

PoloJean-LouisLCSW

OFFICIAL WEBSITE: www.polojeanlouis.com

LCSW/LCPC CLINICAL SUPERVISION PACKET

CLINICAL SUPERVISION APPLICATION

BASIC IDENTIFYING INFORMATION

EDUCATIONAL BACKGROUND

CURRENT LICENSING INFORMATION

SELF ASSESSMENT SECTION

CONSENT FOR CLINICAL SUPERVISION

AGENCY POLICIES

BILLING & PAYMENTS

NO-SHOW/CANCELLATION POLICY

AGENCY POLICY AGREEMENT

ADDITIONAL REQUIRED DOCUMENTS:

An official graduate transcript (sent to our agency by applicant's college/university)

A current professional resume

A copy of applicant's valid LMSW-CC or LCPC-CC license

612 GRAY ROAD, GORHAM, MAINE 04030

TELEPHONE: (207) 200-7050 & FAX: (207) 893-1865

1. BASIC Identifying Information:

Name: _____

(Last) (First) (MI) (Maiden)

Mailing Address: _____
(Street)

(City) (State) (Zip) (County)

Phone: _____
(Home / Cell) _____ (Work) _____

Check only if is it OK for me to call you at: _____ Home _____ Cell _____ Work

DOB: _____ E-Mail Address: _____

Gender _____ Age: _____

Any Disabilities?: _____ If Yes Identify: _____

Emergency Contact Person:

Name: _____ Telephone: _____

Relationship to you: _____

Please have an official copy of your GRADUATE PROGRAM sent to our agency by your college/university.

Undergraduate Institution: _____ Degree Received _____

Major(s) _____ Minor (s): _____

Month/Year Started _____ Month/Year Completed _____

Major G.P.A. out of 4.0 _____ Overall GPA: _____

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Graduate Institution: _____ Degree Received _____

Major(s) _____ Minor(s): _____

Month/Year Started _____ Month/Year Completed _____

Major G.P.A. out of 4.0 _____ Overall GPA: _____

3. CURRENT LICENSING INFORMATION:

Please submit a copy of your valid current LMSW-CC or LCPC-CC License.

License Number: _____ License Type: _____

Type of Exam Taken: _____ State Issued: _____

Month and Year of Passing Examination _____

Did you pass the first time taking it? YES / NO Was your licensed ever revoked? YES / NO

IF YES: WHEN: _____ &

EXPLAIN EACH:

4. A CURRENT RESUME IS TO SUBMITTED FOR REVIEW including MS/MSW internship experience.

5. SELF ASSESSMENT SECTION:

Did you enjoy your graduate program & find value in it? What was great about it and what was missing for you?

What brings you to the field of clinical social work or counseling? Any life events, influences, etc?

Personal: What inherent character traits, you or others have identified as strengths and areas are to be improved?

Identify 3 of your strengths

Identify 3 areas of development

Professional: What professional traits, skills you or others have identified as strengths and what areas are to be improved?

Identify 3 of your strengths

Identify 3 areas of development

What are you looking to learn/develop during your clinical supervision with us?

ADDITIONAL COMMENTS, ISSUES, OR CONCERNS:

5. Signature: I certify I have read the information provided and that all the information on this application is correct and complete to the best of my knowledge.

Applicant's Signature

Date

THANK YOU FOR CHOOSING POLO LCSW FOR YOUR PROFESSIONAL DEVELOPMENT.

I look forward to meeting you. You have my commitment to provide you with the best and most efficient services.

Consent to Clinical Supervision

I, _____,

authorize and request that Mr. Polo Jean-Louis, MS, LCSW, provide clinical supervision to myself. I understand and agree that the frequency and type of supervision will be decided between Mr. Jean-Louis, MS, LCSW and I.

I understand that the purpose of these procedures will be explained to me and I will be subject to my verbal agreement.

I understand that there is an expectation that I will benefit from clinical supervision, but that there is no guarantee that I will pass the required examination of my state professional board.

I understand that the maximum benefit will occur with consistent attendance and participation.

I have read, fully understand, and agree to this consent for clinical supervision form.

Client Signature: _____ Date: _____

Witness: _____ Date: _____

AGENCY POLICIES AGREEMENT

I understand and agree to the information as outlined in the "Agency Policies" statement.

Client Signature

Date

Witnessed By

Date

AGENCY POLICIES
Effective March 2012

BILLING & PAYMENTS:

STANDARD SERVICE FEE: Clinical Supervision:

Sliding Scale	per 50 minute/weekly Individual Session
\$30.00	per 50 minutes/weekly Group (Maximum number: 5/group)

Personal/Business checks, money orders, and/or cash are welcome. We do not accept credit cards at this time. Make checks payable to Polo Jean-Louis, LCSW.

Checks not honored by your financial institution will be assessed a returned check fee of either \$25 or the maximum amount allowed by law, whichever is greater, upon replacement. More than one dishonored check will place your account into a "cash only" status.

An agency service retainer fee - \$30 for group supervision & full individual fee session is required prior to each appointment which must be reconciled prior to each session. The retainer fee will be used as deposit for any now shows or cancellation policy violation.

RETAINER FEE:
\$30.00 - GROUP SUPERVISION
(SLIDING SCALE) FULL AGREED UPON FEE SESSION - INDIVIDUAL CLINICAL SUPERVISION,

NO-SHOW/CANCELLATION POLICY An agency service retainer fee is required prior to each appointment which must be reconciled prior to each session. The retainer fee will be used If you cancel a scheduled appointment without a minimum 48 hour notice, we will not be able to use this time for another client. You will be billed for the entire cost of your missed appointment and the retainer fee will be used as payment. Within 48 hours of the next scheduled session, the retainer fee and the service fee must be reconciled in full.

If it is assessed necessary to file civil charges due to non-payment, client will be assessed full court, legal, filing cost fees, and other appropriate fees in addition to the original balance due.. All major credit bureaus may be notified debt sent to a collection agency.

_____ **Client Signature**

DATE: _____

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