

MEDICARE SET-ASIDE CERTIFIED CONSULTANT (MSCC) APPLICATION CHECKLIST

Please use the following form to assist with your application for the MSCC credential.

Copies of the following must be included with your application. Please note that these will not be returned to you.

Fully Completed Application

Copy of diploma

Copy of certificate from completed training course(s)

Curricula Vitae

Copy of MSA Work Sample

Copy of the peer review critique of your MSA worksample

Test Fee of \$445 payable to ICHCC

Applications may be faxed, mailed, or emailed to:

ICHCC

13801 Village Mill Drive, Suite 103

ICHCC 13801 Village Mill Drive, Suite 103 Midlothian, VA 23114 Office: (804) 378-7273 Fax: (804) 378-7267

email: ichccl@gmail.com

Credit card payments may be processed online at <u>ichcc.org</u>. If paying online choose the shopping cart icon in the top right corner of the page.



APPLICATION FOR CERTIFICATION

Medicare Set-Aside Certified Consultant

INSTRUCTIONS	Date:		
 Print and complete all items that apply to you are submitted with your application. Please n Allow 5 business days to process your MSCO Please write clearly and legibly 	ote that these items will not be		
APPLICANT INFORMATION			
Name			
Address			
City	State	Zip	
Phone	Email		
Mailing Address (if different from above):			
Address			
City	State	Zip	
EDUCATION INFORMATION			
Please attach a copy of your educational degree(s) to have recognized by the Commission.	and any other certification	or credential you wish	
College/University		Degree Awarded	
Bachelor's			
Master's			

Doctoral

Nursing



Diploma-RN	_ Associates-RN	_ BSN-RN	_ MSN-RN
ADDITIONAL CERTIFICAT	ΓΙΟΝS		

Please use the following space below for additional certifications or credentials awarded. A copy of the credential must be attached.

Designation	A 200 00-000	E-mination Data
Designation	Acronym	Expiration Date

APPROVED MSCC TRAINING INFORMATION

A minimum of 30 hours is required to satisfy this section of the application. A copy of your certificate of completion must be attached for each documented training program/course relating to MSA. Certification must be obtained within five years from graduation date.

30 hour MSCC Program Attended: _		
-		
Completion Date:	 _	

EMPLOYMENT HISTORY

Please list by most recent. Include only the past five years of employment. Attach additional information if necessary.

Current Professional Title	_
Employer Name	_
Address	



City	State	Zip
Employment History – Continued Phone		
Professional Title		
Employer Name		
Address		
City	State	Zip
Phone	Time Employed	
Professional Title		
Employer Name		
Address		
City	State	Zip
Phone	Time Employed	

TESTING INFORMATION



Our online administration of the examination is proctored by ExamPro. Once your MSCC application is ap[proved you will be sent an application approval letter from the ICHCC as well as an Exam Voucher from nonreply@provexams.com. Your Exam Voucher will contain your Candidate ID number contact information for Pro exams, as well as additional information on the MSCC examination. When you receive your Exam Voucher, you may call Pro to schedule your MSCC exam date and time.

Req	uested	Exam	Date	
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EXAM FEES

Medicare Set-Aside Certified Consultant Examination Fee: \$445

Payments by check or money order should be made payable to ICHCC. Credit card payments may be processed online at ichcc.org by choosing the shopping cart icon in the top right hand corner of the page.



DISCLAIMER AND SIGNATURE

I HEREBY CERTIFY that the facts set forth in this application for the Medicare Set-Aside Certified Consultant credential are true and complete to the best of my knowledge. I understand that if I am certified, false statements on this application shall be considered sufficient cause for dismissal and revocation of my credential. I authorize the Commission on Health Care Certification to provide validation to any organization on my certification status upon request.

I have read and fully understand the standards and guidelines of the ICHCC, and will abide by those standards and guidelines set forth by the Commission. Signature Date **Printed** Please print name and credentials exactly as they should appear on your certificate below: **OPTIONAL:** The following is <u>not</u> required and is used for statistical analysis only. Number of years since acquired degree: 3-5 6-110 11-15 15-19 20-25 $\Box 26+$ Number of Years employed In the Healthcare Field: 3-5 6-110 11-15 15-19 20 - 25 \Box 26+ □under 25 \square 26-30 \square 31-35 \square 36-40 $\Box 41-45$ Age: \square 46-50 **□**51-55 $\Box 56-60$ \Box 61+ Gender: Female Male Ethnicity ☐African American □Asian □Hispanic □Native American **□**White □Other