**PM FORM 3.20.1**

SUPERVISOR OF CLINICAL LIAISONS
ATTESTATION OF COMPETENCIES FOR CLINICAL LIAISONS PERFORMING INITIAL ASSESSMENTS

I have provided clinical supervision of _____ _____
Name (Print) Title

I hereby confirm that the above named person has satisfactorily completed _____ (minimum of 3 adequate assessments required) supervised ADHS Behavioral Health Assessments, has demonstrated competency in performing evaluations, and in performing as a Clinical Liaison for the initial evaluation process.

I hereby confirm that he/she has demonstrated competencies in all of the following:

1. Ability to communicate with clients and establish rapport to engage the client in the evaluation and treatment process
2. Ability to conduct and adequately complete and document all components of the ADHS Behavioral Health Assessment
3. Ability to identify client needs and strengths
4. Ability to elicit information and to interpret data accurately to complete an assessment of current risks
5. Ability to conduct and document Mental Status Evaluations of children and/or adults
6. Ability to gather and synthesize information into a clinical formulation of the person and document appropriately
7. Ability to use the DSM-IV, TR in making appropriate diagnoses of mental disorders, including all five Axes
8. Ability to determine and document the recommended appropriate next steps for services for the client and communicate these to the client
9. Ability to develop and document appropriate treatment planning for the client that is responsive to the identified needs and strengths
10. Understanding, developing, and implementing the Child and Family Team model for children. *If individual does not work with children, check here. ☐

_____ _____ _____
Signature of Clinical Supervisor Credentials/Position Date

_____
Clinical Supervisor (Print Name)