Trillium HEALTH RESOURCES

Transforming Lives. Building Community Well-Being.

ELIGIBILITY DETERMINATION FOR NC-SNAP TRAINING

Name: _____

Agency: _____

Degree: _____

Discipline (what your degree is in): _____

Institution (College/University) you received your degree from: _____

Date you received your degree: _____

Professional License or Certification Type and Number (if applicable):

Current Professional Credential Status:

QP (Qualified Professional) in: ☐ I/DD ☐ MH ☐ SU

AP (Associate Professional) in: ☐ I/DD ☐ MH ☐ SU

If AP, name and qualifications/credentials of current clinical supervisor. Is your supervisor privileged to perform the NCSNAP? _____

What is your current position? _____

What services will you be providing? _____

Age and disability of population to be served in current position: _____

Number of years of supervised work experience providing I/DD habilitative services: _____

Please provide a brief synopsis of your work experience with people with I/DD. Include number of years worked, agency name, and type of work/position held.