



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>

ALCOHOL AND DRUG PEER SUPPORT SPECIALIST: APPLICATION INFORMATION SHEET / CHECKLIST

Description: Applicants typically hold a current Temporary Alcohol and Drug Peer Support Specialist registration, and are ready to take the Peer Support Specialist exam. Must have a High School Diploma or equivalent and have obtained all the required work experience, supervision, and training. Must attest to being in recovery for a minimum of two years from a substance related disorder.

- 1. Eighteen (18) years of age or older.
- 2. Section 1 of application completed.
- 3. Section 2 completed – describing education attainment of at least high school diploma/equivalent
- 4. Provided a copy of a high school diploma, high school transcript, or equivalent (unless it was previously provided for Temporary PSS). Let the Board Administrator know if your diploma/transcript is under a different last name than your current one.
- 5. Section 3 completed – Must have completed **500 hours** of experience working with persons having a substance use disorder
- 6. Sign the Affidavit at bottom of page 2
- 7. Attestation of Recovery – Signed and dated.
- 8. Peer Support Specialist Verification of Alcohol / Drug Training – Completed and documented the **60 classroom hours** of board-approved curriculum.
- 9. Peer Support Specialist Supervisory Agreement – Completed and signed by you and your Board Approved Supervisor
- 10. Peer Support Specialist Verification of Supervision – **25 hours** of direct supervision documented and signed by your Board Approved Supervisor.
- 11. Supervision Evaluation for Peer Support Specialist – Completed and signed by your supervisor.
- 12. Two letters of reference from credentialed alcohol and drug counselors.
- 13. Check or money order made payable to the Kentucky State Treasurer (DO NOT SEND CASH)

Peer Support Registration Application Fee **\$50.00**
(This is the only fee due at the time of application)

Peer Support Specialist Written Exam Fee **\$150.00**
Peer Support Specialist Initial Registration Fee **\$100.00**

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:

Supervision occurring prior to August 24th, 2015 must be with a Kentucky CADDC in good standing with the board and 2+ years of post-certification experience. Supervision sessions occurring after August 24th, 2015 must adhere to the new requirements: Both the supervisor and the supervision agreement must be approved by the Board first.

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.

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

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

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

<u>WRITTEN EXAM SCHEDULE</u>	<u>APPLICATION FILING DEADLINE</u> (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 Peer Support Specialist Exam. You will be automatically “registered” for the exam, and will need to pay the exam fee. Check or money order made payable to the Kentucky State Treasurer (DO NOT SEND CASH)

Peer Support Specialist Written Exam Fee **\$150.00**

EXAM PREPARATION: <http://internationalcredentialing.org> (PR Exam)

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 your initial Registration fee and issue you a Registrant 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.)

Peer Support Specialist Initial Registration Fee **\$100.00**

6. Annually, from the issuance date of your registration, YOU MUST SUBMIT A SUPERVISION ANNUAL REPORT to the Board.
7. If you CHANGE SUPERVISORS, you must submit a new Peer Support Specialist Supervisory Agreement to the Board for approval.
8. Download, print and read through the Laws and Regulations if you have not already done so. <http://adc.ky.gov> > Resources
9. Review requirements for the training program in suicide assessment, treatment, and management.
10. If you plan to earn a Bachelor’s Degree in the near future and want to work towards your CADAC, print off and start recording your training and supervision on the Certification as an Alcohol and Drug Counselor (CADAC) Application. The approved supervision, training, and work experience you have already earned may be carried over.

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 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



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>

ATTESTATION OF RECOVERY

TEMPORARY REGISTRATION AS PEER SUPPORT SPECIALIST ()

REGISTRATION AS PEER SUPPORT SPECIALIST ()

Pursuant to KRS 309.0831(7), I attest to being in recovery for a minimum of two (2) years from a substance-related disorder.

Signature (Must not be printed or typed)

Date

Printed Name



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>

PEER SUPPORT SPECIALIST **VERIFICATION OF ALCOHOL / DRUG TRAINING**

In accordance with 201 KAR 35:050, Section 1 (1), an applicant seeking registration as an alcohol and drug peer support specialist shall complete sixty (60) classroom hour which shall include:

1. Sixteen (16) hours of interactive, in person, face-to-face ethics training;
2. Two (2) hours of training in transmission, control, treatment and prevention of the human immunodeficiency virus;
3. Ten (10) hours of training in mentoring and education; and
4. Ten (10) hours of training in recovery support

(Make as many copies of these pages as needed. Number each page.)

ETHICS TRAINING (16)

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

Total Number of Hours: _____

HIV TRAINING (2)

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

Total Number of Hours: _____

Page _____

Applicant Name _____

MENTORING AND EDUCATION TRAINING (10)

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

Total Number of Hours: _____

RECOVERY SUPPORT TRAINING (10)

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

Total Number of Hours: _____

Page _____



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>

PEER SUPPORT SPECIALIST SUPERVISORY AGREEMENT

To Be Completed By Applicant and Supervisor

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 Hospital
 Non-Profit DUI/Private Practice
 School Rehab Center

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

Rehabilitation Center Judicial/Corrections
 Child & Adolescent Individual Counseling
 Adult Group Counseling
 Family Treatment
 Other

Describe

Describe specifically, and in detail, what work experience will be obtained to meet the criteria for Recovery Support work experience.(201 KAR 35:070)

Describe specifically, and in detail, how supervision will focus on recovery support.(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)

Denied by _____
(Initials of Reviewer)

Deferred by by _____ Date: _____
(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>

SUPERVISION EVALUATION FOR PEER SUPPORT SPECIALIST

(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. Spontaneity with client.
- _____ G. Capacity for appropriate self-disclosure.
- _____ H. Sense of immediacy.
- _____ I. Concreteness.

Applicant's Name _____

AREAS OF COMPETENCY

Evaluate the applicant as you feel he/she demonstrates his/her abilities in the area of recovery support. Mark the rating most nearly descriptive of the applicant's demonstrated skills using the scales given.

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, practicing recovery support 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 (attach additional pages, if needed):

I recommend _____ for registration as a peer support specialist.
Applicant's Name

I do not recommend _____ for registration as a peer support specialist.
Applicant's Name

Signature: _____ Credential: _____

Current Address: _____

Date Signed: _____