OREGON BOARD OF LICENSED SOCIAL WORKERS

CSWA ~ PLAN CHANGE

FOR OFFICE USE ONLY ~ RECEIVED ON:

Form Updated: 01/10/2014

SUPERVISION REQUIREMENT:

OAR 877-020-0012(8) *requires LCSW's to have (2) years of post license experience in this or any other state, and completed (6) hours of continuing education courses specific to Supervision. These hours are good for (5) years from the completion date. A copy of the completion certificate documenting the CE must be on file with the Board office before beginning supervision with a CSWA.*

CSWA NAME: _____
Last Name, First Name Middle Initial

DATE OF REQUEST: _____ ***CERTIFICATE #*** A _____

REASON(S) FOR REQUEST:

- ☐ ***SAME*** *Employment /* ***NEW*** *Supervisor*
- ☐ ***NEW*** *Employment /* ***NEW*** *Supervisor*
- ☐ ***ADDING*** *Group /* ***SAME*** *Supervisor*
- ☐ ***NEW*** *Employment /* ***SAME*** *Supervisor*
- ☐ ***ADDING*** *Group /* ***NEW*** *Supervisor*
- ☐ ***ADDING*** *Individual /* ***SAME*** *Supervisor*
- ☐ ***CHANGE IN*** *Employment Location*
- ☐ ***ADDING*** *Individual /* ***NEW*** *Supervisor*

BRIEFLY DESCRIBE THE REASON(S) FOR REQUESTING THIS CHANGE:

_____

NUMBER OF PEOPLE IN THE PROPOSED GROUP: _____
(NO MORE THAN (5) PEOPLE ALLOWED IN THE GROUP SETTING)

CHANGE IN EMPLOYMENT INFORMATION:

ARE YOU WORKING? ***FULL TIME:*** ☐ ***PART TIME:*** ☐

EMPLOYER NAME: _____

EMPLOYER ADDRESS: _____

_____ _____ _____
City *State* *Zip Code*

EMPLOYER TELEPHONE: _____

BEGINNING DATE OF THIS EMPLOYMENT: _____ ***JOB TITLE:*** _____

BRIEFLY DESCRIBE CLIENT POPULATION AND YOUR DUTIES:

SUPERVISOR

(LCSW SUPERVISOR)

(Print Name of LCSW Supervisor) (License #) (Signature of LCSW Supervisor)

(Date) (Email) (Telephone)

ADMINISTRATIVE SUPERVISOR

(PERSON YOU REPORT TO FOR WORK)

(Print Name of Supervisor) (License #) (Signature of Administrative Supervisor)

(Date) (Email) (Telephone)

C.S.W.A

(Print Name of CSWA) (Signature of CSWA)

(Date)

877-020-0000 DEFINITIONS:

An **"agency"** is a private or public organization that, through its employees, engages in clinical social work (defined in ORS 675.510) generally characterized by the following:

(1) Cases are assigned through a central process;
(2) Billing is centralized and done in the organization's name;
(3) The organization collects all fees including deductibles and co-payments;
(4) The organization controls client records and is responsible for their proper storage and destruction;
(5) The organization controls office space by renting, owning or leasing it;
(6) The organization displays its name on the premises so as to be clearly visible to clients;
(7) The name of the organization is on all forms given to the client;
(8) The organization maintains the responsibilities for hiring and firing of staff;
(9) The organization pays the staff for clinical services;
(10) Supervision of clinical social work associates is provided on a regular basis;
(11) Evaluation of the competence of social workers who provide social work services at the organization, are provided on a regular basis; and
(12) Policies and procedures of the organization are available in written form for the staff and clients.

Mail this form to: OREGON STATE BOARD OF LICENSED SOCIAL WORKERS
ATTN: CSWA COORDINATOR
3218 PRINGLE ROAD S.E., SUITE #240
SALEM, OR 97302-6310

QUESTIONS? ☎: 503.378.5735
✉: Oregon.BLSW@state.or.us

APPROVED BY: _____ **DATE:** _____

CSWA Plan Change Form Updated: 01/10/2014 **DATABASE UPDATED BY:** _____ **DATE:** _____

OREGON BOARD OF LICENSED SOCIAL WORKERS

CLINICAL SOCIAL WORK ASSOCIATE
PLAN OF SUPERVISION

FOR OFFICE USE ONLY ~ RECEIVED ON:

SUPERVISOR REQUIREMENTS:

OAR 877-020-0012(8) *requires LCSW's to have (2) years of post license experience in this or any other state, and have completed (6) hours of continuing education courses specific to Supervision. These hours are good for (5) years from the completion date. A copy of the completion certificate documenting the CE's, must be on file in the Board office before beginning supervision with a CSWA.*

CSWA NAME: _____
Last Name, First Name Middle Initial

TELEPHONE: _____

INDIVIDUAL LCSW SUPERVISOR NAME: _____
Last Name, First Name Middle Initial

TELEPHONE: _____

WHERE WILL THE SUPERVISION TAKE PLACE? *SUPERVISOR'S OFFICE* ☐ *CSWA'S OFFICE* ☐

OTHER _____

IS THERE A FEE FOR SUPERVISION? ***$*** _____ *PER HOUR:* ☐ *PER MONTH:* ☐

BRIEFLY DESCRIBE THE PROPOSED ***INDIVIDUAL SUPERVISION:***

GROUP LCSW SUPERVISOR NAME: _____
Last Name, First Name Middle Initial

TELEPHONE: _____

WHERE WILL THE SUPERVISION TAKE PLACE? *SUPERVISOR'S OFFICE* ☐ *CSWA'S OFFICE* ☐

OTHER _____

IS THERE A FEE FOR SUPERVISION? ***$*** _____ *PER HOUR:* ☐ *PER MONTH:* ☐

BRIEFLY DESCRIBE THE PROPOSED ***GROUP SUPERVISION ~ (NO MORE THAN (5) INDIVIDUALS PER GROUP SESSION):***

ALL LCSW SUPERVISORS

ATTACH TO THIS PLAN OF SUPERVISION, A COPY OF THE CERTIFICATE OF COMPLETION WHICH DOCUMENTS AT LEAST (6) HOURS OF CONTINUING EDUCATION SPECIFIC TO SUPERVISION WITHIN THE LAST (5) YEARS.

CERTIFICATION SIGNATURES FOR CURRENT PLAN OF SUPERVISION:

I certify that the information provided in this document is true and correct to the best of my knowledge. I agree to work with this Plan as described above. ***ALL PLANS*** *require signatures of the* ***Clinical Supervisor, Administrative Supervisor, and the CSWA Applicant.*** *Be sure that all signatures are in place before submitting your application. Unsigned forms will be returned, thereby causing a delay in processing your application and issuing your certificate. No hours count toward your plan until approved by the Board.*

INDIVIDUAL SUPERVISOR

(LCSW INDIVIDUAL)

(Print Name of LCSW Supervisor) | (License #) | (Signature of LCSW Supervisor)

(Date) | (Email) | (Telephone)

GROUP SUPERVISOR

(LCSW GROUP)

(Print Name of LCSW Supervisor) | (License #) | (Signature of LCSW Supervisor)

(Date) | (Email) | (Telephone)

ADMINISTRATIVE SUPERVISOR

(PERSON YOU REPORT TO FOR WORK)

(Print Name of Supervisor) | (License #) | (Signature of Administrative Supervisor)

(Date) | (Email) | (Telephone)

C.S.W.A

(Print Name of CSWA) | (Signature of CSWA)

(Date)

CSWA RESPONSIBILITIES:

- ☐ ***I UNDERSTAND…..*** that my title will be **CLINICAL SOCIAL WORK ASSOCIATE (CSWA)** and I am NOT permitted, under Oregon Law, to be called or represent myself as a Licensed Clinical Social Worker.
- ☐ ***I WILL FOLLOW…..*** the Code of Ethics for Social Workers as defined in Oregon Administrative Rules, Chapter 877, Division 30.
- ☐ ***I UNDERSTAND…..*** I must meet with my Supervisor(s) at least (2) times a month for a minimum of (1) hour each meeting, where my clinical work will be discussed, evaluated, and directed. In the case of an individual and group supervisor, (1) meeting with each supervisor will meet this requirement.
- ☐ ***I UNDERSTAND…..*** it is my responsibility to obtain, prior to Board approval, of changes to my Plan of Supervision, and to keep the Board office informed of any name or address changes.
- ☐ ***I UNDERSTAND…..*** that the Associate Plan cannot be completed in less than (24) months, post MSW supervision, and can take no longer than (60) months to complete each Associate Plan, as defined in Oregon Administrative Rules 877-020-0010(3)(A).
- ☐ ***I WILL……*** maintain client confidentiality at all times, including during supervision.
- ☐ ***I WILL……*** communicate to the Board, any interruptions, concerns, or proposed termination of the Plan.

ADMINISTRATIVE SUPERVISOR RESPONSIBILITIES:

☐ ***I AGREE....*** to facilitate and encourage the Supervision Plan for supervision between the applicant (Associate) and the Supervisor.

☐ ***I AGREE....*** to inform the Board of any changes in agency practices or policies, which may adversely affect the successful completion of the Plan of Supervision.

LCSW SUPERVISOR RESPONSIBILITIES:

☐ ***I WILL.....*** closely review and supervise representative and problem cases with attention to diagnostic evaluation, treatment planning, ongoing case management, emergency intervention, record keeping and termination.

☐ ***I WILL.....*** review case records, billings, appointment book and client population as appropriate.

☐ ***I WILL.....*** determine appropriate client populations to be served and direct the Associate to refer inappropriate clients to other therapists

☐ ***I WILL.....*** maintain confidentiality of all client and supervisory materials.

☐ ***I WILL.....*** review with the Associate, the Oregon Laws and Administrative Rules related to the ethical principles of Clinical Social Workers, with specific attention to Division 30, the Code of Ethics.

☐ ***I WILL.....*** submit ***TIMELY*** (6) Month Evaluation Reports to the Board, of the Associate's progress, with a ***FINAL*** evaluation at the conclusion of the Plan.

☐ ***I WILL.....*** communicate to the Board, any interruptions, concerns or proposed termination of the Plan.

☐ ***I HAVE READ AND UNDERSTAND MY RESPONSIBILITIES AS A CSWA APPLICANT*** ***INITIAL:*** _____

☐ ***I HAVE READ AND UNDERSTAND MY RESPONSIBILITIES AS AN LCSW SUPERVISOR*** ***INITIAL:*** _____

☐ ***I HAVE READ AND UNDERSTAND MY RESPONSIBILITIES AS AN ADMINISTRATIVE SUPERVISOR*** ***INITIAL:*** _____

SUPERVISORS:

NO DIRECT CLIENT, WORK OR SUPERVISION HOURS CAN BE COUNTED FOR A PLAN OF SUPERVISION PRIOR TO BOARD APPROVAL.

CSWA'S: APPLICATIONS CANNOT BE APPROVED BY THE BOARD WITHOUT THE FOLLOWING:

- *Results from the Criminal Background Check, which takes approximately 2 to 3 weeks*
- *Completed Application with all appropriate signatures by the Applicant, Administrative Supervisor and Clinical Supervisor (If the Clinical and Administrative Supervisor are the same person, have them sign both areas)*
- *Official transcript in a sealed envelope documenting MSW degree accredited by the Council on Social Work Education at the time of conferred degree date*
- *Fees for Application, Criminal Background Check and Initial Certificate*

DEFINITION: OREGON ADMINISTRATIVE RULE (OAR) 877-020-0000

An "agency" is a private or public organization that, through its employees, engages in clinical social work (defined in ORS 675.510(2)), generally characterized by the following:

(1) Cases are assigned through a central process;
(2) Billing is centralized & done in the organization's name;
(3) The organization collects all fees including deductibles & co-payments;
(4) The organization controls client records & is responsible for their proper storage & destruction;
(5) The organization controls office space by renting, owning or leasing it;
(6) The organization displays its name on the premises so as to be clearly visible to clients;
(7) The name of the organization is on all forms given to the client;
(8) The organization maintains the responsibilities for hiring & firing of staff;
(9) The organization pays the staff for clinical services;
(10) Supervision of clinical social work associates are provided on a regular basis;
(11) Evaluation of the competence of social workers who provide social work services at the organization is provided on a regular basis; and
(12) Policies & procedures of the organization are available in written form for the staff & clients.