

**MONTANA BOARD OF BEHAVIORAL HEALTH**  
**PO BOX 200513 (301 S. Park Ave, 4<sup>th</sup> Floor)**  
**Helena, MT 59620-0513**  
**Licensing Phone Number: 406-444-5773**  
**E-Mail: [dlibsdbbh@mt.gov](mailto:dlibsdbbh@mt.gov) Website: [www.bbh.mt.gov](http://www.bbh.mt.gov)**

**BEHAVIORAL HEALTH PEER SUPPORT SPECIALISTS**  
**Supervision Forms**

The Supervision Agreement/Supervision Plan, is required for initial certification and anytime a new Supervisor assumes supervision duties of a CBHPSS. Please review all supervision rules located within this application. The Supervision Termination Summary is completed by the Supervisor and filed with the Board office when a CBHPSS discontinues services under a Supervisor.

A Supervision Agreement/Supervision Plan must be completed for EACH SUPERVISOR PRIOR to commencing supervision with that Supervisor. Certificate holders may have more than one Supervisor. Submit this form with the Candidate application to the Board of Behavioral Health at 301 South Park, 4<sup>th</sup> Floor, P.O. Box 200513, Helena, MT 59620-0513 or it may be uploaded to your on-line license record. If you don't have an account, one can be created at <https://ebiz.mt.gov/pol/default.aspx>.

A Supervisor Termination Summary must be received at the Board office when supervision services cease. All Supervision forms are included with the application and posted on the Montana Board of Behavioral Health website.

**SUPERVISION AGREEMENT, (Make additional copies as needed)**

It is the understanding of the Board of Behavioral Health of the State of Montana that

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Supervisee's Name and Credential, if available

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Address	City	ST	Zip Code
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Cell phone	Work Phone	E-Mail Address
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will be a post-certification supervisee as a Certified Behavioral Health Peer Support Specialist at

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Facility or agency

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Address	City	ST	Zip Code	Phone number
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under the ongoing supervision of

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Supervisor's Name and Credential

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Address	City	ST	Zip Code
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Cell phone	Work Phone	E-Mail Address
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**SUPERVISION PLAN**, (Make additional copies as needed)

The Supervisor and the Supervisee assume professional responsibility for compliance with the ongoing supervision requirements and for the statutes and rules pertaining to the practice of CBHPSS. This statement constitutes the written agreement of ARMs 24.219.902 & 24.219.916.

Duties and obligations of the CBHPSS: \_\_\_\_\_

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Duties and obligations of the Supervisor: \_\_\_\_\_

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Frequency of supervision: \_\_\_\_\_

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Duration of supervision: \_\_\_\_\_

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Method of supervision: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Termination provision: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### ATTESTATION

The Certified Behavioral Health Peer Support Specialist, CBHPSS and Supervisor(s) have read, understand, and acknowledge the requirements of the Supervision Forms. All have been approved by the CBHPSS and the Supervisor.

In signing below, the CBHPSS and the Supervisor attest to the terms of the agreement, compliance, with applicable patient privacy laws, confirmation that the qualifications of the supervisor are in accordance with current statute and administrative rule, and confirmation that it's understand that the CBHPSS and Supervisor are responsible for ensuring compliance with the requirements of their profession always.

Upon termination of the Supervision Agreement/Supervision Plan, the Supervisor shall provide a written Supervision Termination Summary of the clinical supervision experience highlighting performance in each of the 18 core competences and identification of any areas in need of improvement. The summary, along with a copy of the Supervision Logs must be submitted to the Board office prior to the CBHPSS commencing work under a new Supervisor.

Supervisor (Print name and license): \_\_\_\_\_

Supervisor (Signature): \_\_\_\_\_

Date

Supervisee (Print name and license): \_\_\_\_\_

Supervisee (Signature): \_\_\_\_\_

Date