

**New York State Office of Alcoholism and Substance Abuse Services
 Credentialed Alcoholism and Substance Abuse Services (CASAC) Application**

PART C - WORK EXPERIENCE VERIFICATION RECORD

****TO BE COMPLETED BY APPLICANT** (PLEASE PRINT)**

APPLICANT CONSENT TO RELEASE INFORMATION

APPLICANT NAME

SOCIAL SECURITY NO.

BY MY SIGNATURE BELOW, I AM AUTHORIZING THE PROVIDER/PERSON IDENTIFIED BELOW TO PROVIDE INFORMATION AND DOCUMENTATION TO THE NEW YORK STATE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES (OASAS).

APPLICANT SIGNATURE

DATE

****TO BE COMPLETED BY SUPERVISOR** (PLEASE PRINT)**

INFORMATION AND INSTRUCTIONS TO SUPERVISOR/PROVIDER/EMPLOYER: PLEASE COMPLETE THIS FORM WHICH REFLECTS YOUR KNOWLEDGE OF THE APPLICANT'S WORK EXPERIENCE AND/OR SUPERVISED PRACTICAL TRAINING WHILE EMPLOYED AT THE WORK SETTING INDICATED. BE SURE THAT THE APPLICANT HAS SIGNED THE ABOVE "APPLICANT CONSENT TO RELEASE INFORMATION" ALLOWING YOU TO MAKE AVAILABLE TO OASAS ANY AND ALL INFORMATION REGARDING HIS/HER WORK EXPERIENCE NEEDED TO MEET THE CASAC ELIGIBILITY REQUIREMENTS. PLEASE RETURN THIS COMPLETED FORM TO THE APPLICANT WITH ANY OTHER DOCUMENTATION REQUIRED.

DO NOT COMPLETE THE WORK EXPERIENCE VERIFICATION RECORD UNLESS THE RELEASE IS SIGNED.

IF YOU HAVE QUESTIONS RELATED TO THIS FORM, PLEASE CONTACT THE OASAS CREDENTIALING UNIT AT 1-800-482-9564.

WORK EXPERIENCE VERIFICATION

PROVIDER/EMPLOYER NAME

PROGRAM UNIT WHERE APPLICANT WORKED

PROVIDER/EMPLOYER ADDRESS

WORK SITE TELEPHONE NO.

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TYPE OF WORK SETTING (CHECK ONLY ONE)

- 1. IT IS OPERATED BY OASAS.
- 2. IT HOLDS A CERTIFICATE OF APPROVAL OR OPERATING CERTIFICATE TO PROVIDE SUBSTANCE ABUSE, ALCOHOLISM OR CHEMICAL DEPENDENCE SERVICES FROM OASAS ISSUED PURSUANT TO ARTICLES 19, 23, 31 OR 32 OF THE MENTAL HYGIENE LAW OR A SIMILAR LICENSE OR APPROVAL FROM ANOTHER STATE'S ALCOHOLISM OR SUBSTANCE ABUSE AUTHORITY FOR THE STATE IN WHICH THE AGENCY, FACILITY OR PROGRAM IS LOCATED (ATTACH A COPY OF LICENSE/CERTIFICATE FROM OASAS. FOR ANOTHER STATE, ATTACH A COPY OF CERTIFICATE OF APPROVAL, OPERATING CERTIFICATE OR SIMILAR LICENSE OR APPROVAL FROM THAT STATE'S ALCOHOLISM AND SUBSTANCE ABUSE AUTHORITY).
- 3. IT IS ACCREDITED BY THE COMMISSION ON ACCREDITATION OF REHABILITATION FACILITIES (CARF), SPECIFICALLY FOR THE PROVISION OF ALCOHOLISM AND/OR SUBSTANCE ABUSE TREATMENT SERVICES (ATTACH EVIDENCE OF CARF ACCREDITATION FOR THE PROVISION OF ALCOHOLISM AND/OR SUBSTANCE ABUSE TREATMENT SERVICES).
- 4. IT IS ACCREDITED BY THE JOINT COMMISSION ON ACCREDITATION OF HEALTH CARE ORGANIZATIONS (JCAHO) FOR THE PROVISION OF ALCOHOLISM AND/OR SUBSTANCE ABUSE SERVICES (ATTACH EVIDENCE OF JCAHO ACCREDITATION FOR THE PROVISION OF ALCOHOLISM AND/OR SUBSTANCE ABUSE SERVICES).
- 5. IT IS ORGANIZED AND OPERATED BY THE FEDERAL GOVERNMENT, TO INCLUDE THE INDIAN HEALTH SERVICE AND VETERANS ADMINISTRATION, AS A PROGRAM OF ALCOHOLISM AND/OR SUBSTANCE ABUSE TREATMENT WHICH IS CONSISTENT WITH OASAS' STANDARDS (ATTACH A COMPLETED WORK EXPERIENCE VERIFICATION RECORD ADDENDUM -- WORK SETTING CERTIFICATION [PDS 13.1]).
- 6. IT IS A SCHOOL OR COMMUNITY-BASED PREVENTION/INTERVENTION PROGRAM WHICH IS DESIGNATED FOR THE PROVISION OF THE FULL RANGE OF CHEMICAL DEPENDENCE COUNSELING SERVICES (ATTACH A COPY OF LICENSE/CERTIFICATE FROM OASAS).
- 7. IT IS A PROGRAM THAT INCLUDES ALCOHOLISM AND/OR SUBSTANCE ABUSE TREATMENT DEEMED TO BE CONSISTENT WITH OASAS' STANDARDS AND IS LICENSED AND/OR OPERATED BY ANY OTHER NEW YORK STATE AGENCY (ATTACH A COPY OF THE CERTIFICATE OF APPROVAL, OPERATING CERTIFICATE OR SIMILAR LICENSE OR APPROVAL FROM THE STATE AGENCY AND A COMPLETED WORK EXPERIENCE VERIFICATION RECORD ADDENDUM -- WORK SETTING CERTIFICATION [PDS 13.1]).
- 8. IT IS AN AGENCY OR PROGRAM NOT SUBJECT TO LICENSURE BY OASAS BUT WHICH HAS BEEN DEEMED BY OASAS TO BE PROVIDING SERVICES WHICH CONFORM TO OASAS' STANDARDS FOR ALCOHOLISM AND/OR SUBSTANCE ABUSE TREATMENT (ATTACH A COMPLETED WORK EXPERIENCE VERIFICATION RECORD ADDENDUM -- WORK SETTING CERTIFICATION [PDS 13.1]).

INFORMATION ON REVERSE SIDE OF PAGE MUST BE COMPLETED

PART C - WORK EXPERIENCE VERIFICATION RECORD (CONT'D)

APPLICANT EMPLOYMENT STATUS

UNDER THE APPROPRIATE HEADING, INDICATE THE APPLICANT'S JOB TITLE DURING EMPLOYMENT; DATES OF EMPLOYMENT (MONTH/YEAR); AND TOTAL WORK EXPERIENCE HOURS (INCLUDING SUPERVISED PRACTICAL TRAINING, IF APPLICABLE).

PAID WORK EXPERIENCE <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME		
APPLICANT JOB TITLE DURING EMPLOYMENT	DATES OF EMPLOYMENT (MONTH/YEAR) TO	TOTAL WORK EXPERIENCE HOURS (INCLUDING SUPERVISED PRACTICAL TRAINING)
VOLUNTARY OR OTHER NON-PAID WORK EXPERIENCE (MAXIMUM: 2000 HOURS) <input type="checkbox"/> VOLUNTEER <input type="checkbox"/> FORMAL INTERNSHIP OR FORMAL FIELD PLACEMENT		
APPLICANT JOB TITLE DURING EMPLOYMENT	DATES OF EMPLOYMENT (MONTH/YEAR) TO	TOTAL WORK EXPERIENCE HOURS (INCLUDING SUPERVISED PRACTICAL TRAINING)

APPLICANT JOB RESPONSIBILITIES

I CERTIFY THAT, DURING THE DATES OF EMPLOYMENT INDICATED ABOVE, THE APPLICANT WAS RESPONSIBLE FOR PRACTICE IN THE FOLLOWING AREAS:		
<input type="checkbox"/> DIAGNOSTIC ASSESSMENT	<input type="checkbox"/> INTERVENTION	<input type="checkbox"/> ALCOHOLISM AND/OR SUBSTANCE ABUSE COUNSELING (INDIVIDUAL)
<input type="checkbox"/> EVALUATION	<input type="checkbox"/> REFERRAL	<input type="checkbox"/> ALCOHOLISM AND/OR SUBSTANCE ABUSE COUNSELING (GROUP)

SUPERVISED PRACTICAL TRAINING

IN EACH OF THE FOLLOWING 12 CORE FUNCTIONS (AREAS OF PROFESSIONAL EXPERTISE), ENTER THE TOTAL NUMBER OF HOURS IN WHICH YOU PROVIDED SUPERVISED PRACTICAL TRAINING TO THE APPLICANT AS PART OF HIS/HER WORK EXPERIENCE. APPLICANTS MUST DOCUMENT 300 HOURS OF SUPERVISED PRACTICAL TRAINING. EACH OF THE 12 CORE FUNCTIONS (AREAS OF PROFESSIONAL EXPERTISE) MUST HAVE BEEN PERFORMED FOR A MINIMUM OF 10 HOURS UNDER THE SUPERVISION OF A QUALIFIED HEALTH PROFESSIONAL. THESE MINIMUM HOURS MAY BE OBTAINED FROM ONE OR MORE SUPERVISOR(S)/PROVIDER(S)/EMPLOYER(S).

Screening	Intake	Orienta- tion	Assess- ment, Evaluation, and Inter- vention	Referral	Treat- ment Planning	Counseling	Crisis Inter- vention	Patient Education	Case Management	Reporting and Record Keeping	Consultation with Other Professionals	TOTAL SUPERVISED PRACTICAL TRAINING HOURS (MINIMUM: 300 HOURS)

SUPERVISOR CERTIFICATION

I HAVE REVIEWED OUR RECORDS AND CERTIFY THAT THE INFORMATION PROVIDED ON THE WORK EXPERIENCE AND SUPERVISED PRACTICAL TRAINING (IF APPLICABLE) OF THE ABOVE-NAMED APPLICANT IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF. ADDITIONAL DOCUMENTATION IS ATTACHED, AS REQUIRED.		
NAME OF APPLICANT SUPERVISOR	JOB TITLE OF APPLICANT SUPERVISOR	
CHECK ALL CREDENTIALS OR LICENSES THAT VERIFY YOUR STATUS AS A QUALIFIED HEALTH PROFESSIONAL (ATTACH A COPY OF AT LEAST ONE OF THE CURRENT CREDENTIALS OR LICENSES INDICATED).		
<input type="checkbox"/> CASAC	<input type="checkbox"/> PHYSICIAN	<input type="checkbox"/> REHABILITATION COUNSELOR
<input type="checkbox"/> CERTIFIED SOCIAL WORKER	<input type="checkbox"/> PHYSICIAN'S ASSISTANT	<input type="checkbox"/> THERAPEUTIC RECREATION SPECIALIST
<input type="checkbox"/> NURSE PRACTITIONER	<input type="checkbox"/> PROFESSIONAL NURSE	<input type="checkbox"/> FAMILY THERAPIST
<input type="checkbox"/> OCCUPATIONAL THERAPIST	<input type="checkbox"/> PSYCHOLOGIST	<input type="checkbox"/> COUNSELOR CERTIFIED BY THE NATIONAL BOARD FOR CERTIFIED COUNSELORS
SIGNATURE OF APPLICANT SUPERVISOR	WORK SITE TELEPHONE NO. ()	DATE

HUMAN RESOURCES DEPARTMENT (OR EQUIVALENT) AUTHORIZED REPRESENTATIVE CERTIFICATION

I HAVE REVIEWED OUR EMPLOYMENT RECORDS AND CERTIFY THAT THE INFORMATION PROVIDED ON THE DATES OF EMPLOYMENT AND TOTAL WORK EXPERIENCE HOURS OF THE ABOVE-NAMED APPLICANT IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.		
NAME OF AUTHORIZED REPRESENTATIVE	JOB TITLE OF AUTHORIZED REPRESENTATIVE	
SIGNATURE OF AUTHORIZED REPRESENTATIVE	WORK SITE TELEPHONE NO. ()	DATE

PLEASE RETURN THIS COMPLETED FORM TO THE APPLICANT WITH ANY OTHER DOCUMENTATION REQUIRED