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 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)

☐ **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 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_____