HICAP Verification of Certification

Area Agency on Aging of: _____

Director _____ verifies the
Please print name of Director

application of _____ (name of applicant) for:

Note: The steps required for certification must be completed before this form is submitted.

A. Please check one of the following six categories:

1. ☐ Benefits Counselor not certified (check if new staff, certification pending)
2. ☐ Benefits Counselor I:
   - ☐ 25 hours required training (list the training hours on page 3).
   - ☐ 20 hours counseling, with oversight (list the counseling hours on page 4).
   - ☐ At least a 70 passing score on the self-assessment 100 question test or requesting test.
3. ☐ Benefits Counselor II:
   - ☐ One day BC II training on administrative appeals (list training on page 3).
   - ☐ Served as advocate in at least one mock or real administrative appeals hearing or requesting mock hearing.
4. ☐ Recertification for Benefits Counselor I:
   - ☐ 12 additional hours of training on public/private benefits and related legal issues (list the training hours on page 3).
5. ☐ Recertification for Benefits Counselor II:
   - ☐ 12 additional hours of training on public/private benefits and related legal issues (list the training hours on page 3).
6. ☐ Long Term Care Planning Certification (list training hours on page 3).

SECTION B

B. The applicant is (check all that are applicable):

☐ an employee of the Area Agency on Aging

☐ a volunteer of the Area Agency on Aging

☐ an employee of the Aging and Disability Resource Center of

_____

☐ a volunteer of an Aging and Disability Resource Center of

_____

☐ an employee of an agency or entity other than an Area Agency on Aging or an Aging and Disability Resource Center. The employer of the applicant is:

_____

Located at _____

_____

The Director further verifies that the applicant does not present a conflict of interest with the HICAP program.

_____

DIRECTOR, AREA AGENCY ON AGING

DATE _____

Submit this completed form ,including any necessary supporting documentation, to BCtraining@tlsc.org

25 hours of training, and name of provider	Date	Hours or fractions of hours
		Total Hours: _____

20 hours of client counseling services, and name of supervisor	**Date**	**Hours or fractions of hours**
		Total Hours: _____

Revised 10/2020