

The Commonwealth of Massachusetts
Division of Professional Licensure, Board of Registration of Social Workers
c/o, ASWB
17126 Mountain Run Vista Ct., Culpeper, VA 22701
866.527.2384

Instructions for Social Worker Licensure Application Update

An application approval and examination authorization must have been in effect within the past 12-months

General Information

The Association of Social Work Boards (ASWB) processes social work licensing applications on behalf of the Commonwealth of Massachusetts Board of Registration of Social Workers, as authorized by the Division of Professional Licensure.

Forms and fees should be submitted to **ASWB, Attn: Massachusetts Application, 17126 Mountain Run Vista Ct., Culpeper, VA 22701**. Do **not** send forms to the Board of Registration of Social Workers. Please read these instructions thoroughly before completing the attached application forms. Update applicants for licensure in Massachusetts must have **previously applied and been approved to register for the ASWB examination**.

- If non-standard testing arrangements are required, email specialarrangements@aswb.org. Request for Nonstandard Testing Arrangements must be submitted to ASWB, Attn: CSC, 17126 Mountain Run Vista Ct., Culpeper, VA 22701. Copies of the forms are also available at www.aswb.org.
- Your name **MUST** match your name as it appears on one current, valid non-expired government issued photo-bearing ID.
- **Copied/faxed** documents, references, and applications are **not** acceptable.
- Applicants will be notified by mail when the application has been approved or disapproved. If approved, applicants will also receive information regarding registering for the ASWB examination and a link to ASWB's Candidate Handbook that explains the procedure. Applicants may not register for an examination until this application has been approved.
- If you have any questions, contact the ASWB at **866.527.2384**, 8:30 a.m. to 5:00 p.m. Eastern time, Monday-Friday, or by email: mass.sw.app@aswb.org

Fees

Application fees for an application update are listed on page 7. 1) Application fee must be submitted with this application; 2) Licensure fees will be assessed and collected **after** the applicant has met all examination and licensure requirements.

Acceptable methods of payment are certified check, money order or credit card (VISA, MasterCard or Discover). Please note that personal checks are **not** accepted. All fees are payable to ASWB in U.S. dollars only. Fees are non-refundable and are subject to change.

Applicant Information

The following is required for applicants whose 12-month authorization expired and who are requesting an additional 12-month window to sit for the ASWB exam:

- Application, signed and **notarized**
 - **Signature date must correspond to date of notarization**
- Payment by certified check or money order, payable to ASWB; or credit card information
- Please review the reference requirement chart on page 3. Your professional references must be current (completed within the past year). Your references must complete an updated reference form (attached). Supervisory references do not need to be updated.
- The attached criminal history acknowledgment form must be signed and submitted with this application.

MassHealth Enrollment Requirement

Additional Instructions for Applicants for Licensure as LICSW

Section 6401 of the Affordable Care Act requires that, for MassHealth services that must be ordered, referred or prescribed, the provider who ordered, referred or prescribed the service must be enrolled with MassHealth for the claim for the service to be payable.

Licensed Independent Social Workers are eligible to order, refer or prescribe services for MassHealth members and, under state law, must apply to enroll with MassHealth at least as ordering and referring (nonbilling) providers to obtain and maintain state licensure. Providers who are already enrolled with MassHealth have already met the requirement and do not need to take further action.

MassHealth has created a Non-billing Provider Application for providers in provider types that are **not** eligible to enroll as fully participating providers. This application can also be used by providers who **are** eligible to enroll in MassHealth as fully participating providers but who choose not to now.

Providers who wish to apply to enroll as non-billing providers must download the materials from the MassHealth website at <http://www.mass.gov/eohhs/provider/insurance/masshealth/aca/aca-section-6401enrollment-information.html> and send their completed and signed Nonbilling Provider Application and Nonbilling Provider Contract by mail to the MassHealth Customer Service Center (CSC) at:

MassHealth Customer Service Center
Attn: Provider Enrollment and Credentialing
PO Box 121205
Boston, MA 02112-1205

Providers who enroll with MassHealth as nonbilling providers via the Nonbilling Provider Application are not fully participating MassHealth providers and are not eligible to submit claims to MassHealth.

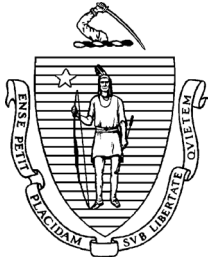
Providers who have questions, or, if eligible, would like to request a fully participating provider application should contact the MassHealth Customer Service Center at 1-800-841-2900 with any questions or, if eligible, to request a fully participating provider application.

Reference Information

- Please see the chart below indicating the requirements for each level of licensure.
- Professional reference forms as well as the waiver of liability that were submitted previously and are dated over a year are not acceptable.
- Supervisory reference forms that were submitted previously for the original application are not to be used as an updated professional reference. Supervision references do not expire; however, professional references do.

Licensure Type	Professional References
LICSW	<ul style="list-style-type: none"> • A total of two professional reference forms along with a waiver of liability • One must be licensed at the LICSW level (or equivalent in another jurisdiction) • The other reference may hold a LMHC, LMFT, psychiatry, psychology, or MD or nursing with a specialty in clinical mental health • Please do not submit the individual who documented your required supervision
LCSW	<ul style="list-style-type: none"> • A total of two professional reference forms along with a waiver of liability • One professional reference must be licensed at the LICSW or LCSW level (or equivalent in another jurisdiction) • Please do not submit your most recent advanced field placement as a professional reference
LSW	<ul style="list-style-type: none"> • A total of two professional reference forms along with a waiver of liability • One professional reference must be licensed at the LICSW or LCSW level (or equivalent in another jurisdiction) • Please do not submit your field placement supervisory reference or the individual who documented your required supervision
LSWA	<ul style="list-style-type: none"> • A total of three professional reference forms along with a waiver of liability • One professional reference must be licensed at the LICSW or LCSW level (or equivalent in another jurisdiction) • Please do not submit the individual who documented supervision (if applicable)
Reciprocity All Levels	<ul style="list-style-type: none"> • A total of two professional reference forms along with a waiver of liability • LCSW, LSW and LSWA applicants: at least one reference must be licensed at the LICSW or LCSW level (or equivalent in another jurisdiction) • LICSW applicants: at least one reference must be licensed at the LICSW level (or equivalent in another jurisdiction)

Social Worker Licensure Application Update



The Commonwealth of Massachusetts
 Division of Professional Licensure, Board of Registration of Social Workers
 c/o, ASWB
 17126 Mountain Run Vista Ct.
 Culpeper, VA 22701
 866.527.2384

License Level applying for:	<input type="checkbox"/> Licensed Independent Clinical Social Worker (LICSW) <input type="checkbox"/> Licensed Certified Social Worker (LCSW) <input type="checkbox"/> Licensed Social Worker (LSW) <input type="checkbox"/> Licensed Social Work Associate (LSWA)
Application Type:	<input type="checkbox"/> New Applicant <input type="checkbox"/> Reciprocity Applicant
Special Accommodations Required?	<input type="checkbox"/> Yes (see instructions on page 1) <input type="checkbox"/> No

Identification & Contact Information

Last Name:		First:		Middle:	
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NOTE: For examination purposes, your name must match your name as it appears on one current, valid non-expired government issued photo-bearing ID. If you have had a legal name change, please attach pertinent documents (court order, marriage certificate, etc.) attesting to this fact.

Maiden/Another Name: _____

NOTE: Your social security number is required on page 7 of this application.

Gender:	<input type="checkbox"/> Female <input type="checkbox"/> Male	Birth Date: _____
		Place of Birth: _____

NOTE: The mailing address listed below will be a **matter of public record**. It will appear on your license and will be used for all board correspondence. The mailing address and the business address listed on page 5 may be the same.

Mailing address: _____

Email address: <small>(print clearly)</small>		
Business phone:	()	-
Home phone:	()	-
Cellular phone:	()	-

Current Employment:

Business name:	
Current position:	
Date started:	
Business address:	_____

Applicant Attestations:

1. Has a licensing/certification board in any U.S. or foreign jurisdiction taken any disciplinary action against you? Yes No

2. Are you the subject of pending disciplinary actions by a licensing/certification board in any U.S. or foreign jurisdiction? Yes No

3. Have you ever voluntarily surrendered or resigned a professional license to a licensing/certification board in any U.S. or foreign jurisdiction? Yes No

4. Have you ever applied for and been denied a professional license in any U.S. or foreign jurisdiction? Yes No

5. Have you ever admitted to or been convicted of a felony or misdemeanor in any U.S. or foreign jurisdiction, other than a traffic violation with an assessed fine of less than \$200? Yes No

6. All applicants:

As part of the Acts of 2014, Chapter 260, An Act Relative to Domestic Violence, Section 9, the Massachusetts Department of Public Health was tasked with creating a Domestic and Sexual Violence Training for professionals receiving licensure from the Board of Registration of Social Workers.

Domestic and Sexual Violence Training must be completed to meet the social worker licensure requirements. You must complete training before a license will be issued.

Review the required Domestic and Sexual Violence Training here: <https://chapter260training.org/>.

I have completed board-approved training in Domestic and Sexual Violence.

Yes No

7. LICSW APPLICANTS ONLY: You must have submitted a thoroughly completed fully participating or nonbilling provider application and signed provider contract to MassHealth.

I have complied

NOTE: Please state the details of any 1 thru 5 “yes” attestation answer on a separate sheet and attach the explanation to this application. The Board is certified by the Criminal History Systems Board [ID# MAREG G] to access data about convictions and pending criminal cases. Those records—and other Federal and professional records—will be checked as part of your licensing process. No records are automatic disqualifiers; you will be given an opportunity to discuss any issues with the Board.

By signing this form, you are providing your consent for the Massachusetts Boards of Registration and, where relevant, their supervising state agencies and the Massachusetts Executive Office of Health and Human Services, and where relevant, its provider enrollment vendor, to obtain, read, copy, and share with each other information regarding your MassHealth application and enrollment status and Massachusetts licensure status.

I certify under the pains and penalties of perjury that the information in this application has been reviewed and signed by me, and is true, accurate, and complete, to the best of my knowledge. I understand that the failure to provide accurate information may be grounds for the Massachusetts Board of Registration of Social Workers to deny me the right to sit as a candidate or to suspend or revoke a license issued to me in accordance with Massachusetts' Law. I further attest that, pursuant to G.L. c. 62C, s. 49A, to the best of my knowledge and belief, I have filed all state tax returns and paid all state taxes required by law. I further certify under the pains and penalties of perjury that, if I am applying for licensure as a LICSW, I have submitted a completed application to be a fully participating or nonbilling provider to MassHealth. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Applicant's signature * _____ **Date **** _____

Notary name (printed): _____

Notary signature: * _____ Date: ** _____ **SEAL**

Notary commission expires: _____

*** Must be signed in the presence of a notary public**

**** Signature date must correspond with notarization date; the application must be received within 90 days of the date notarized**

Applicant's Name:

NOTE: This page will not be retained with your application.

U.S. Social Security Number

Social Security Number (mandatory):

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NOTE: Pursuant to G.L. c. 62C, s. 47A, the Division of Professional Licensure is required to obtain your social security number and forward it to the Department of Revenue to ascertain whether you are in compliance with the tax laws of the Commonwealth.

Application Payment

Application Fee: (due with this application)

Indicate application type and fee: (All fees are non-refundable and subject to change.)

Application Type

- Application update (all licenses) for an additional 12-month window to re-test

Fee

\$50.00

Payment Method:

- Certified check or money order- payable to ASWB (**personal checks not accepted**)
OR
 Visa
 MasterCard
 Discover

Credit card number:

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Exp.
Date:

MM

YYYY

CID code (last 3 digits from signature panel on back of card): _____

Card Holder's Zip Code: _____

Card Holder's Name (please print): _____

Card Holder's Signature: _____

Social Worker Reference Form - Page 1



The Commonwealth of
Massachusetts Division of
Professional Licensure Board of
Registration of Social Workers
c/o, ASWB
17126 Mountain Run Vista Ct.
Culpeper, VA 22701

This section must be completed by the licensure applicant

Applicant's name: _____

Maiden name or another name: _____

Address: _____

City: _____ State/Province: _____ Zip/Postal Code: _____

Date of graduation (highest degree): _____ Degree conferred: _____

List the highest professional license held:

License: _____ License Number/Jurisdiction _____

License applied for (check one): LICSW LCSW LSW LSWA

WAIVER OF LIABILITY- must be completed by the licensure applicant

I, _____, hereby authorize _____
Applicant's name *Reference's name*

(hereinafter "the reference") to provide the Board of Registration of Social Workers with all information of any kind that the reference may, in his or her absolute discretion, deem relevant to my qualifications as an applicant. I hereby release and discharge the professional reference from all claims arising out of the provision of such information.

Applicant's signature: _____ **Date:** _____

INFORMATION AND INSTRUCTIONS FOR REFERENCES

General information for references completing this form:

1. The Board assumes that you, in recommending this applicant, will be willing to interpret or to substantiate to the Board your recommendation, should the Board desire to contact you. The Board will keep all information confidential to the maximum extent permitted by law.
2. Complete this reference form only if the applicant has signed the above waiver of liability.
3. **Professional References-** complete section A and the signature block.
4. **Supervision References-** complete sections A, B, duties, and signature block.
5. Return pages 1 and 2 of this reference forms to the applicant.



Social Worker Reference Form - Page 2

The Commonwealth of Massachusetts Division of Professional
Licensure Board of Registration of Social Workers
c/o ASWB 17126 Mountain Run Vista Ct.
Culpeper, VA 22701

This page must be completed by the reference

Applicant's name _____

A) ALL REFERENCES: Please complete section A and signature box on page 3

Reference's name: _____ Title: _____ License Type: _____

• Reference's license number & Jurisdiction: _____ Relationship to applicant: _____

• Dates the reference has known the applicant: from _____ to _____
MM/YY MM/YY

• Extent of knowledge of applicant's professional and ethical behavior: Thorough Moderate Limited

• Based on my experience, to the best of my knowledge, the applicant is an individual of good moral character: Yes No (If no, please explain on a separate sheet)

• Quality and extent of endorsement:
 Without reservation With reservation No recommendation
(If with reservation or no recommendation, please explain on a separate sheet)

B) SUPERVISION REFERENCES ONLY- Please complete section B and duties:

• _____
Supervisor's degree College/University Major Date of degree

• I certify that I supervised the above applicant in the field of social work at the following organization: _____ from * _____ to * _____
organization MM/DD/YYYY MM/DD/YYYY

• The applicant worked _____ hours per week for _____ weeks for a total of * _____ work hours

• I supervised _____ hours per week for a total of * _____ hours of face-to-face supervision

• Applicant's title: _____ Note: * supervision/experience hours must correspond to dates listed

Please select one:

Applicant is applying for LSWA, LSW, or LCSW (Complete section below) Applicant is applying for LICSW (Complete duties on page 3)

Non- Clinical Social Work Duties/Responsibilities:

Applicant Specialties:

Note: Signature required on Page 3 of reference form.

Social Worker Reference Form - Page 3

SUPERVISION INFORMATION FOR LICSW APPLICANTS ONLY

Supervisors:

Please refer to the definition below prior to completing the clinical social work duties/responsibilities. Complete whether the applicant is completing the supervision under the 258 CMR 12.02: Scope of Practice for a Licensed Certified Social Worker (LCSW) under one of the following provisions (1) or (2). Supervisors **must** select either 1 or 2, not both.

- (1) **Provide clinical social work services**, as defined in 258 CMR 8.03: *Definitions*, as an employee of an agency, health care facility or unrelated individual, under the clinical supervision of another social worker who is licensed or eligible for licensure as a Licensed Independent Clinical Social Worker (LICSW) and who provides at least one hour per week, or equivalent pro-rata amount for part-time employees, of face-to-face individual clinical supervision. An individual who holds a license as a Licensed Certified Social Worker shall not provide clinical social work services as an independent practitioner.

Clinical Social Work Services: The application of social work theory and specialized clinical knowledge and methods to assess, diagnose, prevent and treat mental, emotional or behavioral disorders, conditions or addictions through the provision of individual, marital, couples, family or group counseling and psychotherapy of a non-medical nature for the purpose of improving, restoring or enhancing the social and/or psychosocial functioning of such individuals, couples, families or groups. Such services include, but are not necessarily limited to, the provision of individual, marital, couples, family or group counseling and psychotherapy services and the performance of related collateral contacts and record-keeping. Clinical social work services expressly exclude the diagnosis of any organic illness or the treatment of any illness by medical or organic therapies.

- (2) **Provide case management services** which involve the application of clinical diagnostic, assessment or treatment knowledge or skills as an employee of an agency, health care facility or unrelated individual, under the clinical supervision of another social worker who is licensed or eligible for licensure as a Licensed Independent Clinical Social Worker (LICSW) and who provides at least one hour per week, or equivalent pro-rata amount for part-time employees, of face-to-face individual clinical supervision. An individual who holds a license as a Licensed Certified Social Worker shall not provide clinical social work services as an independent practitioner.

• Clinical Social Work Duties/Responsibilities:

• Applicant Specialties:

Signature Box:

Reference Signature: _____

Date: _____

Address: _____

Phone: _____

City: _____ State/Province: _____

Zip/Postal Code: _____

COMMONWEALTH OF MASSACHUSETTS
c/o, ASWB
17126 Mountain Run Vista Ct.
Culpeper, VA 22701

CRIMINAL OFFENDER RECORD INFORMATION (CORI)
ACKNOWLEDGEMENT FORM

The Division of Professional Licensure by itself and on behalf of boards of registration pursuant to M.G.L. c. 13, §9 [hereinafter, "Division of Professional Licensure"] is registered under the provisions of M.G.L. c. 6, § 172 to receive CORI for the purpose of screening current and otherwise qualified prospective license applicants and current licensees.

As a license applicant or current licensee, I understand that a CORI check will be submitted for my personal information to the Department of Criminal Justice Information Services ("DCJIS"). I hereby acknowledge and provide permission to the Division of Professional Licensure to submit a CORI check for my information to the DCJIS. This authorization is valid for one year from the date of my signature. I may withdraw this authorization at any time by providing the Division of Professional Licensure written notice of my intent to withdraw consent to a CORI check.

FOR LICENSING PURPOSES ONLY:

I understand that the Division of Professional Licensure may conduct a subsequent CORI check within one year of the date this Form was signed by me.

By signing below, I provide my consent to an initial CORI check and a subsequent CORI check, both within one year of the date of this Form, and acknowledge that the information provided on Page 2 of this Acknowledgement Form is true and accurate.

Signature

Date

Please provide the name of the board of registration and license type for which you are applying or currently hold:

Board of Registration

License Type

NOTE: DPL CANNOT ACCEPT THIS TWO-PAGE CORI ACKNOWLEDGMENT FORM UNLESS IT IS EITHER (1) SIGNED IN PERSON AT THE BOARD'S OFFICES IN THE PRESENCE OF A DPL EMPLOYEE WHO HAS VERIFIED THE APPLICANT'S IDENTITY THROUGH ACCEPTABLE IDENTIFICATION, OR (2) SIGNED IN THE PRESENCE OF A NOTARY PUBLIC WHO HAS LIKEWISE VERIFIED IDENTITY AND THEN MAILED OR OTHERWISE DELIVERED TO THE BOARD'S OFFICES AT THE ADDRESS SET FORTH ABOVE.

SUBJECT INFORMATION: (A red asterisk (*) denotes a required field)

*Last Name *First Name Middle Name Suffix

*Maiden Name (or other name(s) by which you have been known)

*Date of Birth Place of Birth

* Last Six Digits of Your Social Security Number: _____ - _____

Sex: _____ Height: _____ ft. _____ in. Eye Color: _____

Driver's License or ID Number: _____ State of Issue: _____

Current and Former Addresses:

Street Number & Name City/Town State Zip

Street Number & Name City/Town State Zip

IDENTITY VERIFICATION SECTION: If this form is submitted by hand at DPL Offices, Section A must be completed. Otherwise, Section B must be completed.

<p>SECTION A: VERIFICATION BY DPL EMPLOYEE: I hereby certify that I verified the identity of the above-referenced subject by reviewing the following form(s) of government-issued identification:¹</p> <p><input type="checkbox"/> <input type="checkbox"/> Passport <input type="checkbox"/> State-issued driver's license <input type="checkbox"/> Military identification <input type="checkbox"/> State-issued identification card</p> <p>VERIFIED BY: _____ Name of Verifying DPL Employee (Please Print)</p> <p>_____ Signature of Verifying DPL Employee Date</p>	
<p>SECTION B: VERIFICATION BY NOTARY:</p> <p>On this _____ day of _____, 20____, before me, the undersigned notary public, personally appeared _____ (name of document signer), and proved to me through satisfactory evidence of identification, which was the following:¹</p> <p><input type="checkbox"/> <input type="checkbox"/> Passport <input type="checkbox"/> State-issued driver's license <input type="checkbox"/> Military identification <input type="checkbox"/> State-issued identification card</p> <p>to be the person whose name is signed on the preceding or attached document and acknowledged to me that (he) (she) signed it voluntarily for its stated purpose.</p> <p>_____ Notary Public: Notary Commission Expires On</p>	

¹ If a subject does not have an acceptable government-issued identification, his or her identity shall be verified by other forms of documentation as determined by DCJIS. 803 CMR 2.09(2).