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 ASSOCIATE (LCADCA)

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. They have met all the requirements to apply for Licensure (LCADC) with the exception of required work experience and supervision. Applicants are ready to take the licensure exam.*

- ☐ 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 – list your relevant work experience obtained thus far, if any.
- ☐ 6. Sign the Affidavit at bottom of page 2
- ☐ 7. Supervisory Agreement – Completed and signed by you and your Board Approved Supervisor
- ☐ 8. Supervision Annual Report – Completed and signed by your and your Supervisor.
- ☐ 9. Verification of Classroom Training – Completed and documented the **180 classroom hours** of board-approved curriculum.
- ☐ 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 Associate Application Fee **(This is the only fee due at the time of application)**	**$50.00**
Licensure Written Exam Fee	**$200.00**
Initial Issuance of License (LCADCA) 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 10 days prior 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:

For all LCADC/LCADCA candidates: ALL 300 hours of required supervision MUST be with a Board-approved LCADC supervisor of record. Supervision prior to August 24th, 2015 that was with a CADC in good standing with the Board for at least 2 years of post-certification experience **will NOT count towards the licensure requirement**, even if your supervisor was a Master's level CADC. Any supervision occurring after August 24th, 2015, must be with a Board-approved LCADC supervisor of record.

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 CADC application packet (Or LCADC packet if you are pursuing Licensure).

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.

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 Supervisory Agreement approximately 2 weeks following the Board meeting.

2. 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.

3. 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. You will need to pay the exam fee. Check or money order made payable to the Kentucky State Treasurer (DO NOT SEND CASH)

   EXAM PREPARATION: http://internationalcredentialing.org (AADC Exam)

   Licensure Written Exam Fee **$200.00**

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

5. 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 will not be given by phone/email.)

   Initial Issuance of License (LCADCA) Fee **$300.00**

6. Annually, from the issuance date of your licensure, YOU MUST SUBMIT A NEW SUPERVISION ANNUAL REPORT to the Board.

7. If you CHANGE SUPERVISORS, you must submit a new Supervisory Agreement to the Board for approval.

8. A minimum of 20 continuing education hours EACH YEAR shall be accrued by a LCADCA.

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

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

11. Print off the LICENSURE AS A CLINICAL ALCOHOL AND DRUG COUNSELOR APPLICATION and begin/continue documenting your supervision. Upon completion of the required hours of work experience and supervision, you may apply for licensure as a Licensed Clinical Alcohol and Drug Counselor. You will not need to take another exam since you would have already passed the exam above.

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.

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

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

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

SUPERVISORY AGREEMENT

To Be Completed By Applicant and Supervisor (Please Check One)

_____Temporary Certification **_____Licensed Associate**

INSTRUCTIONS

1. Forms submitted without the appropriate signatures will be returned.
2. The completed form may be submitted to the Kentucky Board of Alcohol and Drug Counselors either by mail to P.O. Box 1360, Frankfort, Kentucky 40602 or by delivery to 911 Leawood Drive, Frankfort, Kentucky 40601.

SECTION 1
APPLICANT INFORMATION

First Name | Middle Name | Last Name

/ / | ( ) - | ( ) -

Social Security Number | Home Telephone | Work Telephone

Email Address

Street Address

City | State | Zip Code

SECTION 2
SUPERVISOR INFORMATION

First Name | Middle Name | Last Name

Email Address

Street Address

City | State | Zip Code

( ) -

Telephone Number | Type of License/Certification Held and Number

/ / | / /

Date of issue (Attach a copy) | Expiration Date (Attach a copy)

Date of Board Approved Supervision Training (Attach copy of certificate of attendance)

Number of Supervisee's Currently Providing with Board Approved Supervision

SECTION 3
INFORMATION RELATED TO SUPERVISED EXPERIENCE

Applicant Name _____

Name of organization or agency where experience will be gained (complete a separate form for each setting.)

_____

_____
Street Address of Organization or Agency

_____
City State Zip Code

Average number of hours expected to be gained per week: _____

Type of Setting:
- ☐ State/Government Agency
- ☐ Non-Profit
- ☐ School
- ☐ Hospital
- ☐ DUI/Private Practice
- ☐ Rehab Center

Type of peer support/counseling experience to be gained (check all that apply):

- ☐ Rehabilitation Center
- ☐ Child & Adolescent
- ☐ Adult
- ☐ Family Treatment
- ☐ Other

_____
Describe

- ☐ Judicial/Corrections
- ☐ Individual Counseling
- ☐ Group Counseling

Describe specifically, and in detail, what work experience will be obtained to meet the criteria in the following 12 core functions: (a) Screening; (b) Intake; (c) Client orientation; (d) Assessment; (e) Treatment planning; (f) Counseling; (g) Case management; (h) Crisis intervention; (i) Client education; (j) Referral; (k) Reports and recordkeeping; and (l) Consultation. (201 KAR 35:070)

_____
_____
_____
_____
_____
_____
_____
_____

Describe specifically, and in detail, how supervision will focus on: (a) Screening; (b) Intake; (c) Client orientation; (d) Assessment; (e) Treatment planning; (f) Counseling; (g) Case management; (h) Crisis intervention; (i) Client education; (j) Referral; (k) Reports and recordkeeping; and (l) Consultation..(201 KAR 35:070)

_____
_____
_____
_____
_____
_____
_____

I, as applicant, affirm that all information provided by me on this form is true and accurate and I affirm the following:

- That I have read the board Law and Regulations related to supervised experience and that all supervised experience will be completed in accordance with board rules;
- That I will meet with my supervisor at a minimum of 2 hours every 2 weeks of documented supervised experience;
- That I will abide by all rules of the board, including ethics requirements;
- That I understand the registration/temporary certification/clinical alcohol and drug counselor associate license is only valid while I practice under supervision;
- That I notify the board if this supervisory arrangement is terminated; and
- That I understand any additional supervisors and settings shall be approved by the board in advance.

_____ _____

Signature of Applicant Date

_____

Printed Name

This agreement shall not be effective until the board has issued the letter approving the agreement.

I, as the board approved supervisor of the above named applicant, affirm that all information provided by me on this form is true and accurate and I affirm the following:

- That all supervised experience will be completed in accordance with the Law and Regulations related to supervised experience and all subsequent board rules.
- That I will provide supervision to the above name applicant at least 2 hours every 2 weeks of documented experience.
- That I understand the full professional responsibility for services of the supervisee shall rest with the supervisor.
- That I understand the supervisory arrangement is only valid while my credential remains in good standing.
- That I will notify the board if the supervisory arrangement is terminated.
- That I understand that I shall not serve as a supervisor of record for more than twelve persons obtaining experience for peer support/certification/licensure at the same time.

_____ _____

Signature of Supervisor Date

APPLICANT AND SUPERVISOR SHOULD KEEP A COPY OF THIS FORM FOR RECORDS

BOARD USE ONLY

☐ **Approved by _____ Date: _____**
(Initials of Reviewer)

☐ **Deferred by by _____ Date: _____**
(Initials of Reviewer)

_____

_____

☐ **Denied by _____**
(Initials of Reviewer)

_____

_____

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

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: _____