St. Clair County Community Mental Health

Attestation Statement for Populations Served

Name (please print): _____

Agency Affiliation/Job Title: _____

QIDP (Qualified Intellectual Disability Professional)

Have you had at least one year of experience working with individuals with Intellectual/Developmental Disability (IDD)?

☐ yes ☐ no

If yes, provide specific, narrative evidence outlining your experience below (include dates/years)

QMHP (Qualified Mental Health Professional)

Have you had at least one year of experience working with individuals with Mental Illness (MI)?

☐ yes ☐ no

If yes, provide specific, narrative evidence outlining your experience below (include dates/years)

CMHP (Child Mental Health Professional)

Master level - Have you had at least one year of experience working with children?

Bachelor level - Have you had at least three years of supervised experience with children?

EXCEPTION: BCBA, BCaBA, Psychologist in ABA practice (please explain in narrative below)

☐ yes ☐ no

If yes, provide specific, narrative evidence outlining your experience below (include dates/years)

Signature of Employee: _____ Date: _____

I certify that I am the Supervisor of the above named employee and that I have the credentials and experience required to supervise them in the capacity of their current position.

_____ _____

Printed Name of Supervisor Date

_____

Signature of Supervisor