State of Illinois
Illinois Department of Public Health
HHA - Medical Social Worker/Social Work Assistant Qualification Review Form

HOME HEALTH ONLY - If Applicable

Attachment D - Medical Social Worker/Social Work Assistant Qualification Review Form

Attachment D must be completed for each social worker and social work assistant used by your home health agency, whether directly employed or employed by contract. Section 245.20 of the 77 Illinois Administrative Code 245 requires that the medical social worker be a licensed social worker/clinical social worker under the Clinical Social Work and Social Work Practice Act.

Before forwarding Attachment D to the social worker for completion, please fill in the name, address and city of your home health agency at the top of the form.

The person(s) completing Attachment D also should appear on the (Licensed or Registered Employees) page for Home Health and check F/T, P/T or contract.

Home Health Agency Name _____

Address _____

City _____ State _____ ZIP Code _____

Medical Social Worker Information

Last Name _____ First Name _____ Middle Initial _____

Address _____

City _____ State _____ ZIP Code _____

Daytime Phone Number _____ Extension _____

State of Illinois
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HHA - Medical Social Worker/Social Work Assistant Qualification Review Form

THE FOLLOWING TO BE COMPLETED BY MEDICAL SOCIAL WORKER

Section 245.20 requires that the **medical social worker** be a ***licensed*** social worker/clinical social worker under the Clinical Social Work and Social Work Practice Act and **have one year of social work experience in a health care setting.**

List applicable professional licenses, registrations and/or certifications currently held. **Attach a copy of your current Illinois license.**

Date MSW Degree Awarded (if applicable) _____ Date of Initial License _____

Expiration Date of Current License _____ State of Issuance _____

Name of College _____ Date of Graduation _____

Address of College _____

City _____ State _____ ZIP Code _____

Specialty Degree _____

Describe your relevant work experience to meet the requirements of Section 245.20.

Employer Name _____

Address of Employer _____

City _____ State _____ ZIP Code _____

Starting (month and year) _____ Ending (month and year) _____ Total Hours Worked Weekly _____

Duties _____

_____

Employer Name _____

Address of Employer _____

City _____ State _____ ZIP Code _____

Starting (month and year) _____ Ending (month and year) _____ Total Hours Worked Weekly _____

Duties _____

_____

IF YOU ARE A MEDICAL SOCIAL WORKER, PROCEED TO THE SIGNATURE BLOCK AND SIGN AT THE BOTTOM OF PAGE FOUR.

HOME HEALTH ONLY

THE FOLLOWING SECTION MUST BE COMPLETED BY THE SOCIAL WORK ASSISTANT

Section 245.20 requires that the **social work assistant** have a ***baccalaureate degree*** in social work, psychology, sociology or related field and at least ***one year of social work experience*** in a health care setting. For persons initially licensed by a state or seeking initial qualifications as a social work assistant prior to December 31, 1977, refer to 77 Illinois Administrative Code.
Please list the college(s) attended, the address, date of graduation, specialty and degree obtained.

Name of College _____

Address of College _____

City _____ State _____ ZIP Code _____

Date of Graduation _____ Specialty/Degree _____

Describe your relevant work experience to meet the requirements of Section 245.20.

Employer Name _____

Address of Employer _____

City _____ State _____ ZIP Code _____

Starting (month and year) _____ Ending (month and year) _____ Total Hours Worked Weekly _____

Duties _____

_____

_____

Employer Name _____

Address of Employer _____

City _____ State _____ ZIP Code _____

Starting (month and year) _____ Ending (month and year) _____ Total Hours Worked Weekly _____

Duties _____

_____

_____

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Section 245.40 requires a social work assistant to be under the supervision of a social worker (social worker as defined in Section 245.20. Both social work assistant and supervision licensed social worker should complete Page 1 of Attachment D.

Name of licensed social worker providing supervision (if applicable)

I signify that that information contained in this form is true and correct to the best of my knowledge and belief. I realize that misrepresentation of this information at any time my be cause for denial of this application, or future revocation of a license.

Signature of Medical Social Worker Applicant (Original Only)

Date

Signature of Social Worker Assistant (if applicable) (Original Only)