

Medicaid & Long-Term Care Use Only	
Medicaid ID #	
N-Focus ID #	

Applicant information

Name	Social Security Number

Education and Training

Degree and major

Additional coursework, study, or trainings

If degree is not in psychology, social work, child development or related field, please include the course title and number of hours of the coursework that relates to these topics:

Telephone	Fax	E-mail

Certification Experience (salary or volunteer work-related) (Please indicate full or part-time work)

Name of employer

Position held

Role and responsibility for the agency

Telephone	To

Name of employer

Position held

Role and responsibility for the agency

Telephone	To

Competency and Skill

Prior to actual work assignments, the applicant must successfully complete the agency's training and the program supervisor must determine that the applicant has demonstrated competency in the following areas:

- Has understanding of mental health diagnosis, symptoms and issues
- Has understanding of substance abuse symptoms and issues
- Has ability to work as a member of a treatment team
- Has agreed to accept direction from the treatment team (supervising practitioner and therapist)
- Has ability to communicate with treatment team members (supervising practitioner, therapist, guardian, caregiver or parent) regarding the child's needs
- Has ability to document treatment interventions and the outcome of treatment interventions in the client's clinical record
- Has a basic understanding of development issues of children and adolescents
- Has ability to provide treatment interventions including but not limited to the following:
 - a. Teaching youth relationship skills
 - b. Training youth on and demonstrating appropriate boundaries to youth and caregiver
 - c. Behavior management training for youth and caregiver
 - d. Instructing caregiver on appropriate parenting techniques in the presence of youth
 - e. Communicating appropriate discipline interventions for youth to youth and caregiver
 - f. Has an excellent understanding of professional boundaries
 - g. Other

Signature and Date

After thorough review of our Agency's competency requirements and NMAP policy, I have determined that

_____ meets the requirements for the position of a Community Treatment Aide and has
(Name of Applicant)
completed our Agency's training program.

It is understood that should this applicant not meet the minimum requirements as outlined in NMAP they will not be considered for enrollment as a CTA.

Signature **and Licensure** of Agency Supervisor/Community Treatment Aide Program

Date