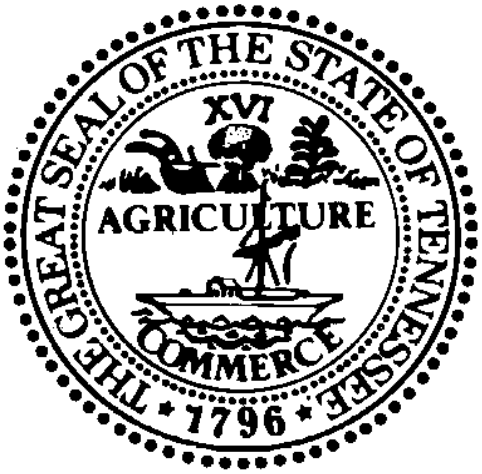

State of Tennessee

Department of Health

Tennessee Board of Social Worker Licensure

665 Mainstream Drive
Nashville, TN 37243

1-800-778-4123 ext 25088
(615) 532-5088
www.state.tn.us/health

Applications and Procedures for

LICENSED CLINICAL SOCIAL WORKER

No members of any other mental health or medical discipline will qualify as an approved supervisor for L.C.S.W. or L.A.P.S.W. licensure.

Conflict of Interest Supervision - Supervision provided by the applicant's parents, spouse, former spouse, siblings, children, cousins, in-laws (present or former), step-children, grandparents, grandchildren, aunts, uncles, employees, or anyone sharing the same household shall not be acceptable toward fulfillment of licensure requirements. For the purposes of this rule, a supervisor shall not be considered an employee of the applicant, if the only compensation received by the supervisor consists of payment for actual supervisory hours.

GENERAL INFORMATION

It is the applicant's responsibility to review the current Rules and Laws for Social Work. To determine if you meet the qualifications for licensure. You may obtain a copy by going to www.health.state.tn.us.

Individuals who do not qualify for licensure at this time are encouraged to complete deficient requirements if you intend to practice as a social worker in Tennessee.

It is the applicant's responsibility to keep the board notified whenever a change of name or mailing address occurs. Such notification must be in writing and you must reference your profession and the board in your correspondence. Supporting documentation and written request for a name change must state the reason for the change, i.e., marriage, divorce, etc .

Every effort is made to keep you informed, **in writing**, of the status of your application and to process your application in a timely, efficient manner. Inquiries regarding the status of a file will be responded to in writing.

SECTION I

LICENSED CLINICAL SOCIAL WORKER BY EXAMINATION:

CHECK LIST FOR LICENSED CLINICAL SOCIAL WORK

You send	**You request others to send**
_____ Completed and signed application _____ Fees of $ 235.00 ($100.00 application fee plus $ 125.00 license fee plus $ 10.00 State regulatory fee) payable to: the Board of Social Worker Licensure _____ Passport-style photograph _____ All applicants must complete the attached Declaration of Citizenship form _____ Copy of Current LMSW renewal card _____ Professional Reference _____ Verification of Supervision _____ Verification of supervisors six (6) hours of continuing education related to clinical supervision _____ Detailed supervision logs indicating 3000 clinical and 100 supervision hours. _____ Completed Mandatory Practitioner Profile Questionnaire (**mail with the application)**	_____ Official transcripts (page 14) _____ Verification of licensure, if licensed in other jurisdiction regardless of the status of the license (i.e., inactive) (page 15) _____ Criminal Background Check For instructions go to: http://health.tn.gov/CBC **(once you have successfully passed the ASWB exam you must apply for the criminal background check)**

Note: At least sixty (60) of the one hundred (100) supervisor contact hours must be one-to-one supervision between the supervisor and supervisee; no more than forty (40) hours may be in a situation where the supervisor is working with no more that four (4) supervisees in a group setting.

SECTION II

LICENSED CLINICAL SOCIAL WORKER BY RECIPROCITY:

CHECK LIST FOR LICENSED CLINICAL SOCIAL WORK

You send	**You request others to send**
_____ Completed and signed application _____ Fees of $ 235.00 ($100.00 application fee plus $ 125.00 license fee plus $ 10.00 State regulatory fee) payable to: the Board of Social Worker Licensure _____ Passport-style photograph _____ All applicants must complete the attached Declaration of Citizenship form _____ A copy of the original State's law and rules, if available _____ Photocopy of the original license from the original state of licensure with applicants current license number, if available; and _____ Photocopy of the applicants current renewal certificate with the license number and expiration date _____ Completed Mandatory Practitioner Profile Questionnaire http://health.state.tn.us/Downloads/PH-3585.pdf **(mail with the application)**	_____ Official transcripts (page 14) _____ Verification of licensure, if licensed in other jurisdiction regardless of the status of the license (i.e., inactive) (page 15) _____ Verification of applicant taking and passing the ASWB examination (page 16) _____ Criminal Background Check For instructions go to: http://health.tn.gov/CBC

NOTE: IF AN APPLICANT DOES NOT QUALIFY FOR LICENSURE BY RECIPROCITY, HE OR SHE MUST APPLY FOR LICENSURE BY EXAMINATION. IF DOCUMENTATION OF APPROPRIATE SUPERVISION MEETING THE REQUIREMENTS PURSUANT TO RULE 1365-01-.01 (A) OR BEFORE DECEMBER 31, 2010 PURSUANT TO RULE 1365-01-.04 (5) IS PROVIDED THE APPLICANT MAY NOT HAVE POSSESSED THE CREDENTIAL OF LICENSED MASTER SOCIAL WORKER IN THE STATE OF TENNESSEE PRIOR TO APPLICATION TO SIT FOR THE EXAMINATION.

ATTACH
PASSPORT TYPE
PHOTO HERE

Application fee	46-001	$100
License fee	46-001	$125
State Reg fee	46-017	$ 10
		$235

Tennessee Board of Social Worker Licensure
665 Mainstream Drive
Nashville, TN 37243

615-532-5088 or 800-778-4123 ext 25088
www.state.tn.us/health

Licensed Clinical Social Worker

Please Check One: _____ **LCSW BY RECIPROCITY**
_____ **LCSW BY INITIAL/EXAM**

NAME: _____
(Last) (First) (Middle/Maiden)

NOTE: This name will be used to register you with the testing agency (ASWB). You will be required to present the original ASWB Authorization Letter and one currently valid, non-expired government-issued photo-bearing i.d. (driver's license, military i.d., passport, etc.) at the testing center. The name on your i.d. MUST match your name as it appears on your Authorization Letter. You will not be allowed to test and will forfeit your exam fee without the Authorization Letter and proper identification.

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (_____) _____ HOME E-MAIL: _____

Do you wish to receive notification, including renewal notification, from the Department of Health via email? ____ Y ____N

SOCIAL SECURITY NO: _____ - _____ - _____ BIRTH DATE: _____ / _____ / _____

You must put your social security number on this form for the application to be complete. State and federal law require social security numbers on this application. Tenn. Code. Ann. § 36-5-1301(a), as authorized by 42 U.S.C. § 405(c)(2)(C)(i). The number will be used to verify your identity, to ask questions about your financial responsibility, and for any other purpose allowed by state or federal law. When you provide your social security number on this application and sign the form, you are agreeing that Department of Health may use your social security number in furtherance of federal and state law, for example, to collect delinquent fees.

RACE: _____ SEX: _____

U.S. CITIZEN: Yes_____ No_____
All applicants must complete the attached Declaration of Citizenship form

---

EDUCATIONAL INFORMATION:

NAME OF COLLEGE/UNIVERSITY: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

DEGREE RECEIVED: _____ DATE CONFERRED: _____ / _____ / _____

Do you or have you ever held a certificate or license to practice social work in any other state?

YES: _____ NO: _____

If yes, you must submit a letter of good standing from each state in which you have or have ever held a certificate and/or license.

_____/_____, _____/_____, _____/_____,
(State) (License No.) (State) (License No.) (State) (License No.)

LICENSURE INFORMATION: RECIPROCITY APPLICANTS

1. Have you taken and passed the ASWB Clinical exam? YES: _____ NO: _____

2. If yes, please have the ASWB send a copy of your test scores.

EMPLOYMENT HISTORY:

CURRENT EMPLOYER: _____

EMPLOYER ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

WORK PHONE: (_____) _____-_____ WORK E-MAIL: _____

JOB TITLE: _____ TYPE OF POSITION: _____

FULL TIME: _____ PART TIME: _____ WORKING IN PROFESSION: YES: _____ NO: _____

EMPLOYMENT DATES: FROM: _____/_____/_____ TO: _____/_____/_____

SUPERVISOR'S NAME: _____

MAJOR RESPONSIBILITIES: _____

_____

_____

PLEASE ANSWER THE FOLLOWING QUESTIONS: If any answers to the questions in this part are in the affirmative, attach an explanation on a separate sheet. In support of your explanation, the final documents or orders from the issuing states, courts, and/or agencies must be submitted along with this application.

For the purpose of these questions, the following phrases or words have the following meanings:

1. "Ability to practice social work" is to be construed to include all of the following:

    a. The cognitive capacity to make appropriate diagnosis or evaluation, exercise reasonable judgment, to learn, and keep abreast of developments in the field of social work.

    b. The ability to communicate those judgments and information to clients and other health care providers, with or without the use of aids or devises, such as voice amplifiers.

2. "Chemical Substance" is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction as well as those used illegally.

3. "Currently" does not mean on the day of or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's function as a licensee or within the past two (2) years.

QUESTION:	YES	NO
1. Do you currently have a medical condition which in any way impairs or limits your ability to practice social work with reasonable skill and safety?	_____	_____
a. If yes, are they reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program?	_____	_____
b. If you have any limitations or impairments caused by an existing medical condition, are they reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?	_____	_____
(If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individual assessment of the nature, the severity, and the duration of the risks associated with an ongoing medical condition so as to be determined whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure).		
2. Do you currently use chemical substance?	_____	_____
a. If yes, please submit a letter from your physician regarding your prescribed medication. (Must be submitted on physician letter head, and must contain information on whether this medication will impair or limit your ability to practice social work with reasonable skill and safety).		
3. Are you currently engaged in the illegal use of controlled substance?	_____	_____
a. If yes, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaged in the Illegal use of controlled substance? (Submit a letter from your Physician regarding your Treatment).	_____	_____
4. Have you ever been diagnosed as have or have you ever been treated for pedophilia, exhibitionism, or voyeurism?	_____	_____
5. If you have ever held or applied for a license to practice social work in any state, country, or province, was or has it ever been denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	_____	_____

QUESTION:	YES	NO
6. If you have ever had staff privileges at any hospital or health care facility, have they ever been revoked, suspended, curtailed, restricted, limited, otherwise disciplined, or voluntarily surrendered under threat of restriction or disciplinary action?	_____	_____
7. Have you ever been convicted of a felony or a misdemeanor other than a minor traffic violation?	_____	_____
8. Have you ever been rejected or censured by a professional association?	_____	_____
9. In relation to the performance of your professional services in any profession:		
a. Have you ever had a final judgment rendered against you?	_____	_____
b. Have you ever had a settlement of any legal action rendered against you?	_____	_____
c. Are there any legal actions pending against you or to which you are a party?	_____	_____
10. If you have ever held a license or certificate in any health care profession, has it ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat if investigation or disciplinary action?	_____	_____

AFFIDAVIT OF APPLICANT
APPLICANT'S CONSENT AND RELEASE

In applying for licensure in the State of Tennessee, I HEREBY:

AUTHORIZE THE BOARD, its staff, and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competency, character, health status, ethical qualifications, ability to work cooperatively with others, and other qualifications.

CONSENT TO THE RELEASE of such information.

RELEASE FROM LIABILITY the Board, its staff, and all their representatives for their acts performed and statements made in good faith and without malice in connection with evaluation of my application, my credentials, and my qualification.

ACKNOWLEDGE THAT I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical, and other qualifications, and also for resolving any doubt about such qualifications.

THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IN MY APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

_____ _____

(Applicant's Signature) (Date)

REFERENCE FORM LETTER

Applicant's Name	Social Security Number

You must put your social security number on this form for the application to be complete. State and federal law require social security numbers on this application. Tenn. Code. Ann. § 36-5-1301(a), as authorized by 42 U.S.C. § 405(c)(2)(C)(i). The number will be used to verify your identity, to ask questions about your financial responsibility, and for any other purpose allowed by state or federal law. When you provide your social security number on this application and sign the form, you are agreeing that Department of Health may use your social security number in furtherance of federal and state law, for example, to collect delinquent fees.

I hereby certify that _____ has had the equivalency of two (2) years full-time clinical supervision experience under the supervision of a licensed clinical social worker (3000 clinical hours in not less than a two-year period with a minimum equivalency of one hour per week supervision).

Supervision information regarding the applicant follows:

Place of Supervision	Dates of Supervision	Name and Degree of Supervisor

_____
(Signature)*

_____
(Title)

*** This letter must be signed by an LCSW who did not provide the applicant's supervision. If the signator is not licensed in Tennessee, enclose documentation of the other state license.**

Please return this form to address listed above.

PROFESSIONAL REFERENCE ASSESSMENT
(Verification of Supervision)

THIS SECTION TO BE FILLED OUT BY APPLICANT:

License Number (LMSW) _____
Effective Date ____/____/____
Expiration Date ____/____/____

_____ _____
Applicant's Name Social Security Number

You must put your social security number on this form for the application to be complete. State and federal law require social security numbers on this application. Tenn. Code. Ann. § 36-5-1301(a), as authorized by 42 U.S.C. § 405(c)(2)(C)(i). The number will be used to verify your identity, to ask questions about your financial responsibility, and for any other purpose allowed by state or federal law. When you provide your social security number on this application and sign the form, you are agreeing that Department of Health may use your social security number in furtherance of federal and state law, for example, to collect delinquent fees.

I have applied to the Tennessee Board of Social Worker Licensure to become a licensed clinical social worker. Your assessment of my characteristics will enable the board to evaluate whether I meet their standards.

_____ _____
(Signature) (Date)

REMAINDER OF THIS FORM TO BE FILLED OUT BY SUPERVISOR .

1. Supervisor's Name: _____

Profession: _____ Educational Degree(s): _____

Business address (street/city/state/zip): _____

_____

Position Title: _____ Telephone: (_____) _____

2. Supervisor's License No.: _____ Licensing State: _____

Date Licensed: _____

Clinical experience: Yes ___ No ___ Number of years: _____

3. Recordkeeping: Dates of Supervision: from ____/____/____ to ____/____/____

Total number of months of supervision _____
Total weekly clinical contact hours _____
Total weekly supervisor-supervisee hours _____
Total weekly group supervisee-supervisor hours _____

1. Total clinical hours during supervision period _____
2. Total supervisor-supervisee hours during supervision period _____
3. group supervisee-supervisor hours during supervision period _____

(Add #2 and #3) Total number hours of supervision _____

4. Nature of setting in which supervised practice took place:

5. Please rate the applicant on the following characteristics. Place a check mark in every category!

Characteristics	Outstanding	Above Average	Average	Below Average	Can Not Evaluate
Individual counseling skills					
Appropriate referral making					
Group counseling skills					
Personal integrity					
Consulting skills					
Insight into client's problems					
Ability to relate to co-workers					
Ability to be objective on the job					
Ethical conduct					
Concern for welfare of clients					
Sense of responsibility					
Recognition of own limits					
Supervisory abilities					
Ability to keep material confidential					

6. Explain any rating of below average, poor, or can not evaluate (use additional paper if necessary).

I certify that the information contained herein is an accurate account of my supervision of:

_____

(Applicant Signature)

_____ _____

(Supervisor's Signature) (Date)

_____

(Print Name of supervisor)

Return completed form to:

Board of Social Worker Licensure
665 Mainstream Drive
Nashville, TN 37243

This Form May Be Duplicated.

Supervision Log

Subject of Supervision Sessions: Theory / Technique / Termination / Diagnosis and Assessment / Self Analysis / Laws and Regulations / Individual Counseling Skills / Group Counseling Skills / Confidentiality / Ethics / Boundaries

_____ Individual Supervision _____ Group Supervision Date from: _____/____/_____ Date to: _____/____/_____
Time In: _____ Time Out: _____
Content:

	Ind hour	Group hour	Clinical hour

Subject of Supervision Sessions: Theory / Technique / Termination / Diagnosis and Assessment / Self Analysis / Laws and Regulations / Individual Counseling Skills / Group Counseling Skills / Confidentiality / Ethics / Boundaries

_____ Individual Supervision _____ Group Supervision Date from: _____/____/_____ Date to: _____/____/_____
Time In: _____ Time Out: _____

Content:

	Ind hour	Group hour	Clinical hour

Subject of Supervision Sessions: Theory / Technique / Termination / Diagnosis and Assessment / Self Analysis / Laws and Regulations / Individual Counseling Skills / Group Counseling Skills / Confidentiality / Ethics / Boundaries

_____ Individual Supervision _____ Group Supervision Date from: _____/____/_____ Date to: _____/____/_____
Time In: _____ Time Out: _____

Content:

	Ind hour	Group hour	Clinical Hour

Total this page			
Cumulative total			

(Supervisor Signature) (Date) (Print Name) (LCSW/ or LAPSW #)

(Supervisee Signature) (Date) (Print Name) (LMSW#)

This form may be duplicated

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
BUREAU OF HEALTH LICENSURE AND REGULATION
DIVISION OF HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243

TENNESSEE BOARD OF SOCIAL WORKER LICENSURE

EDUCATION REQUEST

APPLICANT: Supply the information requested and mail this entire form to the school at which you completed your Social Work program.

NOTE: Most schools require a fee, so you may want to contact the institution before mailing this form so that you can attach their fee.

TO WHOM IT MAY CONCERN: I am applying for a license to practice as a social worker in the State of Tennessee. The Board of Social Worker Licensure requires verification of my educational attainment. Please forward an original transcript bearing the institution's official seal to the Board's address below.

Applicant's Full Name: _____
(Last) (First) (Middle/Maiden)

Applicant's Address: _____

_____
(City) (State) (Zip)

Applicant's Social Security Number: ____-____-____

Applicant's Student Identification Number: _____

Year of Graduation: _____ Degree: _____ Conferred Date: _____

Please forward an official graduate transcript bearing the institution's official seal to:

Tennessee Board of Social Worker Licensure
665 Mainstream Drive
Nashville, TN 37243

Thank you for your cooperation and prompt response.

_____ _____
(Applicant's Signature) (Date)

STATE OF TENNESSEE

DEPARTMENT OF HEALTH

BUREAU OF HEALTH LICENSURE AND REGULATION

DIVISION OF HEALTH RELATED BOARDS

665 MAINSTREAM DRIVE

NASHVILLE, TN 37243

TENNESSEE BOARD OF SOCIAL WORKER LICENSURE

VERIFICATION OF LICENSURE

Please complete the top portion and mail this form to the regulatory board in each state where you hold or have held a license or certificate to practice as a Social Worker. (If additional forms are required, this form may be duplicated.) Please disregard this page if you are not licensed or certified or have never been licensed or certified as a social worker in another state.

NOTE: Some states require a fee for providing verification information. In order to expedite your application, you may wish to contact the applicable state or states.

I was granted _____ on _____ by the State of _____
(License #) (Date)

The Tennessee Board of Social Worker Licensure requests that I submit evidence that my license or certificate in your state is in good standing. You are hereby authorized to release any information in your files, favorable or otherwise, directly to the Tennessee Board of Social Worker Licensure. Your early attention is appreciated. _____ _____
(Signature) (Date)

THIS PORTION IS TO BE COMPLETED BY STATE LICENSING BOARD VERIFYING LICENSURE

<table>
<tr><td>Name of Licensee</td><td>Licensure Level</td><td>License No.</td><td>Date Issued</td></tr>
<tr><td colspan="4">Please Verify All Requirements Met in Your Jurisdiction</td></tr>
<tr><td>Education:
____ BSW from CSWE Accredited School
____ MSW from CSWE Accredited School</td><td colspan="2">Experience clinical:
_____ # Months Post LMSW Clinical Experience
_____ # Hours of face to face supervision
_____ # Hours clinical experience</td><td>Experience non-clinical:
_____ # Months Post LMSW Non-clinical Experience
_____ # Hours of face to face supervision
_____ # Hours non-clinical experience</td></tr>
<tr><td>Exam Taken
_____ ASWB (Only ASWB will be accepted)
_____ Other _____</td><td>Date Exam Passed</td><td>Level Exam Taken</td><td>If no Exam score is on file, how was licensure obtained?
_____ Grandfathered _____ Endorsement:
If endorsement, what state?
_____</td></tr>
<tr><td colspan="2">License Current?
_____ Yes _____ No</td><td colspan="2">Expiration Date
_____/_____/_____
Complaints and/or Disciplinary Action
_____ Yes* _____ No</td></tr>
</table>

***Explain Complaints or Disciplinary Actions (please enclose a copy of any board order)**

_____ _____ _____/_____/_____
(Signature of person completing form) (Title) (Date)

_____ (_____) _____-_____ Board Seal Here
(Print name of person completing form) (Phone number)

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
BUREAU OF HEALTH LICENSURE AND REGULATION
DIVISION OF HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243

TENNESSEE BOARD OF SOCIAL WORKER LICENSURE

EXAM SCORE REQUEST

If you have taken the ASWB exam please complete this form and mail it along with a cashiers check or money order (NO personal checks accepted) in the amount of $40.00 to the ASWB at the following address requesting an original copy of your test results:

Association of Social Work Boards
400 South Ridge Parkway, Suite B
Culpeper, VA 22701
www.aswb.org

You may also request the information from: https://www.aswb.org/exam-candidates/after-the-exam/

Name: _____
(First) (Last) (Middle/Maiden)

Address: _____

_____
(City) (State/Province) (Zip) (Country)

Daytime Phone: (___) ___-_____ Social Security Number: ___-___-____

Date of Birth: ___/___/___ Date of Exam: ___/___/___

Exam Taken: Basic _____ Intermediate _____ Advanced _____ Clinical _____

I am applying for a license to practice as a social worker in the State of Tennessee. The Board of Social Worker Licensure requires verification of my examination results. Please forward the results of the exam to the Board's address below.

Tennessee Board of Social Worker Licensure
665 Mainstream Drive
Nashville, TN 37243

_____ _____
(Applicant's Signature) (Date)

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243

DECLARATION OF CITIZENSHIP
MUST ACCOMPANY ALL APPLICATIONS FOR INITIAL LICENSURE OR REINSTATEMENT OF LICENSURE

The "SAVE Act" requires Tennessee Department of Health (including all Boards, Commissions, and contractors), along with every local health department in the State, to verify that *every* ***adult* applicant for a professional license is either a U.S. citizen, a "qualified alien," or a nonimmigrant who meets the requirements set out at 8 U.S.C. 1621.**

I am a(n) _____ _____.
Healthcare Profession (Please Print) **License number if applicable**

Please Print Legibly

1. Name:_____
   Last First Middle Maiden_
2. Mailing Address: _____
3. Phone Number: Home: (____)_____-_____ Office: (____)_____-_____ Fax: (____)___-_____
4. I am a United States Citizen: ____Yes ____No
5. I am a foreign national not physically present in the United States _____Yes _____No. If you answered yes, to this question please sign this form in the presence of a notary and return it with your application. No further documentation is required.
6. Applicants Claiming United States Citizenship **MUST** provide one of the following:

   a) Tennessee Driver's License, or photo ID issued by Department of Safety.
   b) A valid driver license or ID issued by another state, provided its issuance requirements meet Department of Safety criteria.
   c) An official birth certificate issued by a U.S. state, territory, or other jurisdiction. Puerto Rican birth certificates issued before July 1, 2010 do not count.
   d) A federally issued birth certificate.
   e) A valid, unexpired U.S. passport.
   f) A report of birth abroad of a U.S. citizen.
   g) A certificate of citizenship.
   h) A certificate of naturalization.
   i) A U.S. citizen ID card.
   j) Any successor document to #'s a-i above.
   k) SSN that the entity or local health department may verify with the Social Security Administration in accordance with federal law.

7. If you checked "No" in question 4 please indicate from the list below which category applies to you: (circle one)

   a) Permanent Residents
   b) A nonimmigrant applicant for a professional or commercial license whose visa for entry into the United States is related to such employment, or a nonimmigrant under the Immigration and Nationality Act (8 U.S.C. 1101 *et seq.*).

c) Asylees who meet the qualifications set out in 8 U.S.C. 1158
d) Refugees who meet the qualifications set out in 8 U.S.C. 1157
e) Persons who have been "paroled into the United States," under 8 U.S.C. 1182(d)(5) or whose deportation has been withheld under 8 U.S.C. 1253.
f) Cuban or Haitian entrants as defined by section 501(e) of the Refugee Education Assistance Act of 1980
g) Persons granted conditional entry into the U.S. under 8 U.S.C. 1153(a)(7) before April 1, 1980, because of persecution or fear of persecution on account of race, religion, or political opinion or because of being uprooted by catastrophic national calamity.
h) An alien who has been "battered" or subjected to "extreme cruelty" by a parent or spouse as defined by 8 U.S.C. 1641(c), and also meets the qualifications set out 8 U.S.C. 1641(c)(1)(B). Under the circumstances set out in 8 U.S.C. 1641(c)(2) and (3), victims' children, or the parents of children who are victims, may also apply for benefits as qualified aliens.

Applicants claiming **qualified alien status** (question 7 above), please submit two of the following forms of "documentation of identity and immigration status" as determined by U.S. Homeland Security to be acceptable for verification through the SAVE program. Common types of documents used to verify immigration status are listed below. (Note: If you can provide only one document, your status will be verified through the U.S. Department of Homeland Security's SAVE program):

I-327 (Reentry Permit)

I-551 (Permanent Resident Card or "Green Card")

I-571 (Refugee Travel Document)

I-766 (Employment Authorization Card)

Machine Readable Immigrant Visa (with Temporary I-551 language)

Temporary I-551 stamp (on passport or I-94)

I-94 (Arrival/Departure record)

Unexpired foreign passport

WT/WB Admission Stamp in unexpired foreign passport

I-20 (Certificate of Eligibility for Nonimmigrant F(1) student status– "student visa")

DS2019 (Certificate of Eligibility for Exchange Visitor (J-1) Status)

I affirm under the penalty of perjury that the above is true and correct.

Signed this _____ day of _____, 20__.

_____
Signature

Sworn to before me this _____day of _____, 20__.

_____ AFFIX SEAL HERE
NOTARY PUBLIC

My Commission Expires:_____

If an applicant is discovered to be an unqualified alien, or otherwise ineligible for benefits under the Act, all recurring benefits provided to that applicant must be immediately terminated. Anyone who purposefully makes a false, fictitious, or fraudulent claim of U.S. citizenship or qualified alien status will be liable under the Tennessee Medicaid False Claims Act, or Tennessee's False Claims Act. Any person who conspires to defraud the state or any local health department by securing a false claim allowed or paid to another person in violation of the Act may be liable under Tennessee's False Claims Act. Upon discovery of an applicant's false, fictitious, or fraudulent claim of U.S. citizenship, state governmental entities and local health departments must also file a criminal complaint with the United States Attorney.