MID-VALLEY BEHAVIORAL CARE NETWORK

Credentialing for Adjunct Service Providers

PURPOSE: The purpose of this form is to document and certify that a person who provides QMHA or QMHP services and who cannot be qualified as defined in OAR Chapter 309 for the corresponding certification, has the education, experience, competence, and supervision adequate to permit the person to perform his/her specific assigned duties. In these cases, this form fulfills the requirement that MVBCN participating providers maintain documentation of relevant licenses, degrees, certifications, and/or qualifications in each person's file.

Use of this form to credential a person to provide mental health services applies *only to his/her services to MVBCN members.* It does not apply to services provided to members of other public or private health plans, nor does it apply to services paid for directly by the State of Oregon or any other funding source.

INSTRUCTIONS: This form must be completed and maintained for each individual employee, intern/student, volunteer, and contractor who provides mental health services to MVBCN members if the person:

- Is not required to be licensed or certified by a State of Oregon board or licensing agency, as is the requirement for an Licensed Medical Practitioner or a Licensed Health Care Professional; and
- Cannot be qualified as a QMHP, QMHA, or Peer Support Specialist (whichever certification is applicable to services provided) as defined in OAR Chapter 309.

Examples of persons for whom use of this form may be appropriate include: paraprofessionals; peer counselors; vocational trainers; interns/students in a bachelor's or master's degree program.

NOTE: If an individual has been granted a variance by the State to provide QMHP or QMHA services, a copy of the State application and documentation that the variance has been granted may be attached to this form in lieu of completing the table below.

LEGAL NAME: _____ **DATE HIRED:** _____

COMPETENCY ASSESSMENT	***Level of Assigned Duties:***
Job Title:	☐ **QMHP** ☐ **QMHA**

Required skills	**Description of the person's education, experience and competence for each skill**

SUPERVISION & TRAINING PLAN _____

_____

_____

_____

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_____

CERTIFIED BY _____ _____ _____

Supervisor's Printed Name *Supervisor's Signature* *Date*

ATTACH ADDITIONAL PAGES IF NECESSARY

Original:	02/12/1998	Revised:	12/01/2006	7/23/2008	12/30/2010	