



KENTUCKY BOARD OF ALCOHOL AND DRUG COUNSELORS

P.O. Box 1360, Frankfort, Kentucky 40602

Email: adc@ky.gov Website: <http://adc.ky.gov> Phone: (502) 782-8814

CERTIFIED ALCOHOL AND DRUG COUNSELOR ASSOCIATE 2 (CADCA2) APPLICATION CHECKLIST

Description: Applicants have been certified by the Board as a CADCA1 for a period of at least 8 months.

1. **18 years of age** or older.
2. **Certified by the Board as a CADCA1** for at least 8 months
3. **Section 1** of application completed.
4. **Section 2 completed** – describing education attainment of a high school diploma or equivalent.
5. **Submit an official copy of your high school diploma or equivalent** with your application. If this is already on file, let the Board Administrator know on your application.
6. **Section 3 completed** – list your relevant work experience obtained thus far, as well as where you expect to obtain your relevant work/supervision experience.
7. **Sign the Affidavit Form 1** at bottom of page 3.
8. **Complete the Supervisory Agreement Form 3** with a Board approved supervisor.
9. **Complete the Verification of Board Approved Training Form 20** – demonstrating that you have completed 70 classroom hours of Board approved curriculum, 20 hours of which shall have been obtained in the previous 2 years in addition to the classroom hours required in KRS 309.0841 for a certified alcohol & drug counselor associate 1 (CADCA1) that include the 4 domains below.
 1. Screening assessment and engagement;
 2. Treatment planning, collaboration, and referral;
 3. Counseling;
 4. Professional and ethical responsibilities;
10. **Have 400 hours of documented chemical dependency counseling-related compensated work or supervised internship experience** of which a minimum of 80 hours shall be in chemical dependency counseling and all of which shall have been under the direct supervision of a CADC or LCADC.
11. **Submit payment with application** (check or money order ONLY) payable to Kentucky State Treasurer

Certification as an Alcohol and Drug Counselor Associate 2 Application Fee

\$50.00

The completed application may be submitted with payment to the PO Box address at the top of the page.
Materials must be received by our office at least **10 DAYS PRIOR** to the next scheduled Board Meeting to ensure review.

If this deadline is not met, your application will most likely be added to the next month's agenda for review.
The Board meets on a monthly basis. Board meeting dates are on our website under "Quick Links" Board Members & Meetings.

IMPORTANT INFORMATION

- **Incomplete applications will not be reviewed.**
- **Applicants will not be notified when their application arrives.**
- **Your check being cashed does not mean your application has been reviewed.**
- **It is the applicant's responsibility to ensure materials have been received by the Board Administrator.**
- **Applicants may contact the office to check on the status of their application. Email is best: adc@ky.gov**

For those working to obtain the CADC:

Supervision hours accrued prior to February 5th, 2016 must be with a Kentucky CADC in good standing with the Board for at least 2 years of post-certification experience at the time of supervision. Any supervision occurring after February 5th, 2016 must be with a Board-approved CADC or LCADC supervisor of record and Board-approved supervisory contract as tied to the supervisee's active and issued Temporary CADC. One must be an approved and active TCADC, approved by the Board, **prior** to starting supervision and engaging in the practice of alcohol and drug counseling.

CADCA2 Requirements by Law:

Please visit <http://adc.ky.gov> and click on "LEGAL" in the bar across the top of the page. On this page, you will find requirements for the Certified Alcohol and Drug Counselor Associate 2 (CADCA2).

Where to find a list of Board-approved Supervisors: <http://adc.ky.gov> under "Quick Links."

When you start supervision:

It is best to document it on a regular basis. Keep good notes and **maintain copies of everything for your own records**. You should begin to document your supervision on the **Verification of Supervision Form 13** found on the ADC website under "Forms & Documents." **Your supervision hours must be submitted on an annual basis** (based on the issuance date of your CADCA2) using eservices, along with the **Supervision Annual Report Form 14** via your online eServices account.

Supervision sessions: Should not be documented as "blocks" of dates. List each session individually with the corresponding date, time and board-approved supervisor signatures under the appropriate domain.

If you have long supervision sessions:

Document as much detail as possible as to what those sessions looked like/the activities completed or it could cause your CADC application to be deferred. Supervision sessions do not "typically" last 3+ hours and should not be occurring every day. For information regarding the difference between "work experience" and working alongside of your board-approved supervisor versus "clinical supervision", please review the laws and regulations booklet found at <http://adc.ky.gov> under "LEGAL"

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. More information can be found within 201 KAR 35:050 Curriculum of Study under "LEGAL."

The period of a temporary credential is two (2) years. Upon receipt of an extension/renewal request cosigned by the Board-approved supervisor. The Board may approve no more than two, two-year extensions of the temporary credential. Should you extension request not be approved, you are welcome re-apply for the CADCA2 if you need more time.

NEXT STEPS:

1. Read the Board's Laws and Regulations Booklet <http://adc.ky.gov>
2. If approved, you will receive an approval letter sent to your home address or via email, within **approximately 2 weeks** following the Board meeting with information about registering for the exam. Board meeting results **will not be disclosed via phone**. You must wait for your letter or email to arrive.

If not approved, you will receive a letter or email of explanation within **approximately 2 weeks following the Board meeting**. Board meeting results **will not be disclosed via phone**. You must wait for your letter or email to arrive. You will have an opportunity to submit additional/missing information in time for the next monthly board meeting so your application can be reviewed a second time
3. Remain under your Board-approved supervisor(s) of record and continue meeting the minimum monthly supervision requirement of 4 hours.
4. Print off the Verification of Clinical Supervision Form 13 to start documenting your supervision. <http://adc.ky.gov> under "Forms & Documents"
5. CADCA2 Continuing Education Requirements A minimum of 30 continuing education hours relevant to the field shall be accrued each year INCLUDING 6 hours in ethics. See **201 KAR 35:040E** for more information <https://apps.legislature.ky.gov/law/kar/201/035/040E.pdf>.
6. Make sure to read the Board's supervision regulation in full <http://adc.ky.gov> click on "LEGAL" and select **201 KAR 35:070 Supervision Experience**.
7. YOU MUST RENEW YOUR CREDENTIAL every 2 years on the anniversary of issuance. The fee to renew is \$100. You will receive renewal reminders to the email address on file.
8. It is your responsibility to keep the Board informed of any change of address, name, contact information, employment and/or supervisor changes. Changes should be submitted using eServices <https://oop.ky.gov/DPLServices/Login.aspx>. From the main menu click RECORD CORRECTION.



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- APPLICATION FOR:**
- TEMPORARY REGISTRATION AS PEER SUPPORT SPECIALIST ()
 - REGISTRATION AS PEER SUPPORT SPECIALIST ()

 - CERTIFIED ALCOHOL AND DRUG COUNSELOR ASSOCIATE I ()
 - CERTIFIED ALCOHOL AND DRUG COUNSELOR ASSOCIATE II ()

 - TEMPORARY CERTIFICATION AS AN ALCOHOL AND DRUG COUNSELOR ()
 - CERTIFICATION AS AN ALCOHOL AND DRUG COUNSELOR ()

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

8. Are you or your spouse a member of the United States military, Reserves, or National Guard, or are you or your spouse a veteran? YES NO

If yes, do you currently hold or recently held an equivalent credential issued by another state, the District of Columbia, or any possession or territory of the United States? YES NO

If yes, please answer the following questions:

Has your credential issued by another state, the District of Columbia, or any possession or territory of the United States been expired for more than two years? YES NO

Is your credential issued by another state, the District of Columbia, or any possession or territory of the United States in good standing? YES NO

Has your credential issued by another state, the District of Columbia, or any possession or territory of the United States been suspended for disciplinary reasons? YES NO

The United States military service member, Reserves or National Guard member, veteran, or spouse shall submit:

(1) Proof of issuance of a valid license, permit, certificate, or other document issued by another state, the District of Columbia, or any possession or territory of the United States that is active or has been expired for less than two (2) years;

(2) Proof that the valid license, permit, certificate, or other document issued by another state, the District of Columbia, or any possession or territory of the United States is in good standing or was upon the date of expiration; and

(3) His or her DD-214 form or other proof of active or prior military service with an honorable discharge, discharge under honorable conditions, or a general discharge under honorable conditions.

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 highest 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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SUPERVISORY AGREEMENT

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

Certified Associate 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 500 Mero St., 2 SC 32, 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:
- | | |
|--|---|
| <input type="checkbox"/> State/Government Agency | <input type="checkbox"/> Hospital |
| <input type="checkbox"/> Non-Profit | <input type="checkbox"/> DUI/Private Practice |
| <input type="checkbox"/> School | <input type="checkbox"/> Rehab Center |

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

- | | |
|--|--|
| <input type="checkbox"/> Rehabilitation Center | <input type="checkbox"/> Judicial/Corrections |
| <input type="checkbox"/> Child & Adolescent | <input type="checkbox"/> Individual Counseling |
| <input type="checkbox"/> Adult | <input type="checkbox"/> Group Counseling |
| <input type="checkbox"/> Family Treatment | |
| <input type="checkbox"/> Other | |

Describe

Describe specifically, and in detail, what work experience will be obtained to meet the criteria in the following four (4) domains: (a) Screening assessment and engagement; (b) Treatment planning, collaboration, and referral; (c) Counseling; and (d) Professional and ethical responsibilities. (201 KAR 35:070)

Describe specifically, and in detail, how supervision will focus on: (a) Screening assessment and engagement; (b) Treatment planning, collaboration, and referral; (c) Counseling; and (d) Professional and ethical responsibilities.(201KAR 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 two (2) times a month of documented supervised experience;
- That I will abide by all rules of the board, including ethics requirements;
- That I understand the alcohol and drug counselor associate I certification/alcohol and drug counselor associate II certification/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 two times a month 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 Name _____



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CERTIFIED ALCOHOL AND DRUG COUNSELOR ASSOCIATE II **VERIFICATION OF BOARD-APPROVED CURRICULUM**

In accordance with KRS 309.0842(2) and 201 KAR 35:050, Section 1(3)(a), an applicant seeking certification as a certified alcohol and drug counselors associate II shall have seventy (70) hours of approved classroom hours of board-approved curriculum of which twenty (20) hours shall have been obtained in the previous two (2) years and shall be in addition to the classroom hours required in KRS 309.0841 for a certified alcohol and drug counselor associate I, that includes:

1. Screening assessment and engagement;
2. Treatment planning, collaboration, and referral;
3. Counseling; and
4. Professional and ethical responsibilities

I certify, under penalty of perjury, that I have had training or education in each of the four domains related to the practice of alcohol and drug counseling.

Signature: _____ Date: _____

Date of Associate I Certification: _____

Certificate Number: _____

ALCOHOL AND DRUG COMPETENCY TRAINING HOURS All training hours shall specifically related to the knowledge and skills necessary to perform the four alcohol and drug counselor domains: 1. Screening assessment and engagement; 2. Treatment planning, collaboration, and referral; 3. Counseling; and 4. Professional and ethical responsibilities.

PRINT OR TYPE

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

Total Number of Hours: _____

Applicant Name _____

ALCOHOL AND DRUG COMPETENCY TRAINING HOURS (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 _____

ALCOHOL AND DRUG COMPETENCY TRAINING HOURS (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



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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 _____ to _____, which includes approximately _____
(Date) (Date)

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 assessment and engagement
- _____ B. Treatment planning, collaboration, and referral
- _____ C. Counseling
- _____ D. Professional and ethical responsibilities

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:

To be completed upon application for certification or licensure.

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

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

Signature: _____ Credential: _____

Current Address: _____

Date Signed: _____