# THE RHODE ISLAND BOARD

# FOR

# CERTIFICATION OF

# CHEMICAL DEPENDENCY

# PROFESSIONALS

**31 Smith Avenue - 3 Rear**
**Greenville, RI 02828**

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**RICERT@msn.com**

**www.ribccdp.com**

## APPLICATION FOR ACDP II OR ACDP

**(UPDATED JUNE 2010)**

# RIBCCDP ELIGIBILITY REQUIREMENTS

## ADVANCED CHEMICAL DEPENDENCY PROFESSIONAL

**EXPERIENCE:**
The applicant must have a minimum of three (3) years full time experience and 6,000 clock hoursproviding the full range of direct supervised counseling services to persons with the primary problem of alcoholism/drug addiction/dependency under the direct supervision of a individual who meets the Clinical Supervisor requirements as listed below. Applicants may exchange one year (2,000 hours) of the three year experience requirement with a bachelor's or advanced degree in Behavioral Sciences. A copy of transcripts must be submitted documenting degree.

**TRAINING & EDUCATION:**
The applicant must have a minimum of 270 clock hours of training/education in the knowledge and skill areas (see Knowledge and Skill Base). Included in the 270 clock hours there must be a minimum of 120 clock hours of formal training in the field of chemical dependency.

**ADVANCED CHEMICAL DEPENDENCY PROFESSIONAL II- (Master's Level)**
**EXPERIENCE:**
The applicant must have 2,000 hours AODA specific work experience under the supervision of Clinical Supervisor that meets RIBCCDP requirements, providing counseling services to persons with the primary problem of alcoholism/drug addiction/dependency.

**TRAINING & EDUCATION**
The applicant must have a minimum of a Master’s degree in a Behavioral Science field with a clinical application. The applicant must have a minimum of 180 clock hours AODA specific coursework.

**ACDP II & ACDP:**
Fifty percent (50%) of the experience must be gained within five (5) years prior to application. Volunteer and part-time counseling experience is acceptable if it is provided under direct supervision. Actual time spent in a supervised chemical dependency internship, traineeship or practicum may be applied toward the three (3) year requirement.

**ACDP II & ACDP Required courses:**
-12 hours of DSA "Confidentiality of Drug and Alcohol Patient Records (42 CFR, Part 2).
-6 hrs of Chemical Dependency Counselor Ethics.
-6 hours curriculum based HIV/AIDS/Viral Hepatitis workshop, delivered by qualified trainer, that covers areas regarding risk reduction.(approved by RIBCCDP's Quality Assurance Committee)
-12 Hours Medication Assisted Therapy & Attitudes of medication in the recovery process. (Effective 6/1/2008)

**CLINICAL SUPERVISION RECEIVED:**
**ACDP II & ACDP:**
**Clinical Supervisor credentials:**
1) Licensed/Certified Chemical Dependency Clinical Supervisor (LCDCS/CDCS), or;
2) Master's degree in Behavioral Sciences with two (2) years clinical experience and documentation of 120 clock hours Substance Abuse Specific training. Included in this 120 clock hours must be 30hours chemical dependency clinical supervisor education which includes training in the following Domains: Counselor Development, Professional & Ethical Standards, Program Development & Quality Assurance, Performance Evaluation, Administration, and Treatment Knowledge, or;
3) LCDP/ACDP II/ACDP with 30 clock hours Clinical Supervisor training. This training must include education in the following Domains: Counselor Development, Professional & Ethical Standards, Program Development & Quality Assurance, Performance Evaluation, Administration, and Treatment Knowledge, or;
4) Ph.D. in Behavioral Science or M.D.with documentation of two (2) years of specialization/experience in the Chemical Dependency field, or;
5) Recognized Clinical Supervisor (RCS)

**The applicant must submit documentation of at least 300 clock hours of Supervisor's received (See Core Functions). Documentation of a minimum of 20 hours in each Core Function is required.**

**EXAMINATIONS:**
**ACDP:** Applicants must pass the ICRC/AODA written examination
**ACDP II:** Applicants must pass the ICRC/AODA Advanced Alcohol and Drug Counselor written examination.

## POLICIES FOR CERTIFICATION

1) ICRC/AODA written exams for ACDP II, ACDP, CDCS, CCJP, CCDP-D, CCDP and Prevention Professional certification will be given quarterly in March, June, September and December.

2) Portfolio submission deadlines for all Credential Applications will be 1/1 for March exam, 3/1 for June exam, 7/1 for September exam and 10/1 for the December exam. CEU's can begin to accrue after the date your portfolio was received. PCCDP/APS/SAC/PCDP/RCS applications are accepted anytime.

3) ***APPLICATIONS WILL BE OPEN FOR ONE (1) YEAR. IF ALL REQUIREMENTS ARE NOT MET WITHIN ONE (1) YEAR, THAT APPLICATION WILL EXPIRE AND THE APPLICANT WILL BE REQUIRED TO RESUBMIT A NEW PORTFOLIO & FEE TO GO THROUGH THE WHOLE PROCESS AGAIN.**

4) Applicants with incomplete portfolios who do not complete the process within one year after initial submission must reapply.

5) Applicants who fail the ICRC/AODA written exam twice within one year must reapply.

6) Applicants who submit a complete portfolio and get approved but do not sit for the next two ICRC/AODA written exams must reapply.

7) The date a portfolio is received will be recorded on that portfolio. Applicants can use all training after this date for credit towards recertification/requalification.

8) Applicants that apply for certification must either live or work in Rhode Island 51% of their time.

9) Applicants must successfully pass the ICRC/AODA Written Examination to upgrade from PCDP/CDP/CIT to ACDP II/ACDP or PCCDP to CCDP.

10) **Requirements for Clinical Supervisors: ACDPII/ACDP/PCDP applicants only**
Clinical Supervisor credentials:
1) Licensed or Certified Chemical Dependency Clinical Supervisor (LCDCS/CDCS), or;
2) Master's degree in Behavioral Sciences with two (2) years clinical experience and documentation of 120 clock hours Substance Abuse Specific training. Included in this 120 clock hours must be 30 hours chemical dependency clinical supervisor education which includes training in the following Domains: Counselor Development, Professional & Ethical Standards, Program Development & Quality Assurance, Performance Evaluation, Administration, and Treatment Knowledge., or;
3) LCDP/ACDP II/ACDP with 30 clock hours Clinical Supervisor training. This training must include education in the following Domains: Counselor Development, Professional & Ethical Standards, Program Development & Quality Assurance, Performance Evaluation, Administration, and Treatment Knowledge, or;
4) Ph.D. in Behavioral Science or M.D.with documentation of two (2) years of specialization/experience in the Chemical Dependency field, or;
5) Recognized Clinical Supervisor (RCS)

11) Late applications: Applications that are received 1-30 days pass the portfolio submission deadline must submit an additional $50.00 late fee. Applications received more than 30 days pass the portfolio submission deadline will not be accepted.

12) A **formal** job description on facility letterhead must be submitted from the facilities verifying experience. Please note that an acceptable job description must state that you provided substance abuse counseling along with performing all the Core Functions/Performance Domains for each respective credential. **Applicants will not be given an opportunity to revise the job description they have submitted. If the RIBCCDP does not accept the submitted job description, the applicant will be denied application.**

13) Applicants who request the written examination be translated into their native language must pay all fees incurred. In addition, the applicant must choose an organization approved by the Board to provide this service.

**TYPE OR PRINT USING BLACK INK ON ALL FORMS.**
Complete the application process STEP BY STEP. Do one section at a time. Photocopy blank forms before making entries.
Photocopy completed material before sending them to the Certification Board so that you will have a complete copy of your own portfolio. The Certification Board will not return completed applications, even if you are denied certification. (A photocopy of your application is available from the Board for a $10.00 service fee).

Applications for certification will be reviewed when all the above materials have been received by the Certification office. Do not send your application booklet until all sections are completed and signed where required.

**NOTIFY THE CERTIFICATION BOARD OF ANY CHANGE OF MAILING ADDRESS.**

**Completing the portfolio REQUIRED PORTFOLIO FORMAT MUST BE FOLLOWED**

1. **Application for Certification Sheet – page 6** Complete the Application for Certification. Required portfolio format must be followed.

2. **Assurance & Release Forms - page 7 C**omplete form and sign where indicated

3. **Clinical Supervisor Evaluation Forms - page 8** Fill in the upper half of the Supervisor Evaluation Form and give the form (pg 9-12 & 21 -22) to the direct supervisor of your counseling for completion. Clinical Supervisor Evaluation Forms must be received from all facilities from which experience is submitted for credit.
4. **Professional References - page 8** Fill in the upper half of the Professional Reference Form and give the form (pg.13 - 15) to three (3) individuals who know you professionally, not past or present supervisors, and can attest to your competency as an LCDP. These forms must be received by the Board in order to process your application.

5. **Professional Experience Resume - page 16** Complete the Professional Experience Resume. This resume measures the amount of experience you have with alcohol/drug/chemical dependency clients.

6. **Experience Verification Form - page 17** Have your Executive Director complete this form documenting a cumulative amount of hours employed as a chemical dependency counselor.

7. A **formal** job description on facility letterhead must be submitted from the facilities verifying experience. Please note that an acceptable job description must state that you provided substance abuse counseling along with performing all the Core Functions as listed on pages 21 - 22. **Applicants will not be given the opportunity to revise the job description they have submitted. If the RIBCCDP does not accept the submitted job description, the applicant will be denied application.**

8. **Training & Education Forms - pages 18 – 19** Complete the Training and Education Resume. Document all Substance Abuse Specific Training on Table II A. and all Counselor Training in Knowledge/Skills on Table II B. Document appropriate clock hrs, title, date/place and sponsor of training. Any formal training event may fulfill these requirements. Examples of these are: in-service training, seminars, workshops, college courses and training programs. Quantity is measured in clock hours (i.e., sixty minutes = one hour.)

   Convert credit hours to clock hours by using this formula:
   -One (1) college or university semester hour credit is the equivalent of fifteen (15) clock hours.
   -One (1) college or university quarter hour credit is equivalent often (10) clock hours.
   -One (1) hour credit for each clock hour spent in workshops, etc,.

9. Attach copies of transcripts, certificates of completion, statements from your trainer, etc., as documentation that you completed training. Simple enrollment slips are not acceptable.

10. **Clinical Supervision Received - pages 21 - 22**

Complete the Supervision Received Form. Review the list of Core Functions and document supervised training in each of the four groups. Have your documented Clinical Supervisor sign and date form.
This section is designed to address the onsite clinical training you have received in specific counselor functions. We are requesting that you record here the time actually spent discussing your work with a clinical supervisor. Individual, group or team supervisions all apply. Practicum time spent in individual or group on-site supervision may be applicable. Practicum time spent in group supervision in the classroom may be applicable. Actual time spent in performing the Core Functions is not applicable in this section. This work may be recorded in the "Professional Experience Resume."
**ACDPII/ACDP level of counselor certification has a Supervision Received requirement of 300 clock hours with a minimum of 20 hours in each Core Function.**

11) Enclose your check for $200.00 made payable to The Rhode Island Board for the Certification of Chemical Dependency Professionals (RIBCCDP) , and mail to 31 Smith Avenue, 3 Rear Greenville, RI 02828

12) Special **Accommodations- pages 24 – 26** If special accommodations are needed, please complete forms and submit 60 days prior to written exam.

**REQUIRED PORTFOLIO FORMAT**

1. Certification Application
2. Roster of Clinical Supervisor Evaluations
3. Roster of Professional References
4. Completed Assurance and Release
5. Completed Professional Experience Resume
6. Completed Executive Program Director Experience Verification Form.
7. Official Job Descriptions
8. Completed Table II. A -Substance Abuse Specific Training and Education Resume - number each training.
9. All copies of official transcripts or certificates of completion to correspond with complete and numbered Table II A - Substance Abuse Specific - Training and Education Resume.
10. Completed Table II. B - Counselor Training in Knowledge/Skill Base - Training and Education Resume - number each training.
11. All official transcripts or certificates of completion to correspond with complete and numbered Table II B - Counselor Training in Knowledge/Skill Base - Training and Education Resume.
12. Completed Clinical Supervision Received Forms

***PLEASE BE ADVISED - ALL PORTFOLIOS MUST BE SUBMITTED IN THIS FORMAT. IF THIS FORMAT IS NOT FOLLOWED, THE PORTFOLIO WILL NOT BE ACCEPTED AND WILL BE RETURNED TO THE APPLICANT.**

**RHODE ISLAND BOARD FOR CERTIFICATION OF CHEMICAL DEPENDECY PROFESSIONALS**
**31 Smith Avenue - 3 Rear - Greenville, RI 02828**
**Phone: (401) 349-3822 FAX (401) 349-3833**

**PLEASE CHECK ONE:** ☐**ACDP** ☐**ACDP II (Master's level)**
**Testing Date Requested:** ☐**March** ☐**June** ☐**September** ☐**December**

**APPLICATION FOR CERTIFICATION AS AN ADVANCED CHEMICAL DEPENDENCY PROFESSIONAL II or ADVANCED CHEMICAL DEPENDENCY PROFESSIONAL**

**NOTE:** A mandatory prerequisite for licensure is the applicant's Certification as an Advanced Chemical Dependency Professional II, Advanced Chemical Dependency Professional or equivalent certification from another State.

1. Full Name:______________________________________________________________
   (First Name) (MI) (Last Name)
2. Residence Address:________________________________________________________
   (Street) (City) (State) (Zip)
3. Mailing Address:__________________________________________________________
   (Street) (City) (State) (Zip)
4. Telephone Number: Home_______________________________ Work:)______________________
5. Social Security Number:_____________________________ Email:______________________
6. Highest Educational Degree:__________________________ Granted by:___________________
   (Institution)
7. Other Colleges/Universities attended:
   College Dates Degree/Sem. Hrs. to Date Major
   ______________________________________________________________________________
   ______________________________________________________________________________
8. Have you ever been licensed/certified in any state?_________If yes, give state(s), date of licensure, license number, current status, expiration date(s). ______________________________________________
9. Have you ever been convicted of a felony violation of any state or federal law?______________________
   If yes, explain by attachment. NOTE: Non-disclosure may be grounds for denial of certification.
10. Have you ever had any disciplinary actions against any license/certification including but not limited to: Revocation, suspension, probation?_________________________________________________________
11. If yes, identify type of license/certification sanctioned, state sanctioned in, what type of sanction was/is against your certification/license, and date of sanction________________________________________

Optional Information:

Race:☐Caucasian ☐Black/Afro American ☐Asian ☐Hispanic ☐American Indian/Alaskan Native ☐Other

Requested Test Language: Please check only one ___English ____French ____Spanish

**Please note: When selecting TEST DATES, applicants must take the written examination on the test date selected. The RIBCCDP is charged $70.00 for each written examination ordered whether it is used or not. If an applicant does not take the written examination on the test date they have selected, a test fee of $70.00 will be required to sit for the next test date.**

## ASSURANCE AND RELEASE

I ______________________________, of________________________________ do hereby submit the following information, assurances and release relating to my initial certification or renewal of certification with the Rhode Island Board for the Certification of Chemical Dependency Professionals (RIBCCDP)/Rhode Island Board for Licensing of Chemical Dependency Professionals (RIBLCDP)

I acknowledge and understand in answering the following questions that submitting fraudulent, deceitful or misleading statements will be grounds for denial or revocation of certification or renewal of certification.

Have you ever applied for certification/licensure as a chemical dependency professional in another state?

___ yes ____no

1) Have you ever had any action taken against your certification/license?

___ yes ____no

If the answer to Number Two (2) is Yes, please provide details on reverse side

3) Have you ever been disciplined in any way by a Certification/Licensing Board or Professional Organization?

yes no

If the answer to Number Three (3) is yes, please provide details on reverse side.

I hereby certify that I have read this entire application and that all the material contained herein is true, accurate and complete. I further understand that any intentionally false or misleading statements or omissions shall result in the denial or revocation of my certification/license or renewal of certification/license.

I hereby certify that all information contained in this application and any supporting documents is true to the best of my knowledge. I further certify that I do not use any controlled substances or any alcoholic beverages to the extent that the use impairs my ability to conduct with safety to the public the practice authorized by the license for which I am applying.

I hereby certify that I have read and subscribed to the Ethical Standards and Code of Conduct for Chemical Dependency Professionals prescribed by RIBCCDP.

 I authorize RIBCCDP/RILBCDP, its members, officers and employees, to investigate my background as it relates to the statements contained in my application and further consent to the release of information by third parties to RIBCCDP/RILBCDP which information relates directly to my application and statements contained therein so long as said information remains confidential.

 I further agree to hold RIBCCDP/RILBCDP, its members, officers, employees and examiner's harmless and free from all liability from complaints, causes of action, suits, claims, demands and damages of every nature or kind pertaining or arising out of or relating in any manner whatsoever to actions taken by RIBCCDP/RILBCDP in investigating my application and making a determination regarding my certification.



I further authorize the RIBCCDP/RILBCDP to release all documentation/information of application for certification/renewal along with all documentation of ethics complaints, Disciplinary Hearings, and disciplinary sanctions taken against me to the Department of Health, the ICRC/AODA and the Rhode Island Board of Licensing for Chemical Dependency Professionals.

I have read and understand the above.

| ____________________________________ | ____________________________________ |
|---|---|
| Print Name | Witness |
| ____________________________________ | ____________________________________ |
| Signature | Date |
| ____________________________________ | ____________________________________ |
| Address | City, State, Zip Code |

**CLINICAL SUPERVISOR'S EVALUATION FORMS:**

I have given the Clinical Supervisor's Evaluation Form to the following Clinical Supervisors.

Name:__________________________________________________________
Telephone:_______________________________________________________
Name of Agency:__________________________________________________

Mailing Address: __________________________________________________

________________________________________________________________

Name:__________________________________________________________
Telephone:_______________________________________________________
Name of Agency:__________________________________________________

Mailing Address: __________________________________________________

________________________________________________________________

Name:__________________________________________________________
Telephone:_______________________________________________________
Name of Agency:__________________________________________________

Mailing Address: __________________________________________________

________________________________________________________________

**PROFESSIONAL REFERENCES:**

I have requested the following individuals to forward their recommendations to RIBCCDP (Please list three (3) people, other than your supervisors, who know you PROFESSIONALLY and can attest to your PROFESSIONAL SKILLS). Provide your references with a copy of pages 13 to 15. Enclose and envelope addressed to RIBCCDP.

Name:__________________________________________________________
Telephone:_______________________________________________________
Mailing Address: __________________________________________________

Name:__________________________________________________________
Telephone:_______________________________________________________
Mailing Address: __________________________________________________

Name:__________________________________________________________
Telephone:_______________________________________________________
Mailing Address:__________________________________________________

**PLEASE NOTE:** The RIBCCDP reserves the right to request further information from all employers and other persons listed on the application form. The RIBCCDP and its review committees reserve the option to request an oral interview with the applicant. This information will be used strictly to evaluate the professional competence of a counselor and will be kept confidential by RIBCCDP. Further information may be requested in order to verify training, employment, etc. This information is not available to other persons without the written consent of the applicant.

**RHODE ISLAND BOARD FOR THE CERTIFICATION OF**
**CHEMICAL DEPENDENCY PROFESSIONALS**
**31 Smith Avenue -3 Rear**
**Smithfield, Rhode Island 02917**

**CLINICAL SUPERVISOR'S REFERENCE FORM**
**CONFIDENTIAL**

Dear Clinical Supervisor:

Your employee named on the accompanying form is applying to the Rhode Island Board for the Certification of Chemical Dependency Professionals (RIBCCDP) for certification as indicated below. The information requested here is an essential part of the Board's evaluation of the competence of the applicant and must be on file before the application can be processed.

**Requirements for Clinical Supervisors:**

Clinical Supervisor credentials:

1) Chemical Dependency Clinical Supervisor (CDCS/LCDCS), or;
2) Master's degree in Behavioral Sciences with two (2) years clinical experience and documentation of 120 clock hours Substance Abuse Specific training. Included in this 120 clock hours must be 30 hours chemical dependency clinical supervisor education which includes training in the following Domains: Counselor Development, Professional & Ethical Standards, Program Development & Quality Assurance, Performance Evaluation, Administration, and Treatment Knowledge, or;
3) LCDP/ACDP/ACDP II with 30 clock hours Clinical Supervisor training. This training must include education in the following Domains: Counselor Development, Professional & Ethical Standards, Program Development & Quality Assurance, Performance Evaluation, Administration, and Treatment Knowledge, or;
4) Ph.D. in Behavioral Science or M.D. with documentation of two (2) years of specialization/experience in the Chemical Dependency field, or;
5) Recognized Clinical Supervisor (RCS)

RIBCCDP believes that you, as a Clinical Supervisor, will have developed a more complete and accurate impression of the knowledge and skills of the applicant than is available from other sources. Your evaluation together with those received from other references and the data furnished by the applicant will be used to determine eligibility for certification. The process can be only as good as you and others make it by careful and truthful reporting.

The Rhode Island Certification Board reserves the right to request further information from you concerning this applicant. Your cooperation will be very much appreciated in this certification effort.

**Please return the completed evaluation along with documentation of the above requirements or a copy of your RCS certificate.**

RIBCCDP
_____ACDP II
_____ACDP

## CLINICAL SUPERVISOR'S EVALUATION FORM

APPLICANT:____________________________________________DATE:____________________

CLINICAL SUPERVISOR:____________________________________________________________

SUPERVISOR'S CREDENTIALS:_______________________________________________________

TELEPHONE #:_________________________ PROGRAM:_______________________________

ADDRESS:_______________________________________________________________________

A.The following items represent the skills needed by a Chemical Dependency Professional. Evaluate the above named applicant as you feel he/she demonstrates their abilities in each area. Mark the rating most nearly descriptive of the counselor's demonstrated skills.

PLEASE NOTE: Make your evaluations using the scale below.

A rating of 1 is equivalent to NOT APPLICABLE
2 is equivalent to DON'T KNOW
3 is equivalent to POOR
4 is equivalent to AVERAGE
5 is equivalent to ABOVE AVERAGE
6 is equivalent to SUPERIOR

**NOTE: The applicant must earn an average of 4 & be recommended by their supervisor to qualify for licensure.**

1. **Screening-** The process by which a client is determined appropriate and eligible for admission to a particular program.

2. **Intake-** The administrative and initial assessment procedures for admission to a program.

3. **Orientation-** Describing the client:
   –general nature and goals of the program;
   –rules governing client conduct and infractions that can lead to disciplinary action or discharge from the program;
   –in a non-residential program, the hours during which services are available;
   –treatment costs to be borne by the client, if any, and
   –client's rights.

4. **Assessment-** Those procedures by which a counselor/program identifies and Evaluates an individual's strengths, weaknesses, problems and needs for the development of the treatment program.

5. **Treatment Planning-** Process by which the counselor and the client:
   –identify and rank problems needing resolution;
   –establish agreed upon immediate and long term goals, and;
   –decide on the treatment methods and resources to be used.

**Individual**

6. **Counseling-** (Individual, Group & Significant Others) - The utilization of special skills to assist individuals, families or groups in achieving objectives through:

**Group**

   -exploration of a problem and its ramifications

**Significant Others**

   -examination of attitudes and feelings;
   -consideration of alternative solutions, and;
   -decision making.

7. **Case Management-** Activities which bring services, agencies, resources of people together within a planned framework of action toward the achievement of established goals. It may involve liaison activities and collateral contracts.

8. **Crisis Intervention-** Those services which respond to an alcohol/other drug abuser's needs during acute emotional/physical distress.

9. **Client Education-** Provision of information to individuals and groups, concerning Alcohol and other drug abuse and the available services and resources.

10. **Referral-** Identifying the needs of a client that cannot be met by the counselor or agency and assisting that client to utilize the support systems and community resources available.

11. **Reports & Recordkeeping-** Charting the results of the assessment and treatment plan; writing reports, progress notes, discharge summaries and other client- related data.

12. **Consultation-** Relating with counselors and other professionals in regard to the client treatment (services) to assure comprehensive quality care for the client.

13. **Relapse Prevention,** discharge planning, follow-up and aftercare.

B. Evaluate the applicant as you observe(d) him/her in the following areas of interpersonal relationships with clients:

1. Respect for the client.
2. Care and concern for the client.
3. Genuinesswithclient.
4. Empathywith client
5. Flexibility with client.
6. Judgment with client.
7. Spontaneity with client.
8. Capacity for confrontation with client.
9. Capacity for appropriate self-disclosure.
10. Sense of immediacy.
11. Ability to set appropriate boundaries.

c.EVALUATORS STATEMENT

Where did you receive your training in counseling?

______________________________________________________________________

How long have you been employed by this program?_______________________________________________

Professional certificates or license you hold__________________________________________________

Are you involved in the administration/management of the program at which you are employed?
_____ a) no
_____b) Yes, limited to clinical aspects (i.e., supervision of counselors)
_____ c) Yes, limited to administrative responsibilities such as budgeting.
_____ d) Yes, both clinically and administratively

What is/was the overall size of his/her substance abuse case-load? ___________________________________

Average number of hours per week applicant worked in substance abuse specific individual counseling?_______

Average number of hours applicant worked in substance abuse specific group counseling?__________________

Average number of hours applicant worked in substance abuse specific family counseling?_________________

Average number of hours per week applicant worked in other significant and related substance abuse activities?
_______Describe:_______________________________________________________________________

Total number of hours per week applicant spent providing substance abuse specific services:_______________

For what period of time, have you provided substance abuse specific supervision for this applicant?
From_________________ to_____________________________________________

Comments/additional information you feel may be pertinent:________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

I HEREBY CERTIFY THAT I HAVE BEEN IN A POSITION TO OBSERVE AND HAVE FIRSTHAND KNOWLEDGE OF___________________________ 'S WORK AT ______________________________
(Name of Counselor) (Name of Working Setting)

☐ I recommend this applicant for certification
☐ I have some reservations in recommending this applicant
☐ I do not recommend this applicant.

I hereby certify that all of the above materials is, to the best of my knowledge, true.

___________________________________________________________________________________
Signature Agency Title Date

**PLEASE SUBMIT DOCUMENTATION OF THE REQUIRED CREDENTIALS AS STATED ON PAGE 9. DO NOT RETURN THIS FORM TO APPLICANT - PLEASE RETURN TO THE BOARD.**

**RHODE ISLAND BOARD FOR THE CERTIFICATION OF CHEMICAL DEPENDENCY PROFESSIONALS**

**31 Smith Avenue -3 Rear**
**Greenville, Rhode Island 02828**

R.I Certification Board:

ACDP II - Advanced Chemical Dependency Professional II
ACDP - Advanced Chemical Dependency Professional

**Professional Reference Form**
**Confidential**

Dear: :

I am applying to the Rhode Island Board for the Certification of Chemical Dependency Professionals (RIBCCDP) for certification as indicated below. References must be included as part of the application. Please complete the reference material enclosed and return it to the Board.

Your prompt attention to this would be very much appreciated as my application will not be processed until the Board receives this recommendation from you.

Sincerely,

________________________________________________ (Signature of applicant)

RIBCCDP believes that certification should be based on input from a variety of sources, especially the observations of persons who have known the applicant professionally. For this reason, all applicants are required to list three references who will complete this Professional Reference Form. Your evaluation together with those received from others and the data furnished by the applicant will be used in determining eligibility for certification. The process can be only as good as you and others make it by careful and truthful reporting.

Please return the completed evaluation within one week to the Board. Your cooperation will be very much appreciated.

Sincerely,

The Rhode Island Board For The Certification of Chemical Dependency Professionals

_____ACDPII
_____ACDP

**PROFESSIONAL REFERENCE FORM**

Applicant's Name:___________________________________________________________________________

The following areas represent skills and knowledge needed by a Advanced Chemical Dependency Professional. Evaluate the applicant as you feel he/she demonstrates his/her abilities in each area. Mark the rating most nearly descriptive of the counselor's demonstrated ability.

A rating of 1 is equivalent to NOT APPLICABLE
2 is equivalent to DON'T KNOW
3 is equivalent to POOR
4 is equivalent to AVERAGE
5 is equivalent to ABOVE AVERAGE 6
is equivalent to SUPERIOR

1. Common sense in dealing with client.
2. Respect for client.
3. Empathywith client.
4. Care and concern for client
5. Flexibility with clients.
6. Spontaneity with client.
7. Capacity for confrontation with client.
8. Capacity for appropriate self-disclosure.
9. Concreteness.
10. Ability to treat client information in accordance with state and federal confidentiality regulations.
11. Ability to communicate effectively with client and co-workers.
12. Knowledge of the Chemical Dependency field.
13. Capacity to act in an ethical manner with client.
14. Problem recognition and evaluation: Ability to apply knowledge of physical, behavioral, attitudinal and effective manifestations of substance abuse to determine its existence and degree of progression.
15. Counseling: Ability to facilitate appropriate change in client with regard to mood-altering, chemical substances.
16. Ability to set appropriate limits with clients.

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

GENERAL REMARKS:

Person completing Reference:

Your Name:____________________________________________________________________________
Address:______________________________________________________________________________
Position:_____________________________________________________________________________
I have known__________________________________________for__________ ______ years.
(Name of Applicant)

My relationship with him/her was/is___________________________________________________

I hereby certify that this rating is, to the best of my knowledge, truthful and reflects as accurately as possible my knowledge of the applicant.

Signature:_________________________________________________ Date:______________________

**PLEASE NOTE: APPLICANTS MUST EARN AN AVERAGE OF 4 TO QUALIFY FOR CERTIFICATION.**

**PHOTOCOPY FORMS AS NEEDED**

**PLEASE RETURN THIS FORM TO THE BOARD**

**PROFESSIONAL EXPERIENCE RESUME**

Begin with your most recent employment and work backward. Include relevant military service.

EMPLOYER:___________________________________________________________________

TYPE OF INSTITUTION/ESTABLISHMENT:_____________________________________________

FULL ADDRESS:_______________________________________________________________

NAME OF IMMEDIATE SUPERVISOR:_________________________________________________

SUPERVISOR'S POSITION:_______________________________________________________

TITLE OF YOUR POSITION:______________________________________________________

HRS. PER WEEK_________ FROM__ /__ /__ TO __ /__ /__

YOUR DUTIES AND SPECIALTY:____________________________________________________

EMPLOYER:___________________________________________________________________

TYPE OF INSTITUTION/ESTABLISHMENT:_____________________________________________

FULL ADDRESS:_______________________________________________________________

NAME OF IMMEDIATE SUPERVISOR:_________________________________________________

SUPERVISOR'S POSITION:_______________________________________________________

TITLE OF YOUR POSITION:______________________________________________________

HRS. PER WEEK_________ FROM__ /__ /__ TO __ /__ /__

YOUR DUTIES AND SPECIALTY:____________________________________________________

_____________________________________________________________________________

**PLEASE PHOTOCOPY THIS FORM AS NEEDED**

**EXECUTIVE PROGRAM DIRECTOR**
**EXPERIENCE VERIFICATION FORM FOR ACDP II & ACDP APPLICANTS**

I______________________________________ herein certify that___________________________ has been employed **within the past five(5) years** as a chemical dependency counselor **, at _________________________

for ___________________________ hours*, from _____________to______________ .

******************************************************************************************

I_____________________________ herein certify that______________________________ has been employed **prior to the past five(5) years** as a chemical dependency counselor **, at _____________________________

for ___________hours*, from ____________ to ______________ .

This facility is licensed/accredited/recognized by: _____________________________________ as a ___________________________ effective as of_________________________________ .
Date

_____________________________________________________________
Signature
__________________________________
Date

***hours must be documented cumulatively (total of hours worked)***
****describes a principle job function. Principle function must be chemical dependency counselor.**

PLEASE PHOTOCOPY AS NEEDED
ATTACH OFFICIAL JOB DESCRIPTION FROM FACILITIES WHERE EXPERIENCE IS SUBMITTED FOR CREDIT

**TABLE I**
**TRAINING AND EDUCATION RESUME**

**Substance Abuse Specific Training:**

| # TRAINING | DATE ATTENDED | CLOCK HOURS |
|---|---|---|
| **1) Confidentiality of Drug & Alcohol Client Records (Required)** | | **12** |
| **2) Ethics (required)** | | **6** |
| **3) HIV/AIDS/Viral Hepatitis Curriculum based risk reduction RIBCCDP approved (Required)** | | **6** |
| **4) 12 Hours Medication Assisted Therapy & Attitudes of Medication in the Recovery Process** | | **12** |
| 5 | | |
| 6 | | |
| 7 | | |
| 8 | | |
| 9 | | |
| 10 | | |
| 11 | | |
| 12 | | |
| 13 | | |
| 14 | | |
| 15 | | |

TOTAL HOURS:___________________

**TABLE II**
**TRAINING AND EDUCATION RESUME**

A. Counselor Training in Knowledge/Skill Base Performance Domains:

| # TRAINING | DATE ATTENDED | CLOCK HOURS |
|---|---|---|
| 1 | | |
| 2 | | |
| 3 | | |
| 4 | | |
| 5 | | |
| 6 | | |
| 7 | | |
| 8 | | |
| 9 | | |
| 10 | | |
| 11 | | |
| 12 | | |
| 13 | | |
| 14 | | |
| 15 | | |
| 16 | | |
| 17 | | |
| 18 | | |

TOTAL HOURS:______________

The requirements, as outlined, are by group clusters of Core Functions. This grouping of skills acquisitions recognizes that employment sites segment the counselor Core Functions into specific job descriptions. However, the well-rounded counselor will have had minimum supervision in each of the four groups.

**"NOTE: A minimum of 20 hours are required in each Core Function for ACDP II/ACDP. However, the total accumulated hours for ACDPII/ACDP must be 300."**

| | **ACDPII/ACDP** |
|---|---|
| **GROUP A** | |
| Screening<br>Intake<br>Orientation<br>Assessment | 80 HRS. |
| **GROUP B** | |
| Treatment Planning<br>Counseling<br>Case Management<br>Crisis Intervention | 120 HRS. |
| **GROUP C** | |
| Client Education<br>Referral | 40 HRS. |
| **GROUP D** | |
| Reports and Recordkeeping<br>Consultation<br>Relapse prevention, discharge planning, follow-up and aftercare. | 60 HRS. |
| | **TOTALS: 300 hrs.** |

**"NOTE: A minimum of 20 hours is required in each Core Function for ACDP II/ACDP. However, the total accumulated hours for ACDP II/ACDP must be 300."**

## CLINICAL SUPERVISION RECEIVED

| **CORE FUNCTIONS** | **# HOURS** | **Clin.Sup. Initials** |
|---|---|---|
| **GROUP A:** | | |
| **Screening -** The process by which a client is determined appropriate and eligible for admission to a particular program. | ________ **(#Hrs)** | ______________ **(Clin. Sup Initials)** |
| **Intake -** The administrative and initial assessment procedures for admission to a program | ________ **(#Hrs)** | ______________ **(Clin. Sup Initials)** |
| **Orientation** - Describing to the client: -general nature and goals of the program; rules governing client conduct and infractions that can lead to disciplinary action or discharge from the program in a non-residential program, the hours during which services are available; treatment costs to be borne by the client, if any, and; client's rights. | ________ **(#Hrs)** | ______________ **(Clin. Sup Initials)** |
| **Assessment** - Those procedures by which a counselor/program identifies and evaluates an individual's strengths, weaknesses, problems and needs for the development of the treatment plan. | ________ **(#Hrs)** | ______________ **(Clin. Sup Initials)** |
| **GROUP B:** | | |
| **Treatment Planning** - Process by which the counselor and the client: identify and rank problems needing resolution; establish agreed upon immediate and long term goals, and; decide on the treatment methods. | ________ **(#Hrs)** | ______________ **(Clin. Sup Initials)** |
| **Counseling** - (Individual, Group & Significant Others) The utilization of special skills to assist individuals, families or groups in achieving objective through: exploration of a problem and its ramifications ; examinations of attitudes and feelings; consideration of alternative solutions, and; decision making | ________ **(#Hrs)** | ______________ **(Clin. Sup Initials)** |

**TOTAL HOURS**

Supervisor's Signature________________________________________Date:______________________________

**"NOTE: A minimum of 20 hours is required in each Core Function for ACDP II/ACDP. However, the total accumulated hours for ACDP ii?ACDP must be 300."**

**CLINICAL SUPERVISION RECEIVED**

| **CORE FUNCTIONS** | **#HOURS** | **Clin.Sup. Initials** |
|---|---|---|
| **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 contacts. | ________ **(#Hrs)** | _______________ **(Clin. Sup Initials)** |
| **Crisis Intervention** - Those services which respond to an alcohol/drug abuser's needs during acute emotional and/or physical distress. | ________ **(#Hrs)** | _______________ **(Clin. Sup Initials)** |
| **GROUP C:** **Client Education** - Provision of information to individuals and groups, concerning alcohol and other drug abuse and the available services and resources. | ________ **(#Hrs)** | _______________ **(Clin. Sup Initials)** |
| **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 community resources available. | ________ **(#Hrs)** | _______________ **(Clin. Sup Initials)** |
| **GROUP D:** **Reports and Recordkeeping** - Charting the results of the assessments and treatment plan; writing reports, progress notes, discharge summaries and other client-related data. | ________ **(#Hrs)** | _______________ **(Clin. Sup Initials)** |
| **Consultation** - Relating with counselors and other professionals in regard to client treatment (services) to assure comprehensive quality care for the client. | ________ **(#Hrs)** | _______________ **(Clin. Sup Initials)** |
| **Relapse Prevention,** discharge planning, follow up and aftercare. | ________ **(#Hrs)** | _______________ **(Clin. Sup Initials)** |

TOTAL HOURS:______________________________

Supervisor's Signature_______________________________________Date:______________________________

## COMMITTEE ON SPECIAL NEEDS

The Committee on Special Needs was established by the Rhode Island Board for the Certification of Chemical Dependency Professionals in September, 1992, to address and comply with those relevant sections and articles of the American's with Disabilities Act of 1990 (ADA) as they pertain to the RIBCCDP's credentialing and certification/licensure process. The Committee will strive to ensure access to the certification process to all applicants and maintain its certification standards. To this end, the Committee on Special Needs has set forth the following protocol:

1. All portfolios for all credentialed disciplines will include both the statement of need for special accommodations and medical release and/or other source, effective May 1, 1993. The Board shall be responsible for approving these forms, and the Committee will be responsible for ensuring that they are included in all portfolios. The Committee shall be responsible for updating these forms as needed, subject to Board approval.

2. Applicants will be required to submit the request for special accommodations to the Board no less that sixty days prior to the date designated for the administration of the appropriate examination.

3. Applicants will be required to submit the medical release and supporting documentation with the portfolio application by the designated deadline (forty-five days prior to the examination).

4. The Board's Administrative Staff will be responsible for referring all requests for special accommodations to the Committee on Special Needs. The Committee will Approve/Disapprove requests for special accommodations on a case-by-case basis, utilizing the judgment and discretion of the Committee to determine whether the applicant is an "individual with a disability" within the meaning of the ADA and whether the accommodations requested by the applicant are reasonable. A requested accommodation can only be refused if it would fundamentally alter the measurement of the skills or knowledge the exam is intended to test or would result in an undue burden. In cases where a request is denied, the Committee will convey this information to the Board for its consideration and final determination. The Committee shall refer any request to the Board, for accommodations that exceed reasonable financial responsibility in compliance with criteria established by the ADA.

5. The Committee will be responsible for approving the request and making the reasonable accommodations for each of the individual situations. This will include the contracting of interpreters and scribes, as well as securing the necessary equipment. The Committee will establish a comprehensive resource list to facilitate this process.

6. The Committee shall be responsible for ensuring that reasonable accommodations are indeed provided where approved and work with the Quality Assurance Committee to ensure that the standards and criteria of the credentialing process are upheld.

7. Applicant appeals and/or grievances will be directed to the Board for its action to be addressed through the Board's existing procedures.

8. This Board reserves the right to seek legal counsel when necessary for clarification of the ADA law or legal action on the part of an applicant has been indicated.

9. All requests for accommodations and any supporting documentation or medical information must be kept strictly confidential.

**Policies for the Written Examination:**

1) All translators must be approved by the Board, must not be a friend, relative or co-worker of the applicant and must be able to speak the "standard" language.

2) All translators must follow the exact protocol set forth by the ICRC/AODA for administration of all tests. 3)

Translators role is simply to read, not interpret, what is presented; interpretation of questions is inappropriate.

Questions may be repeated if necessary.

4) Translation of questions read is audiotaped.

5) Test is proctored in "standard" language.

6) Time is extended according to ICRC/AODA guidelines.

7) Applicants who request the written examination be translated into their native language must pay all fees incurred. In addition, the applicant must choose an organization approved by the Board to provide this service.

**RHODE ISLAND BOARD FOR THE CERTIFICATION OF CHEMICAL DEPENDENCY PROFESSIONALS**

**ACCOMMODATION REQUEST FORM**

The information requested below and any documentation regarding your disability and your request for accommodation in testing will be considered strictly confidential and will not be shared with any outside source without your express written permission. **Also please supply any documentation (e.g., letter from a physician or other professional, evidence of a prior diagnosis or accommodation, etc.) which support this request.**

**NAME:**______________________________________________________________
**ADDRESS:**___________________________________________________________
**PHONE#:**____________________________________________________________
**S.S.#:**______________________________________________________________

**ACCOMMODATIONS REQUESTED FOR THE** ________________**EXAMINATION**

**PLEASE CHECK ALL THAT APPLY:**

_____**Accessible Testing Site**
_____**Reader as accommodation for visual impairment**
_____**Scribe as accommodation for visual or motor impairment**
_____**Scribe as accommodation for learning disability**
_____**Extended time**
    _____**Time-and-a-half**    _____**Double time**
    _____**More than double time (specify):**____________________________

_____**Separate testing area**
_____**Translator (specify standard language)** ______________________________

_____**Other:**_________________________________________________________

**Comments:**_______________________________________________________

____________________________________________________________________

**Signed:**________________________________________**Date:**_________________

**RHODE ISLAND BOARD FOR THE CERTIFICATION OF CHEMICAL DEPENDENCY PROFESSIONALS**

**CONSENT FOR THE RELEASE OF HEALTH CARE INFORMATION**

Applicant's Name:_____________________________________________

Date of Birth:_________________________________________________

I, ______________________________________, hereby authorize___________________________________
(Applicant's Name) (Name and Address of Health Care Provider)

To disclose and release to the Rhode Island Board for the Certification of Chemical Dependency Professionals, 31 Smith Avenue - 3 Rear, Greenville, Rhode Island 02828, all health care information relevant to the accommodation request made in the attached Accommodation Request Form which is incorporated herewith including, but not limited to, diagnoses and recommendations as to accommodations. This information is needed for the purpose of reviewing my request for accommodation in taking a certification examination.

I understand that I may revoke this consent at any future time in writing and that this consent expires upon completion of the certification process, or two years from the date of this release, whichever is earlier.

________________________________________Signature of Applicant

____________________Date