:

Start Date:

End Date:

REASON FOR TERMINATING CLINICAL SUPERVISION:

Termination of Employment (enter date of separation):

Change of Supervisor

Became Licensed (enter date of license):

Other, please specify:

CHECKLIST OF DOCUMENTS REQUIRED TO SUBMIT TO MCST:

BBS Supervisor Self-Assessment Report Form BBS

BBS Live-Scan Services Form-BBS 90 Day Rule (Contracted Only)

BBS Written Oversight Agreement (if applicable)

2 CSRFs, if there are multiple supervisors (i.e. group & individual)

BBS or BOP Supervision Agreement Form

Clinical Supervisor Agreement Form (County Only)

DHCS Mental Health Professional Licensing Waiver (Psychologist only)

I certify that I understand the responsibilities regarding clinical supervision and that the clinical supervision provided meets the requirements as specified by the Board. I attest that the information submitted on this form is true and correct:

Registered/Waivered Supervisee Signature

Date

Licensed Clinical Supervisor Signature

Date

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



Clinical Supervision Reporting Form

Clinical Supervisor Information

Date:

Name of Primary Clinical Supervisor:

List of All Current Supervisees

Name(s) of Current Supervisee(s)	Type of Supervision	Program Name	Supervisee Classification
Example: Jane Doe	<input checked="" type="checkbox"/> Group <input type="checkbox"/> Individual	AOA: Anaheim Clinic	ASW
<input type="text"/>	<input type="checkbox"/> Group <input type="checkbox"/> Individual	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="checkbox"/> Group <input type="checkbox"/> Individual	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="checkbox"/> Group <input type="checkbox"/> Individual	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="checkbox"/> Group <input type="checkbox"/> Individual	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="checkbox"/> Group <input type="checkbox"/> Individual	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="checkbox"/> Group <input type="checkbox"/> Individual	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="checkbox"/> Group <input type="checkbox"/> Individual	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="checkbox"/> Group <input type="checkbox"/> Individual	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="checkbox"/> Group <input type="checkbox"/> Individual	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="checkbox"/> Group <input type="checkbox"/> Individual	<input type="text"/>	<input type="text"/>

***** Reminder: If clinical supervision is terminated for any reason, a 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.