KENTUCKY BOARD OF ALCOHOL AND DRUG COUNSELORS

P.O. Box 1360, Frankfort, Kentucky 40602 ~ 911 Leawood Drive, Frankfort, Kentucky 40601
Phone (502) 782-8814 ~ http://adc.ky.gov

LICENSURE AS A CLINICAL ALCOHOL AND DRUG COUNSELOR (LCADC):

APPLICATION INFORMATION SHEET / CHECKLIST

Description: *Applicants have a Master's Degree (60 hr. or 30 hr. Advanced Placement) or Doctoral Degree in a behavioral science with clinical application. Applicants have met all the requirements for work experience, training, and supervision and are ready to take the licensure exam if they have not already done so as an LCADCA. An applicant may also be a Temporary CADC meeting all of the LCADC requirements and ready to take the licensure exam. (This application is not for existing CADCs wishing to Grandparent to LCADC.)*

- ☐ 1. Eighteen (18) years of age or older.
- ☐ 2. Section 1 of application completed.
- ☐ 3. Section 2 completed – describing education attainment of at least a Master's degree.
- ☐ 4. Request an official transcript conferring your highest degree be sent from the registrar of the institution directly to the Board (issued to student and copies of transcripts are not acceptable, let the Board Administrator know if your last name was different at the time of your degree).
- ☐ 5. Section 3 completed – Must have completed **2000 hours** of experience working with persons having a substance use disorder.
- ☐ 6. Sign the Affidavit at bottom of page 2
- ☐ 7. Verification of Classroom Training – Completed and documented the **180 classroom hours** of board-approved curriculum (you may submit the same information submitted for LCADCA).
- ☐ 8. Verification of Clinical Supervision – **300 hours** of direct supervision documented and signed by your Board-Approved LCADC Supervisor.
- ☐ 9. Supervision Evaluation– Completed and signed by your supervisor.
- ☐ 10. Two letters of reference from credentialed alcohol and drug counselors.
- ☐ 11. Check or money order made payable to the Kentucky State Treasurer (DO NOT SEND CASH)

Licensed Clinical Alcohol and Drug Counselor Application Fee **(This is the only fee due at the time of application)**	**$50.00**
Licensure Written Exam Fee	**$200.00**
Licensed Clinical Alcohol and Drug Counselor Issuance Fee	**$300.00**

The completed application may be submitted to the Kentucky Board of Alcohol and Drug Counselors by mail to: P.O. Box 1360, Frankfort, KY 40602 or delivered to 911 Leawood Drive, Frankfort, KY. Materials must be received by our office <u>10 days prior</u> to the next scheduled Board Meeting. If this deadline is not met, your application will be automatically added to the next month's agenda for review. Board meeting dates are on our website under "Quick Links."

Please Note:

Effective February 5th, 2016, 201 KAR 35:070 Amendment Section 1 (6) became law. Supervision hours completed prior to February 5th, 2016 can count toward the LCADC supervision requirement as long as the supervisor was a current LCADC, or a current CADC in good standing with at least 2 or more years of post-certification experience at the time of supervision.

After February 5th, 2016, supervision hours MUST be with a Board-approved LCADC supervisor of record in order to count towards the LCADC requirement.

Where to find a Board-approved LCADC Supervisor: http://adc.ky.gov under "Quick Links"

When you start supervision: It is best to document it on a daily basis. Keep good notes and maintain copies of everything for your own records. You may begin to document your supervision on the forms found in the LCADC packet

Supervision sessions: Should not be documented as "blocks" of dates. List each session individually with the corresponding date and time.

If you have long sessions: This could cause your application to be deferred. Provide as much detail as possible as to what those sessions looked like/the activities. Supervision sessions do not "typically" last 3+ hours.

Classroom Training Hours: 1 academic credit hour equals 15 actual training hours. Therefore, if you took a 3 credit hour course related to alcohol/drug counseling, it would equal 45 actual training hours.

The application form and all required supporting documentation, as listed above, must be reviewed and approved by the Board at a monthly Board Meeting: Incomplete applications will not be reviewed. It is the applicant's responsibility to make certain that all materials have been received by the Board administrator. You may contact the office to check on your application. Email is best: Kelly.Walls@ky.gov

WRITTEN EXAM SCHEDULE	APPLICATION FILING DEADLINE (must be received in our office by this date)
December 11, 2015	October 1, 2015
March 11, 2016	December 29, 2015
June 10, 2016	March 22, 2016
September 9, 2016	June 28, 2016
December 9, 2016	September 27, 2016

NEXT STEPS:

1. A letter will be sent to you approving, denying, or deferring your Application. If your application is ***deferred***, you will receive a letter approximately 2 weeks following the Board meeting asking for additional information. Once requested information is received, your application will be scheduled for another review at the following Board meeting. Deferment may keep you from testing at your desired date.

   For example: Your application is received by our office (filed) on December 29th, 2015. Your application is reviewed at the January Board meeting, but instead of approved, you are deferred. You then send in the requested information right away. Your application is now scheduled for a 2nd review at February's meeting. If approved at the February meeting, it will be too late to be registered for the March exam. You will instead be registered for the exam in June.

2. If ***approved***, you will receive a letter approximately 2 weeks following the Board meeting letting you know that you will sit for the next scheduled Licensure Exam if you have not already taken and passed it as an LCADCA. You will need to pay the exam fee. Check or money order made payable to the Kentucky State Treasurer (DO NOT SEND CASH)

   PRACTICE EXAMS AVAILABLE: http://internationalcredentialing.org (AADC – Advanced Exam)

   Licensure Written Exam Fee **$200.00**

3. Exam reminders with details of the testing location, time, and other important information will be mailed approximately 30 days prior to the testing date.

4. After you pass the exam we will send an approval notice and request the initial Licensure fee and issue you a license number. It will not need to be renewed for three years. (Please allow up to three weeks to receive your exam score via mail. Results cannot be given by phone/email.)

   Licensed Clinical Alcohol and Drug Counselor Issuance Fee **$300.00**

5. Download, print and read through the Laws and Regulations if you have not already done so. http://adc.ky.gov > Resources

6. Review requirements for the training program in suicide assessment, treatment, and management.

NOTE: Upon receipt of credential, it is your responsibility to keep the Board Administrator informed of any address change. Do not rely on forwarding services of the United States Postal Service.

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APPLICATION FOR:

TEMPORARY REGISTRATION AS PEER SUPPORT SPECIALIST ( )
REGISTRATION AS PEER SUPPORT SPECIALIST ( )

TEMPORARY CERTIFICATION AS AN ALCOHOL AND DRUG COUNSLOR ( )
CERTIFICATION AS AN ALCOHOL AND DRUG COUNSLOR ( )

LICENSED CLINICAL ALCOHOL AND DRUG COUNSELOR ASSOCIATE ( )
LICENSED CLINICAL ALCOHOL AND DRUG COUNSELOR ( )

SECTION 1 – APPLICANT INFORMATION

1. _____
Name: First Middle Last Maiden

_____-_____-_____
Social Security Number Date of Birth Home Phone Cell Phone

_____
Mailing Address: Street City State Zip Code

_____
Employer Business Phone

_____
Employer's Address: Street City State Zip Code

_____
Home Email Business Email

2. Have you had a credential in Kentucky or any other state that has ever been suspended or revoked?
☐ YES ☐ NO If yes, give details:
_____

3. Have you been convicted of a felony or plead guilty, including an Alford plea (other than minor traffic violations) under the laws of the United States in the last 5 years? ☐ YES ☐ NO If yes, what offense?
_____ (If yes, send supporting documentation.)

4. Are you credentialed as an Alcohol or Drug Counselor in any other state? ☐ YES ☐ NO
If yes, what state? _____ Type of Credential? _____

5. Have you ever been discharged or forced to resign for misconduct or unsatisfactory service from any position from any professional training program, or from the program of any university? ☐ YES ☐ NO
(If yes, send supporting documentation.)

6. Have you ever been sanctioned by the Kentucky Board of Alcohol and Drug Counselors or by any other credentialing board or professional associations for ethical misconduct? ☐ YES ☐ NO
(If yes, send supporting documentation.)

7. Are you currently on active military duty? ☐ YES ☐ NO

SECTION 2 – APPLICANT EDUCATION

School	Name and Location	Dates Attended	Date of Graduation	Number of Hours	Degree Obtained
High School/Equivalent					
Baccalaureate					
Master's					
Doctoral					

Submit proof of your <u>highest</u> education achieved:

- High school / equivalent - submit a copy of your diploma or certificate.
- Other higher education - submit official transcript sent from registrar of the college or university.

SECTION 3 – WORK EXPERIENCE (Attach Additional Related Experience If Needed)

Name of Employer: _____

Title or Position: _____

Employment Start Date: _____ End Date: _____

Address of Employer: _____

Clinical Supervisor: _____ Credential Number: _____

Total Number of Work Hours per Week Related to Alcohol and Drug Clients: _____

Describe Work Duties Related to Alcohol and Drug Clients: _____

_____

Name of Employer: _____

Title or Position: _____

Employment Start Date: _____ End Date: _____

Address of Employer: _____

Clinical Supervisor: _____ Credential Number: _____

Total Number of Work Hours per Week Related to Alcohol and Drug Clients: _____

Describe Work Duties Related to Alcohol and Drug Clients:_____

_____

AFFIDAVIT

I do hereby certify under penalty of law, that the information contained herein is true, correct and complete to the best of my knowledge and belief. I am aware that, should an investigation at any time disclose such misrepresentation or falsification, my application could be rejected or my certification revoked by the Board. Furthermore, I agree to abide by the standards of practice and code of ethics approved by the Board.

_____ _____

Applicant's Signature (Do not type or print) Date

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VERIFICATION OF CLASSROOM TRAINING

_____LCADCA _____LCADC

In accordance with 201 KAR 35:050, Section 1 (3), an applicant seeking licensure as a licensed clinical alcohol and drug counselor or licensed clinical alcohol and drug counselor associate shall complete 180 classroom hours which are specifically related to the knowledge and skills necessary to perform the following alcohol and drug counselor competencies:

1. Understanding addiction;
2. Treatment knowledge;
3. Application to practice;
4. Professional readiness;
5. Clinical evaluation;
6. Treatment planning;
7. Referral;
8. Service coordination;
9. Counseling;
10. Client, family and community education;
11. Documentation; and
12. Ethical responsibilities

I certify that I have had training or education in each of these domains related to the practice of alcohol/drug counseling.

Signature: _____ Date: _____

ETHICS TRAINING (6) – A minimum of 6 hours shall be interactive, face-to-face ethics training related to counseling. PRINT OR TYPE

Title of Course	Dates of Attendance	Entity Offering Training	No. of Actual Training Hours

Applicant Name _____ **Total Number of Hours:** _____

Applicant Name _____

<u>HIV TRAINING (2)</u> – A minimum of two (2) hours of training in transmission, control, treatment and prevention of the human immunodeficiency virus. PRINT OR TYPE

Title of Course	Dates of Attendance	Entity Offering Training	No. of Actual Training Hours

Total Number of Hours: _____

<u>DOMESTIC VIOLENCE (3)</u> – A minimum of three (3) hours of training specific to domestic violence. PRINT OR TYPE

Title of Course	Dates of Attendance	Entity Offering Training	No. of Actual Training Hours

Total Number of Hours: _____

<u>ALCOHOL/DRUG COMPETENCY TRAINING HOURS</u>
PRINT OR TYPE

Title of Course	Dates of Attendance	Entity Offering Training	No. of Actual Training Hours

Total Number of Hours: _____

Applicant Name_____

<u>ALCOHOL/DRUG COMPETENCY TRAINING HOURS</u> (Make as many copies of this page as needed. Number each page.)
PRINT OR TYPE

Title of Course	Dates of Attendance	Entity Offering Training	No. of Actual Training Hours

Total Number of Hours on This Page: _____

Applicant Name _____

<u>ALCOHOL/DRUG COMPETENCY TRAINING HOURS</u> (Make as many copies of this page as needed. Number each page.)
PRINT OR TYPE

Title of Course	Dates of Attendance	Entity Offering Training	No. of Actual Training Hours

Total Number of Hours on This Page: _____

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VERIFICATION OF CLINICAL SUPERVISION

Documentation of 300 hours of direct supervision by a Board Approved Certified Alcohol and Drug Counselor or a Licensed Clinical Alcohol and Drug Counselor must be documented. This form must be completed by the applicant and signed by the clinical supervisor.

In accordance with 201 KAR 35:010, Section 1 (9), "clinical supervision" means a disciplined, tutorial process wherein principles are transformed into practical skills, with four overlapping foci: administrative, evaluative, clinical and supportive. These activities are observed/reviewed by the clinical supervisor who provides timely positive and constructive feedback to assist the counselor in the learning process. Methods of supervision include: face-to-face, video, observation, or telephone/conference. A minimum of 300 hours of direct clinical supervision from a Board approved clinical supervisor is required. **A minimum of 10 hours of face-to-face clinical supervision must be documented in each of the 12 core functions**.

APPLICANT/SUPERVISEE'S NAME: _____

APPLICANT/SUPERVISEE'S STRENGTHS: _____

_____

_____

_____

_____

APPLICANT/SUPERVISEE'S WEAKNESSES:_____

_____

_____

_____

_____

Supervisee's Name: _____

COMPLETE THE FOLLOWING **SUMMARY** OF CLINICAL SUPERVISION HOURS - SPECIFIC DETAILS MUST ACCOMPANY THIS PAGE. USE AS MANY PAGES AS NECESSARY TO PROVIDE DETAILS OF CLINICAL SUPERVISION. NUMBER EACH PAGE.

CORE FUNCTION	**Number of Face-to-Face Hours**	**TOTAL NUMBER OF HOURS**
Screening		
Client Intake		
Client Orientation		
Client Assessment		
Treatment Planning		
Individual Counseling		
Group Counseling		
Family Counseling		
Case Management		
Crisis Intervention		
Client Education		
Referral		
Reports and Recordkeeping		
Consultation		
TOTAL		

Affidavit: I verify that the information documented above is true and accurate to the best of my knowledge and belief.

Applicant Signature: _____ Date: _____

Supervisee's Name: _____

CORE FUNCTION: SCREENING

The process by which a client is determined appropriate and eligible for admission to a particular program. (Methods of supervision include face-to-face, video, observation, or telephone.)

DATE OF SESSION	LENGTH OF SESSION	METHOD OF SUPERVISION	SUPERVISOR'S SIGNATURE (Must be legible)

Total Number of Hours in Screening _____

Supervisee's Name: _____

CORE FUNCTION: CLIENT INTAKE

The process of collecting client information at the beginning of treatment that is used in assessment of a client for treatment. (Methods of supervision include face-to-face, video, observation, or telephone.)

DATE OF SESSION	LENGTH OF SESSION	METHOD OF SUPERVISION	SUPERVISOR'S SIGNATURE (Must be legible)

Total Number of Hours in Client Intake _____

Supervisor's Name _____

CORE FUNCTION: CLIENT ORIENTATION

Individual or group session to familiarize clients with program services, expectations and goals.
(Methods of supervision include face-to-face, video, observation, or telephone.)

DATE OF SESSION	LENGTH OF SESSION	METHOD OF SUPERVISION	SUPERVISOR'S SIGNATURE (Must be legible)

Total Number of Hours in Client Orientation _____

Supervisee's Name_____

CORE FUNCTION: CLIENT ASSESSMENT

The process by which a counselor identifies and evaluates an individual's strengths, weaknesses, problems and needs for the development of the treatment plan. (Methods of supervision include face-to-face, video, observation, or telephone.)

DATE OF SESSION	LENGTH OF SESSION	METHOD OF SUPERVISION	SUPERVISOR'S SIGNATURE (Must be legible)

Total Number of Hours in Client Assessment _____

Supervisee's Name _____

CORE FUNCTION: INDIVIDUAL COUNSELING

A one-to-one counselor/client process for the purpose of assessing a client's problems and facilitating appropriate changes. (Methods of supervision include face-to-face, video, observation, or telephone.)

DATE OF SESSION	LENGTH OF SESSION	METHOD OF SUPERVISION	SUPERVISOR'S SIGNATURE (Must be legible)

Total Number of Hours in Individual Counseling _____

Supervisee's Name _____

CORE FUNCTION: TREATMENT PLANNING

Defining areas of problems and needs, establishing long and short-term goals, and developing appropriate tools for reaching these goals. (Methods of supervision include face-to-face, video, observation, or telephone.)

DATE OF SESSION	LENGTH OF SESSION	METHOD OF SUPERVISION	SUPERVISOR'S SIGNATURE (Must be legible)

Total Number of Hours in Treatment Planning _____

Supervisee's Name _____

CORE FUNCTION: GROUP COUNSELING

A process involving clients for the purpose of jointly exploring the client's problems and facilitating appropriate changes. (Methods of supervision include face-to-face, video, observation, or telephone.)

DATE OF SESSION	LENGTH OF SESSION	METHOD OF SUPERVISION	SUPERVISOR'S SIGNATURE (Must be legible)

Total Number of Hours in Group Counseling _____

Supervisee's Name _____

CORE FUNCTION: FAMILY COUNSELING

A process of exploring the dynamics of the family system and facilitating appropriate changes. (Methods of supervision include face-to-face, video, observation, or telephone.)

DATE OF SESSION	LENGTH OF SESSION	METHOD OF SUPERVISION	SUPERVISOR'S SIGNATURE (Must be legible)

Total Number of Hours in Family Counseling _____

Supervisee's Name _____

CORE FUNCTION: CASE MANAGEMENT

Activities which bring services, agencies, resources or people together within a planned framework of action toward the achievement of established goals. It may involve liaison activities and collateral contracts. (Methods of supervision include face-to-face, video, observation, or telephone.)

DATE OF SESSION	LENGTH OF SESSION	METHOD OF SUPERVISION	SUPERVISOR'S SIGNATURE (Must be legible)

Total Number of Hours in Case Management _____

Supervisee's Name _____

CORE FUNCTION: CRISIS INTERVENTION

Those services which respond to an alcohol and/or drug abuser's needs during acute emotional and/or physical distress. (Methods of supervision include face-to-face, video, observation, or telephone.)

DATE OF SESSION	LENGTH OF SESSION	METHOD OF SUPERVISION	SUPERVISOR'S SIGNATURE (Must be legible)

Total Number of Hours in Crisis Intervention _____

Supervisee's Name _____

CORE FUNCTION: REFERRAL

Identifying the needs of the client that cannot be met by the counselor or agency and assisting the client to utilize the support systems and community resources available. (Methods of supervision include face-to-face, video, observation, or telephone.)

DATE OF SESSION	LENGTH OF SESSION	METHOD OF SUPERVISION	SUPERVISOR'S SIGNATURE (Must be legible)

Total Number of Hours in Referral_____

Supervisee's Applicant Name _____

CORE FUNCTION: CLIENT EDUCATION

Seminars or workshops which have the major goal of increasing the clients knowledge and patterns of problematic behavior. (Methods of supervision include face-to-face, video, observation, or telephone.)

DATE OF SESSION	LENGTH OF SESSION	METHOD OF SUPERVISION	SUPERVISOR'S SIGNATURE (Must be legible)

Total Number of Hours in Client Education _____

Supervisee's Name _____

CORE FUNCTION: REPORTS AND RECORD KEEPING

Charting the results of the assessment and treatment plan; writing reports, progress notes, discharge summaries, and other client related data. This includes written communications and other professionals regarding a client's needs and treatment planning. (Methods of supervision include face-to-face, video, observation, or telephone.)

DATE OF SESSION	LENGTH OF SESSION	METHOD OF SUPERVISION	SUPERVISOR'S SIGNATURE (Must be legible)

Total Number of Hours in Reports and Record Keeping _____

Supervisee's Name _____

CORE FUNCTION: CONSULTATION

Relating with counselors and other professionals in regard to client treatment (services) to assure comprehensive, quality care for the client. (Methods of supervision include face-to-face, video, observation, or telephone.)

DATE OF SESSION	LENGTH OF SESSION	METHOD OF SUPERVISION	SUPERVISOR'S SIGNATURE (Must be legible)

Total Number of Hours in Consultation_____

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SUPERVISION EVALUATION

(Completed by each Supervisor)

This form must be entirely completed by each supervisor of qualifying experience. Please pay special attention to the number of hours of direct clinical supervision and percentage of applicant's time allotted to chemical dependency clients.

Applicant's Name: _____

Applicant's Address: _____

_____

Clinical Supervisor: _____ Credential Number: _____

Current Address: _____

Date of Issue of Certification: _____ Supervisor's Day Phone Number: _____/_____/_____

Program or agency where you supervised the applicant: _____

I have supervised the applicant's work from _____ (Date) to _____ (Date), which includes approximately _____ hours of face to face clinical supervision per month for a total of _____ hours.

The approximate percentage of his/her time spent in delivery of services to substance abuse clients: _____%

PERSONAL ATTRIBUTES:

Evaluate the applicant as you observe(d) him/her in the following areas of interpersonal relationship with clients:
(Please use appropriate number as indicated on scale.)

1	2	3	4	5	6
/	/	/	/	/	/
Weak	Fair	Average	Above Average	Superior	NA

_____ A. Respect for client.

_____ B. Care and concern for client.

_____ C. Genuineness with client.

_____ D. Empathy with client.

_____ E. Flexibility with client.

_____ F. Clinical Judgment with client.

_____ G. Spontaneity with client.

_____ H. Capacity for confrontation with client.

_____ I. Capacity for appropriate self-disclosure.

_____ J. Sense of immediacy.

_____ K. Concreteness.

Applicant's Name: _____

AREAS OF COMPETENCY

The following items are representative of the skills needed by an alcohol and drug counselor in the core functions. Evaluate the applicant as you feel he/she demonstrates his/her abilities in each area. Mark the rating most nearly descriptive of the applicant's demonstrated skills using the scales given.

_____ A. Screening – (Demonstrated competency in determining appropriateness for admission to a program.)

_____ B. Intake – (Demonstrated competency in client intake process.)

_____ C. Client Orientation – (Demonstrated competency in client orientation and motivation.

_____ D. Assessment – (Demonstrated competency in the use of psycho-social tools for assessing the intensity and extent of a client's problem with chemical dependency.

_____ E. Treatment Planning – (Demonstrated competency in establishing treatment goals and plan for client.

_____ F. Counseling – (Demonstrated competency in individual counseling.)

_____ G. Counseling – (Demonstrated competency in group counseling.)

_____ H. Counseling – (Demonstrated competency in counseling of the family of the client and significant others.)

_____ I. Case Management – (Demonstrated competency in coordinating multiple treatment activities and support systems for the client.)

_____ J. Crisis Intervention – (Demonstrated competency in crisis intervention.)

_____ K. Client Education – (Demonstrated competency in didactic presentations.)

_____ L. Referral – (Demonstrated competency in identifying the needs of the client that cannot be met by the counselor and assisting the client to utilize other agency or community resources available.

_____ M. Reports / Record Keeping. – (Demonstrated competency in ability to relate to our own and other professionals to assure comprehensive care for the client.

PROFESSIONAL AND ETHICAL CONDUCT:

1. Employment of fraud or deception in applying for a certificate: ☐ Yes ☐ No. If yes, please comment:
   Comment: _____

2. Practice of Alcohol and Drug Counseling under a false or assumed name or the impersonation of another counselor of a like or different name. ☐ Yes ☐ No. If yes, please comment:
   Comment: _____

3. Habitual abuse of any mood-altering chemical substance to such an extent as to interfere consistently with the competent performance of his/her duties. ☐ Yes ☐ No. If yes, please comment:
   Comment: _____

4. Misrepresentation of one's professional credentials: ☐ Yes ☐ No. If yes, please comment:
   Comment: _____

5. Failure to adhere to KRS 309.080 to 309.089: ☐ Yes ☐ No. If yes, please comment:
   Comment: _____

Describe what you believe to be significant strengths and / or deficiencies of the applicant:

I recommend _____ for certification / licensure.
Applicant's Name

I do not recommend _____ for certification / licensure.
Applicant's Name

Signature: _____ Credential: _____

Current Address: _____

_____

Date Signed: _____