CREDIT FOR WORK EXPERIENCE FORM

DOMAIN 2: COMMUNITY INTEGRATION & INCLUSION

Name of Applicant: _____

Name of Clinical Supervisor*: _____

The Clinical Supervisor must have provided direct clinical supervision to the applicant during the time frame referenced in this request and must be a Master's level clinician. Acceptable credentials include LCPC, LCSW, APRN, Psychologist, MD/DO, and Psychiatrist. For a complete listing of acceptable credentials, please refer to the MHRT/C Procedural Guidelines.*

Dates of Supervision (start & end): _____

Please note that each request for work credit must have its own specified and distinct time frame. No overlapping of dates and domains is permitted.

By initialing **each** knowledge competency for this MHRT/C requirement below the Clinical Supervisor* attests that the applicant has a high level of competence in them. **Please attach a document summarizing the work the applicant has performed under supervision that relates directly to these competencies for this course. Please give specific examples of how the applicant has demonstrated these competencies in their work. Clinical supervisor must sign each additional page.**

____ Demonstrate an understanding of the role of the case manager within community settings and how the community mental health system in Maine supports community inclusion.

____ Describe community inclusion as a process of assisting an individual to move towards greater community inclusion and personal well-being.

____ Identify resources and options in mental health, substance abuse, behavioral health, employment services, crisis services, natural supports, law enforcement and mental health courts available to a consumer and demonstrate understanding of how to provide linkages to these services.

____ Describe how basic interviewing and assessment techniques such as Motivational Interviewing and psychosocial assessments, can support a consumer's coping skills.

____ Illustrate the documentation process and each of its components, including the following: a) a person-centered treatment plan with specific goals/measures/target dates; b) written notes that track progress and inform the dynamic treatment process; and c) a treatment plan review to support progress in goal areas that help individuals live safe, healthy and independent lives.

____ Recall the history of peer support and consumer-directed services in Maine and nationally, including the Intentional Peer Support (IPS) Model.

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*—or administrative supervisor if applicant does not have clinical supervision

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☐ I have enclosed a document summarizing how the applicant has met these knowledge competencies in their work. (Please check when completed.)

By signing below, I confirm that I provided direct clinical* supervision to the applicant during the time referenced in this request. I have discussed the knowledge competencies for this domain with this individual and attest that this individual has acquired the competencies for the domain to be credited as listed in the Procedural Guidelines for MHRT/C.

Signature of Clinical Supervisor	License Type & Number	Date

Signature of Administrative Supervisor	Date

Signature of HR Office Confirming No Clinical Supervision	Date

If no Clinical Supervisor, this form must be signed by BOTH the Administrative Supervisor and the HR Office to attest that there is no clinical supervision.

Please sign, date, and return to applicant. Applicant must submit this form as part of their application. For complete requirements regarding credit for work requests, please refer to the *Guidelines for MHRT/C Certification.*

***—**or administrative supervisor if applicant does not have clinical supervision