Alabama Medicaid Agency

SUPERVISION CONTRACT

THIS FORM IS TO BE COMPLETED BY THE SUPERVISOR AND THE SUPERVISEE

NOTE: In areas of practice in which the supervisor is not qualified, an additional supervisor(s) should be sought who can monitor the work of the allied mental health professional in those practice areas. Likewise, if the supervisor believes he or she cannot insure the allied mental health professional is meeting the above standards in all of the various settings of his/her practice, an additional supervisor(s) should be sought to contract and assume responsibility for the work of the allied mental health professional in his/her various practice settings.

SECTION A. GENERAL INFORMATION

Psychologist (Supervisor) Name:_____
Degree Type: □ PhD □ PsyD □ Other:_____

AMHP Licensed (Supervisee) Name:_____
Licensed Type: □ ALC □ LPC □ LMFT □ LCSW □ LGSW □ LGSW/PIP □ LPT
□ Other:_____
OR

AMHP Non-Licensed (Supervisee) Name:_____
Master Degree Type:_____
1. □ Copy of undergraduate degree 2. □ Copy of graduate degree
and
3. □ Graduate transcript with practicum
OR
3. □ Letters of supervision from experienced licensed mental health professional to satisfy clinical supervision requirements

PLEASE PROVIDE "ALL" INFORMATION

Business Name (Where relationship is established**):**

_____

Business Address (No Post Office Box-Where relationship is established**):**

_____

Business Contact Person (Where relationship is established**):**

_____

Business Telephone Number and Email (Where relationship is established**) :**

_____

NOTE* FOR PROPER COMPLETION, PLEASE REFER TO THE ALABAMA MEDICAID AGENCY PROVIDER MANUAL CHAPTER 34 SECTION 34.1.

SECTION B. LICENSED PSYCHOLOGIST (SUPERVISOR)

I,_____ am agreeing to supervise_____ . As the supervisor, I assume legal, professional and ethical responsibility for the work that (s)he performs in the course of his/her professional relationship. I agree to monitor and insure that (s)he is working within his/her professional competence/scope and is meeting all standards of the Alabama Medicaid Agency and the applicable professional licensing board's rules and regulations. I accept responsibility for all professional activities covered by this contract. I have read and understand all applicable law, rules and ethical requirements.

Please complete the following information:

The allied mental health professional (supervisee) named herein will perform the following Medicaid reimbursable activities and services:

_____
_____
_____
_____

Describe where the services will be performed and how you will maintain continued supervision:

_____
_____
_____
_____

Please describe the basis of your expertise to adequately supervise the allied mental health professional (supervisee) in the specific activities and services that will be performed:

_____
_____
_____
_____

Please read statement (and attest to) the following / initial #14, and #15 as applicable:

I do not have a dual role relationship with the allied mental health professional that might impair my objectivity or otherwise interfere with my effectively performing the functions as a supervisor or which might harm or exploit him/her.

I am fully informed regarding the allied mental health professional's educational and experiential background, including, but not limited to, psychological work under previous supervision, professional training, workshops, and continuing education.

I will review on an ongoing basis all psychological work requiring supervision of the allied mental health professional.

I will review and co-sign reports and other appropriate documents (which include reports, evaluations, notes from treatment sessions, files and other clinical material of the licensee relevant to his or her practice).

I will insure the written notification to clients or patients of the supervisory process, including the disclosure of clinical information to me and the means by which I may be contacted.

I will offer and provide supervision only within the area of my competence and will insure that my professional expertise and experience is congruent with the practice of the supervisee.

I will direct the supervisee to practice only within the areas for which he or she is qualified by education, training and supervised experience.

I will establish and maintain a level of supervisory contact consistent with established professional standards and requirements of the Alabama Medicaid Agency Provider Manual Chapter 34, and remain accessible to the supervisee and his or her clients.

I will direct the supervisee to keep me informed of services provided by supervisee.

If I have reason to believe that the supervisee is practicing in a manner which indicates that ethical or legal violations have been committed, I shall proceed as prescribed by the most recent version of the Code of Ethics of the American Psychological Association.

I will maintain a clear and accurate record of supervision with the supervisee**.**

I will file a final supervision report with the Alabama Medicaid Agency within two weeks of the termination of supervision.

I am informed of the Ethical Principles of Psychologists and Code of Conduct and General Guidelines for Providers of Psychological Services of the American Psychological Association.

14. _____ I will assume responsibility for supervising the allied mental health professional in all settings in which he/she will be practicing.

OR

15. _____ I will not be supervising the allied mental health professional in all settings in which he/she will be practicing. (*Please answer #16 if you checked #15*). Listed below are the areas in which I will not be supervising the allied mental health professional:

_____
_____
_____
_____

16. Please explain why you are not supervising the licensee in all settings in which he/she works:

_____
_____
_____
_____

17. I understand that providing supervision which violates the Alabama Board of Examiners in Psychology's Rules and Regulations or the Alabama Psychology Law may result in the Alabama Medicaid Agency revoking my Medicaid privileges and/or reporting me to the above named agency for potential disciplinary action, i.e. suspension, probation, required remediation, revocation of license to practice as a psychologist, or any other action deemed appropriate by the Board.

Indicate any and all prior relationships between you and the supervisee:

_____
_____
_____
_____

- or -

□ No prior relationship

I declare under penalty of perjury under the laws of the State of Alabama that I have read and fully understand and I am acting in accordance with all of the above and will not provide supervision to the allied mental health professional named herein in areas outside of competencies of my license to practice as a Licensed Psychologist Supervisor.

As supervisor, I assume responsibility for the practice of the individual contracted under my supervision. I hereby agree to this supervision contract which is being filed with the Alabama Medicaid Agency. I further attest that I have read and understand the policy pertaining to allied mental health supervision according to Chapter 34 of the Alabama Medicaid Agency Provider Manual.

I understand that billing for services without the Supervision Contract being on file may result in recoupment of the paid claims in question ***and*** additional action as deemed necessary by the Alabama Medicaid Agency including referral to law enforcement agencies.

"NOTE: The provider's signature on a claim form/medical submission agreement, or the Provider Agreement, confirms that the services filed were medically necessary and performed

by the provider or supervised by the provider; that all information on the unpaid claim is factual and complete; and that the provider understands the claim will be paid from federal and state funds and any falsification or concealment of a material fact may lead to the provider being prosecuted under both federal and state laws."

Print Supervisor/Psychologist Name:_____

Signature of Supervisor/Psychologist:_____

Date: _____ Psychologist NPI:_____

Signature must be legible

SECTION C. ALLIED MENTAL HEALTH PROFESSIONAL (SUPERVISEE)

I, _____ am applying for approval of _____ , a licensed psychologist, to supervise me as an allied mental health professional in the field of _____. I acknowledge that I have read and understand the law, rules and ethics pertaining to the practice of psychology. I do further understand that approval granted under law is for psychological activities and services as defined in the Alabama Medicaid Agency Provider Manual Chapter 34 and the rules and regulations as set forth by my governing state licensure and examination board. I am aware that I am prohibited from using the title "Psychologist" and that the prohibition is not countermanded by this approval. I have read the statements made by the proposed supervisor in Section A and agree with them.

Please read and attest to the following:

I will attend all scheduled supervision sessions.

I will provide the supervisor with a disclosure of all psychological services being offered or rendered by me.

I will cooperate fully with the supervisor to assure that all conditions of the supervision are fulfilled.

I will provide the supervisor with all information necessary for the supervisor to advise me on cases presenting professional, ethical, or legal concerns.

I will file a revised supervision contract form within 45 days of a change in the conditions specified in the supervision contract form on file with the Alabama Medicaid Agency.

I will obtain a written, signed consent from each patient or client that informs them that for billing purposes, I may need to release/share clinical information with our agency-enrolled psychologist. **(*This requirement may be fulfilled as a part of the Informed Consent Document and does not require a separate sheet*).**

I understand that providing services which violates the Alabama Board of Examiners and/or the Administrative Code law for my specific discipline may result in the Alabama Medicaid Agency revoking my Medicaid privileges and/or reporting me to the appropriate above named agency (of my specific discipline) for potential disciplinary action, i.e. suspension, probation, required remediation, revocation of license to practice as an allied mental health professional, or any other action deemed appropriate by the Board.

I agree that the initial supervision contract form shall be filed with and accepted by the Alabama Medicaid Agency prior to any practice.

I agree that a separate supervision contract form shall be filed for each separate work setting. If receiving supervision from more than one supervisor to meet minimum requirements, a separate supervision contract form shall be filed for each individual supervisor.

I understand that additional supervision and reporting to the Alabama Medicaid Agency may be required. I understand and agree to cooperate fully with requests for additional documentation that may be required if questions arise regarding my practice or other investigatory procedures.

I agree that supervision shall be provided in face-to-face and primarily one-on-one sessions by the supervisor of record. The rate of supervision specified as set forth in Alabama Medicaid Agency Provider Manual Chapter 34 shall be provided for each separate work setting in which I engage in an activity requiring supervision.

Print Supervisee Name:_____

Signature of Supervisee: _____

Date: _____

Signature must be legible

*Upon the acceptance or rejection of the supervision contract the Alabama Medicaid Agency does not assume any liabilities for the parties to the contract.