Clinical Supervision Pre-Audit Survey and Staff Attestation

Agency: _____

*Please complete the table and questions below for each of your service locations. (Use additional sheets if necessary)

Service Location Street Address	Staff Name	Designation (Clinical Supervisor QP, QP Trainee)	For QP & QP Trainee: Is There a current Intensive Supervision Plan in Place? (Y/N)

1. Are your Clinical Supervision records stored at each of your site locations?

   ☐ YES ☐ NO

2. If no, which site (s) holds the records?

   _____

3. Does your Clinical Supervisor meet the clinical supervision standards as outlined in IDAPA?

   ☐ YES ☐ NO

4. What level of training has your Clinical Supervisor completed (CS I, CS II, CS III)? ☐ CS I ☐CS II ☐CS III

5. Does your Clinical Supervisor conduct direct clinical observations?

   ☐ YES ☐ NO

6. How many hours per month is your Clinical Supervisor on site?? _____

In accordance with the contractual obligations of the Business Psychology Associates Substance Abuse Provider

Agreement section 2.4:

2.4 Provider shall maintain all required licenses to practice in the state(s) in which services are rendered and operate in compliance therewith. Provider shall maintain all required licenses and be in compliance with State and Federal laws and regulations, including, but not limited to Qualified Professional status as defined in IDAPA 16.06.03, and other Idaho Department of Health and Welfare policies

ATTESTATION:

I, the undersigned applicant, hereby attest and certify that to the best of my knowledge, each individual listed on this roster meets all qualifications and standards of a Clinical Supervisor as outlined in the documents Supervision for Dual Diagnosis Enhance Programs and Clinical Supervision for Non-Dual Diagnosis Enhance Programs and has been approved to provide Clinical Supervision by the Clinical Change Team through BPA. Additionally, I attest and certify that the individuals listed are providing clinical supervision to all staff providing direct care to BPA clients as outlined in the NFATTC model, the Supervision Guidelines and Idaho's guidelines and has attended, or will attend NFATTC model Clinical Supervision Training within 6 months of hire as a Clinical Supervisor. I hereby attest and certify that to the best of my knowledge each individual listed above is free of any physical or mental health impairments and impairment due to chemical dependency or substance abuse that would adversely affect their ability to deliver the care expected of the profession. I also attest that if any of the above listed individuals provide direct client services under my contract with BPA they are provided clinical supervision following the same requirements as all other staff and the clinical supervision file is maintained at this agency.

I also attest and certify that this agency holds an employee or contractor record of each of the individuals listed which includes the employee's certificate or license, resume or job application, current TB test and Criminal background check, if applicable, to document the employee meeting all requirements of a Clinical Supervisor.

I also attest and certify that this document has been completed truthfully and accurately. I understand that falsification of information on this document or substantial error of fact involving documents discovered can be grounds for termination of present and/or future contracts with BPA.

A photocopy of this document will serve as the original. I understand that BPA or its designee will use this information in confidence and only in conjunction with this application.

_____ _____

Director's Signature Date

_____ _____

Print Name Organization Name