LGPC SUPERVISION SUBSIDY APPLICATION

(applicant completes)

ApplicantName: _____

Home address: _____

_____

Telephone number: _____

Email: _____

LGPC license number: _____ LCPCM Member? _____Yes _____No

Graduate school Program: _____

Year of graduation: _____

By signing, I agree to the terms of this subsidy program and will notify LCPCM of any change in the population I am serving. I understand that the supervision subsidy is restricted to my work with underserved populations. _____ signature _____date

Work Site Information

Agency/Organization Name:_____

Address: _____

Name of Director or site supervisor:_____

Contact Telephone Number: _____

Number of hours providing professional clinical counseling: _____

Salary or Fee per hour: _____

Onsite supervisor's license type: _____

Additional Agency/Organization Name: _____

Address: _____

Name of Director or site supervisor: _____

Contact Telephone Number: _____

Number of hours providing professional clinical counseling: _____

Salary or Fee per hour: _____

Onsite supervisor's license type: _____

LCPC Board Approved Supervisor Contract

(For supervisor to complete and return to applicant to submit as part of the application package)

Dear Supervisor,

The Licensed Clinical Professional Counselors of Maryland(LCPCM)has a supervision subsidy program for LGPCs working with underserved populations. They are eligible for assistance if their work site cannot provide the LCPC supervision required for the LCPC license. Ifapproved,your superviseewill receive a subsidy from our association to help pay for individual and/or group supervision.LCPCM will pay 50% ofyourhourly fee up to $100. Our payments will be made directly to you. Your supervisee is responsible for the remainder of the fee. We only ask that you send the attached invoice to be reimbursed for your services. If you agree to this arrangement, please complete the following questions. Give this completed page to your prospective supervisee to submit with her application. Thank you.

Your Name: _____

Address: _____

_____

LCPC license number: _____ email: _____

Are you willing to bill LCPCM for 50% of your fee up to $100? _____

Do you commit to bill at least monthly? _____

Do you agree to charge your supervisee 50% of your customary fee for supervision up to $100? _____

What is your customary fee for supervision? _____

By signing below, I agree to the terms of this arrangement and understand the following:

1) Invoices must be submitted within a month of services provided, to be reimbursed.
2) The applicant's supervision subsidy is limited to a maximum $2,500.
3) If the supervisee changes jobs or position and is no longer working with the underserved, the supervisor agrees not to invoice LCPCM and understands that the subsidy will no longer be available.

Supervisor Signature: _____

Date:_____

Worksite Verification

(For worksite to complete and return to applicant to submit as part of the application package)

Applicant's Name: _____

Name of Agency/Organization: _____

Location: _____

Services Provided:

_____

_____

_____

_____

_____

_____

Please answer yes or no:

- Can you confirm the employment of or contract for services with the applicant to provide clinical counseling services? _____
- Can you confirm that the agency/organization provides more than 50% of its clinical counseling services to the homeless, low-income, and/or Medicaid eligible individuals and/or families? (This includes the diagnosis and treatment of mental health and/or substance abuse disorders as well as crisis intervention services to individuals with these disorders.) _____
- Can you confirm that a LCPC Board Approved Supervisor is not available on site to supervise the applicant? _____

Your Name: _____ Signature: _____

Date: _____

Position or title: _____

Thank you!