



VERIFICATION FORM for SUPERVISED CARE MANAGEMENT EXPERIENCE and DIRECT CLIENT EXPERIENCE

PLEASE TYPE OR PRINT CLEARLY | Questions? Call PTC at 212.356.0660

Your Name _____
phone _____ email _____ fax _____

SUPERVISED CARE MANAGEMENT EXPERIENCE *Required for All Candidates*

Please list paid, **full-time care management experience gained after your degree was awarded** – including 50 hours of supervision per year.

Full-time employment is defined as a minimum of 35 hours per week. (Part-time employment can be used. Refer to the Handbook for a Part-Time to Full-Time Conversion Table.)

Supervision may include but is not limited to case conferences with supervisors or peers, performance appraisal, client record reviews, and consumer satisfaction data.

Supervised care management work experience must begin **after** earning the degree applicant is using to qualify. NACCM will consider employment experiences within the last 10 years towards eligibility.

Option A requires one (1) year of paid, full-time, supervised care management experience.

Option B & C require two (2) years of paid, full-time, supervised care management experience.

Option D requires three (3) years of paid, full-time, supervised care management experience.

Current Employment

Agency/Company _____ Your Position/Title _____

Agency/Company Address _____

Dates of Employment: from MM/DD/YYYY _____ to MM/DD/YYYY _____

Hours per week of care management employment during above dates: _____/week

Hours per year of supervised care management during above dates: _____/year

*Supervisor's name & credential(s) _____ Title _____

Supervisor's phone _____ email _____ fax _____

Agency/Company _____ Your Position/Title _____

Agency/Company Address _____

Dates of Employment: from MM/DD/YYYY _____ to MM/DD/YYYY _____

Hours per week of care management employment during above dates: _____/week

Hours per year of supervised care management during above dates: _____/year

*Supervisor's name & credential(s) _____ Title _____

Supervisor's phone _____ email _____ fax _____

Agency/Company _____ Your Position/Title _____

Agency/Company Address _____

Dates of Employment: from MM/DD/YYYY _____ to MM/DD/YYYY _____

Hours per week of care management employment during above dates: _____/week

Hours per year of supervised care management during above dates: _____/year

*Supervisor's name & credential(s) _____ Title _____

Supervisor's phone _____ email _____ fax _____

**If you are an independent practitioner, please provide the name of the individual who can attest to your professional consulting relationship.*

(continued on next page)

January 2017

VERIFICATION FORM *(continued)*

I perform/ed all content domains and tasks in these position(s) (see Candidate's Handbook for detailed list of tasks in each domain), including

Domain I – Assess and identify client strengths, needs, concerns, and preferences

Domain II – Establish goals and a plan of care

Domain III – Implement care plan

Domain IV – Manage and monitor the ongoing provision of and need for care

Domain V – Ensure professional practice & Supervision of Care Management

I hereby certify that all information on this form is accurate, truthful, and complete. I understand that false or misleading information, whether by inclusion or omission, will result in the rejection of my application.

Applicant's Signature _____ Date _____

DIRECT CLIENT EXPERIENCE Required for candidates using Options C & D only

Direct Client Experience includes working directly with clients, consumers, or patients in fields such as social work, nursing, mental health, counseling, human services, or care management. **Your direct client experience is separate and distinct from Supervised Care Management Experience documented above.**

Full-time employment is defined as a minimum of 35 hours per week. (Part-time employment can be used. Refer to the Handbook for a Part-Time to Full-Time Conversion Table.)

Option C requires one (1) year of full-time direct client experience in addition to required 2 years of supervised experience for a total of 3 years.

Option D requires one (1) year of full-time direct client experience in addition to required 3 years of supervised experience for a total of 4 years.

Agency/Company _____ Your Position/Title _____

Agency/Company Address _____

Dates of Employment: from MM/DD/YYYY _____ to MM/DD/YYYY _____

Hours per week of employment during above dates: _____ /week

Hours per week of Direct Client Contact/Interaction during above dates: _____

I performed the following tasks in this position:

- | | | |
|--|--|---|
| <input type="checkbox"/> Conducted assessments | <input type="checkbox"/> Assisted with long-term planning | <input type="checkbox"/> Regularly monitored client situation |
| <input type="checkbox"/> Recommended and/or coordinated services | <input type="checkbox"/> Developed care plans | <input type="checkbox"/> Advocated on behalf of client |
| <input type="checkbox"/> Provided support to client and/or others involved | <input type="checkbox"/> Educated client about available resources | <input type="checkbox"/> Other: _____ |

Supervisor's name & credential(s) _____ Title _____

Supervisor's phone _____ email _____ fax _____

Agency/Company _____ Your Position/Title _____

Agency/Company Address _____

Dates of Employment: from MM/DD/YYYY _____ to MM/DD/YYYY _____

Hours per week of employment during above dates: _____

Hours per week of Direct Client Contact/Interaction during above dates: _____

I performed the following tasks in this position:

- | | | |
|--|--|---|
| <input type="checkbox"/> Conducted assessments | <input type="checkbox"/> Assisted with long-term planning | <input type="checkbox"/> Regularly monitored client situation |
| <input type="checkbox"/> Recommended and/or coordinated services | <input type="checkbox"/> Developed care plans | <input type="checkbox"/> Advocated on behalf of client |
| <input type="checkbox"/> Provided support to client and/or others involved | <input type="checkbox"/> Educated client about available resources | <input type="checkbox"/> Other: _____ |

Supervisor's name & credential(s) _____ Title _____

Supervisor's phone _____ email _____ fax _____

I hereby certify that all information on this form is accurate, truthful, and complete. I understand that false or misleading information, whether by inclusion or omission, will result in the rejection of my application.

Applicant's Signature _____ Date _____