VERIFICATION FORM for
SUPERVISED CARE MANAGEMENT EXPERIENCE and DIRECT CLIENT EXPERIENCE

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

Candidates must upload a copy of their college degree along with completed verification form.

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 / consultation 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 / consultation 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, care management experience including 50 hours of supervision / consultation per year.
Option B & C require two (2) years of paid, full-time, care management experience including 50 hours of supervision / consultation per year.
Option D requires three (3) years of paid, full-time, care management experience including 50 hours of supervision / consultation per year.

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 care management supervision / consultation during above dates:____ hours/week = _____ **total hours/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 care management supervision / consultation during above dates:____ hours/week = _____ **total hours/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 care management supervision / consultation during above dates:____ hours/week = _____ **total hours/year**

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

Supervisor's phone____________________ email ____________________ fax ____________________

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

(continued on next page)

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 plan of care
Domain III – Initiate, manage and monitor ongoing execution and outcomes of care plan
Domain IV – Promote and maintain professional standards in care management and in business practices

☐ **I have read and agree to adhere to the National Academy of Certified Care Managers Standards of Practice and Code of Ethics at naccm.net.**

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. (Above boxes must be checked.)

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:

☐ Conducted assessments
☐ Recommended and/or coordinated services
☐ Provided support to client and/or others involved
☐ Assisted with long-term planning
☐ Developed care plans
☐ Educated client about available resources
☐ Regularly monitored client situation
☐ Advocated on behalf of client
☐ 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:

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

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

Supervisor's phone_____ email _____ fax _____

☐ **I have read and agree to adhere to the National Academy of Certified Care Managers Standards of Practice and Code of Ethics at naccm.net.**

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_____