Behavioral Health Services
Quality Management Services

Qualified Provider Supervision Form

Instructions: Refer to the Other Qualified Provider Type Matrix on page 2 to identify the correct provider type.

STATUS TYPE

☐ NEW ☐ INFORMATION UPDATE *Any changes (e.g., name, provider type, supervision status, etc.)

QUALIFIED PROVIDER (QP) INFORMATION (select all that apply)

☐ County Employee ☐ Contracted Employee ☐ Children & Youth Services ☐ Adult & Older Adult ☐ Drug Medi-Cal Organized Delivery System

Name: Phone #: NPI #:

Provider Type: Select Provider Type CPSS # (If Applicable):

Job Title: Email:

Clinic/Program: Service Chief/ Program Director:

SUPERVISOR INFORMATION:

Name: Phone #: NPI #:

Provider Type: Select Provider Type: License/Registration #: Email:

Clinic/Program: Service Chief/ Program Director:

For Certified Peer Support Specialist Supervision Only

ATTESTATION REQUIREMENT

I confirm as the supervisor for a Certified Peer Support Specialist, I have completed the CalMHSA Supervision of Peer Workers Training.

☐ **I agree to the Certified Peer Support Specialist Attestation** **CalMHSA Training Completed on :**

SUPERVISION TERM:

Start Date: End Date:

REASON FOR TERMINATING SUPERVISION:

☐ Termination of Employment (enter date of separation): ☐ Change of Supervisor

☐ Became Licensed-Waivered (enter date of registration): (REQUIRED: Complete the Clinical Supervision Reporting Form)

☐ Other, please specify:

I attest that this provider meets the qualifications , experience, and criteria for Other Qualified Provider (OQP), CPSS, or MHRS in the Behavioral Health Plan. I confirm that supervision will be provided regularly and that all services provided are directed by the identified LPHA/LMHP. I will ensure that the provider signs their documentation within the scope of their assignment.

Qualified Provider Signature Date

Supervisor Signature Date

Licensed Clinical Supervisor Signature (required if supervisor is not licensed.) Date

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

Other Qualified Provider Type Matrix

BEHAVIORAL HEALTH PLAN PROVIDER TYPE	Mental Health Rehabilitation Specialist (MHRS) Specialty Mental Health Services (SMHS) ONLY	Other Qualified Provider II SMHS ONLY	Other Qualified Provider I SMHS ONLY	Certified Peer Support Specialist (CPSS)
EDUCATION	BA/BS or AA (in a related field) +2 years post AA clinical experience	High School Diploma or GED	High School Diploma or GED	High School Diploma or GED
WORK EXPERIENCE	Plus, four years of experience in a mental health setting as a specialist in the fields of physical restoration, social adjustment, or vocational adjustment. NOTE: Up to 2 years of graduate professional education may be substituted for the experience requirement on a year-for-year basis.	Plus, four years of related paid or non-paid experience in mental health service provision. NOTE: (A) Completion of an AA degree in a related field may be used to substitute up to 1 year of the required related paid or non-paid experience in mental health service provision. (B) Completion of an BA/BS degree in a related field may be used to substitute up to 2 years of the required related paid or non-paid experience in mental health service provision.	Two years of related paid or non-paid experience (including experience as a service recipient or caregiver of a service recipient).	Certification from CalMHSA
OTHER QUALIFICATIONS	Age 18+	Age 18+	Age 18 +	Age 18+
ALLOWABLE SERVICES	•Contribute to Assessment: Mental Health History, Medication History; Substance Use, Strengths, Risks, Barriers •Problem List/Care Plan •Rehabilitation •Targeted Case Management •Intensive Home-Based Services •Intensive Care Coordination •Mobile Crisis •Crisis Intervention	•Contribute to Assessment: Mental Health History, Medication History; Substance Use, Strengths, Risks, Barriers •Problem List/Care Plan •Rehabilitation •Targeted Case Management •Intensive Home-Based Services •Intensive Care Coordination	•Problem List/Care Plan •Targeted Case Management •Intensive Case Coordination	•Problem List •Self-Help/Peer Services •Behavioral Health Prevention Education Services •Mobile Crisis •Peer Support Specialist Plan of Care
All Specialty Mental Health Services MUST be reccomended by physicians or other LPHAs/LMHPs acting within their scope of practice and in accord with medical necessity.				
SUPERVISION REQUIREMENTS	•MHRS requires close supervision if issues of DTS or DTO are present. •If the MHRS direct supervisor is NOT an LMHP then, the Qualified Provider Supervision Form requires an LMHP signature.	•OQP II requires close supervision if issues of DTS or DTO are present. •If the OQP II direct supervisor is NOT an LMHP then, the Qualified Provider Supervision Form requires an LMHP signature.	•OQP I requires close supervision if issues of DTS or DTO are present. •If the OQP I direct supervisor is NOT an LMHP then, the Qualified Provider Supervision Form requires an LMHP signature.	•Medi-Cal Peer Support Specialists must be supervised by a supervisor who has completed a DHCS approved Peer Support Supervisory training within 60 days of begining to supervise a Medi-Cal Peer Support Specialist. •If the Medi-Cal Peer Support direct supervisor is NOT an LPHA/LMHP then, the Qualified Provider Supervision Form requires an LPHA/LMHP signature.

NOTE: If you have questions about determining which provider type best fits your program needs, contact your support team at BHPAOASupport@ochca.com or BHPCYSSupport@ochca.com.