

# 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 \$495 payable to ICHCC**

Applications may be faxed, mailed, or emailed to:

ICHCC 13801 Village Mill Drive, Suite 103 Midlothian, VA 23114 Office: (804) 378-7273 Fax: (804) 378-7267 email: <u>ichcc1@gmail.com</u>

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. Please DO NOT STAPLE. Make sure all documents are submitted with your application. Please note that these items will not be returned to you.
- Allow 5 business days to process your MSCC application
- Please write clearly and legibly

### **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) and any other certification or credential you wish to have recognized by the Commission.

	College/University		Degree Awarded				
Bachelor's							
Master's							
Doctoral							
Nursing	Diploma-RN	Associates-RN	BSN-RN	MSN-RN			



# ADDITIONAL CERTIFICATIONS

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

Designation	Acronym	<b>Expiration Date</b>

# 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
Phone	Time Employed	
Professional Title		
Employer Name		
Address		
	State	
Phone	Time Employed	
Professional Title		
Employer Name		
City	State	Zip
Phone	Time Employed	

# **TESTING INFORMATION**

# *Pro*√

Our online administration of the examination is proctored by ExamPro $\checkmark$ . 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 <u>nonreply@provexams.com</u>. Your Exam Voucher will contain your Candidate ID number contact information for Pro $\checkmark$  exams, as well as additional information on the MSCC examination. When you receive your Exam Voucher, you may call Pro $\checkmark$  to schedule your MSCC exam date and time. Prov Exams will charge you a \$30 proctoring fee.

Requested Exam Date \_\_\_\_\_

#### EXAM FEES

#### Medicare Set-Aside Certified Consultant Examination Fee: \$495

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

# <u>Please print name and credentials exactly as they should appear on</u> <u>your certificate below:</u>

#### **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	□26+
Number of Years employed In the Healthcare Field:		3-5		6-110	11-15		15-19		20-25	□26+
Age:	□u	nder 2	5 <b>[</b>	26-30	□31-35		□36-4	40	41	-45
	□4	6-50	[	□51-55	□56-60	)	□61+	-		
Gender:		Fema	le		□ Ma	le				
Ethnicity	anicity 🛛 African American		□Asian			□Hispanic				
	۵N	Native 1	Ameri	can	□White				ther	