



**STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
OFFICE OF STATEWIDE SYSTEMS OF CARE
Andrew Jackson Building, 5th Floor
500 Deaderick Street
NASHVILLE, TENNESSEE 37243**

Employment Summary

The person named below is completing an application to be certified as a Family Support Specialist with the OSSOC. In order to complete the application process, the immediate supervisor must complete the following form regarding the applicant's employment, work responsibilities and supervisory plan. Once the form is completed, submit it to TDMHSAS Family Support Specialist Certification Program at 615.253.6822. If you have questions, please contact the Office of Statewide Systems of Care or Melissa McGee at 615-253-4160 or Melissa.McGee@tn.gov.

- 1) Prospective Certified Family Support Specialist:

(Please Print Name)

- 2) Is the applicant named above employed to work in the role as a paid Family Support Specialist?

Yes

No

- 3) **Title of Applicant's paid position within the agency**

Date of employment as a Family Support Specialist _____

- 4) Number of hours assigned to work in this position per week: _____

- 5) A Certified Family Support Specialist must be under the supervision of a *mental health professional* in accordance with acceptable guidelines and standards of practice as defined by TDMHSAS. A Mental Health Professional as defined by TDMHSAS is a board eligible or a board certified psychiatrist or a person with at least a Master's degree and/or clinical training in an accepted mental health field which includes, but is not limited to, counseling, nursing, occupational therapy, psychology, social work, vocational rehabilitation, or activity therapy. Please provide the following information regarding the agency staff that provides direct supervision:

6) Name _____ Phone (____) ____ - _____
Job Title _____ Credentials _____
Agency _____ Email _____
Address _____
City _____ State _____ ZIP _____

6) Please describe the nature of the applicant's work responsibilities in the position and role as a paid Family Support Specialist within the agency:

7) Please describe in detail the nature of your direct one-on-one clinical supervision interactions with this applicant:

8) Please describe in detail the professional development plan or goals for this individual within the agency:

My signature below affirms that all of the information contained in this document is true, and that I support this application.

Signature of Direct Supervisor _____ Date _____