DEPARTMENT OFF BEHAVIORAL HEALTHCARE, DEVELOPMENTAL DISABILITIES AND HOSPITALS

Quality Management Unit
14 Harrington Road
Cranston, RI 02920

Phone: (401) 462-0172
Facsimile: (401) 462-0393

CHECKLIST FOR
BHDDH APPLICATION
FOR DESIGNATION AS A
QUALIFIED MENTAL HEALTH PROFESSIONAL (QMHP)

1. Documentation of Master's Degree in Clinical Practice ☐
   OR
   Documentation of License for Registered Nurse
2. Resume and/or CV ☐
3. Two (2) examples of documentation for the required thirty (30) hours of face-to-face emergency services supervised contact. ☐
4. Supervisor has completed training and competency form. ☐
5. Supervisor has completed Supervision Attestation form: ☐
6. Current copy of RIDOH license (if applicant possesses one) ☐

Applicant's Signature_____ Date_____

Applicant's Printed Name_____

Supervisor's Signature_____ Date_____

Supervisor's Printed Name: _____

Send completed form with all required attachments to:
BHDDH Office of Quality Management
14 Harrington Road
Cranston, Rhode Island 02920
Phone (401) 462-0172 Fax (401) 462-0393
BHDDH.QMHPPrincipalCounselor@BHDDH.RI.GOV

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BHDDH APPLICATION
FOR DESIGNATION AS A
QUALIFIED MENTAL HEALTH PROFESSIONAL (QMHP)

PERSONAL

Last Name_____ First Name_____

Home Address_____

City & State_____ Zip_____

EDUCATION

Qualifying Degree_____ Date Awarded_____

Institution Name_____

Institution City & State_____ Zip_____

SUPERVISED EXPERIENCE

Supervisor's Name & Credentials (Printed)_____

Supervisor's Title_____

Agency Name_____

Agency Address_____

Agency City & State_____ Zip_____

Phone Number_____ E-mail Address_____

Start Date of supervised face-to-face 30 hours emergency service_____

End Date of supervised face-to-face 30 hours emergency service_____

I certify that the above statements are true and correct and hereby apply for designation as a Qualified Mental Health Professional under the Rhode Island Mental Health Law, § 40.1-5-1 et seq.

Applicant's Signature_____ Date_____

Supervisor's Signature_____ Date_____

FOR BHDDH STAFF TO FILL OUT:

Application Approved By:

Printed Name (OQI):_____

Signature _____

Title _____

Printed Name (DBHS):_____

Signature _____

Title _____

Printed Name (OLS):_____

Signature _____

Title _____

Date of Approval _____

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Supervision Certification Attestation Qualified Mental Health Professional

QMHP Applicant: _____

Applicant's Supervisor: _____

Supervisor's Position: _____

Supervisor's Place of Employment: _____

Date of Attestation: _____

Definitions Used on Next Page:

Test – defined as the clinical supervisor giving the individual a test case vignette and allowing the individual to go through a hypothetical disposition by following all steps and procedures related to emergency evaluations.

Observe – defined as the clinical supervisor accompanying the individual to a setting where the individual can conduct an evaluation independently and the clinical supervisor will be there for support but observing readiness for independent practice.

Independent practice – the individual applying for QMHP status is to complete an evaluation independent of supervisor and the evaluation is immediately reviewed, discussed, and signed off by the clinical supervisor.

SELECTED COMPETENCY	Met	Not Met	State Reason if Competency Not Met	Methods to Determine Competence				Initial of Observer /Certifier
				Test	Observe	Independent Practice	Other	
1. Demonstrates ability to perform a crisis assessment								
2. Ability to facilitate inpatient and outpatient dispositions, in considering least restrictive placement, and/or considering utilization of diversion care.								
3. Knowledge of hospital admission procedures								
4. Demonstrates ability to determine level-of-care placement								
5. Demonstrates the ability to independently provide emergency evaluation								
6. Demonstrates ability to complete demographic, administrative, and clinical paperwork, including an Application for Emergency Certification								
7. Demonstrates understanding of the Rhode Island Mental Health Law through attendance at Mental Health Law Trainings provided by BHDDH								

*For each person who observes and/or certifies one or more selected competencies, please provide full name and credentials on the following page.

I attest that the above individual has met the following requirements:

- Employee has completed thirty (30) hours supervised face-to-face emergency crisis evaluation.
- Employee has demonstrated competence in emergency crisis evaluation.

I hereby recommend (name of Applicant) _____for certification as a QMHP.

Supervisor Signature: _____ Date: _____

Print Name: _____

Highest Academic Credential and RIDOH License (type & #): _____

Observers/Certifiers of Seven Competencies

Name of Observer/Certifier	Credentials of Observer/Certifier	Number(s) of the Competency Observed/Certified (#s 1 to #-7 above)	Comments