IMPACT Plus
Targeted Case Management
New Employee/Contract Screening Form

Applicant Name: ____________________ **Applicant Social Security #:** ____________

Subprovider Name: ____________________ **Applicant Date of Birth:** ____________

Supervisor's Name & Credentials (who will provide weekly face-to-face supervision): ____________

Region(s) this applicant will be working: ____________________

Please complete the following information related to education:

- ❑ BA or BS degree name in a behavioral science: ____________
- ❑ Name of college or university: ____________
- ❑ Month and year of graduation: ____________

Please complete the following information related to employment working directly with children after completion of educational requirements. A master's degree in a behavioral science may substitute for the experience:

Begin Date (month/year)	End Date (month/ year)	Place of employment <u>or</u> Name of College/University	Job Title	Number of Hours Worked and/or MA or MS degree earned
			Total # of hours worked/degree earned =	

All of the following boxes must be checked verifying applicable information for each section is included with this form. The Credentialing Committee will not review packets that do not contain all of the required information.

- ❑ Current resume
- ❑ College transcript(s)
- ❑ Current Department for Community Based Services background check results
- ❑ Current Administrative Office of the Courts background check results
- ❑ Current Statement of Disclosure signed by applicant and subprovider

Comments: ____________________

In accordance with 907 KAR 3:030 and the IMPACT Plus Subprovider Agreement, the undersigned do hereby affirm all information related to this applicant has been reviewed for the Targeted Case Management position. References and other documentation submitted have been verified and the undersigned attest to it's accuracy.

In addition, we understand this applicant must be reviewed by the IMPACT Plus Credentialing Committee located in Frankfort, KY, and given "Approval" status before the delivery of IMPACT Plus services can be considered for Medicaid reimbursement.

Subprovider's Signature ____________________
Name Position Date

Applicant's Signature ____________________
Name Position Date

Revised 6/18/2007