

# CCDPD Application

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Co-Occurring Disorders Professional  
Diplomate

## DIRECTIONS/CHECKLIST

- Official transcript required sent directly from college/university to the RIBCCDP Office.
- Certificates of attendance for trainings.
- All required documentation to support employment (i.e. letters from former employers verifying employment, current job description, signed and dated by applicant and supervisor).
- Sign and date the Code of Ethical Conduct.
- Supervision form completed and signed by supervisor.
- Fee of \$250. May be paid by check/money order (payable to RIBCCDP) or with PayPal (by visiting [www.ribccd.com](http://www.ribccd.com) and clicking on Pay Fees. If paying through PayPal, fee must be paid prior to application.

Applications will be open for one year. If all requirements are not met within one year, the application will expire and the applicant will be required to resubmit a new application and fee.

If you have other credentials with RIBCCDP, please call the office before applying.

If there are any problems with the application, you will be notified by email or phone.

Keep a photocopy of the entire application. Send your completed application, copies of certificates of attendance, attachments, and fee to:

RIBCCDP  
298 S. Progress Avenue  
Harrisburg, PA 17109  
Phone: (717) 540-4456 Fax: (717) 540-4458  
Website: [www.ribccd.com](http://www.ribccd.com) Email: [info@ribccd.com](mailto:info@ribccd.com)

# REQUIREMENTS FOR CCDPD

## Employment

- One year (2000 hours) of employment providing integrated services to clients with co-occurring disorders obtained over the last 10 years. Applicant must spend at least 51% of his/her time providing direct services.
- Supervised work experience is defined as paid professional experience in the delivery of counseling services to individuals, families or groups with mental illness, substance abuse disorders or co-occurring disorders or delivery of supervision to those providing said counseling services and must be in the seven CCDPD domains.
- Applicant must be currently employed in a co-occurring disorders position at the time application is submitted.
- If current employment is in an unlicensed facility, an agency brochure and philosophy statement as it relates to the provision of co-occurring disorders services must be included.

## Supervision

- 100 hours with a minimum of 10 hours in each domain.

## Education

- Master's degree in co-occurring disorders or behavioral science with a clinical application from an accredited college or university that is recognized by the US Department of Education or the Council on Higher Education Accreditation. An official transcript sent directly from college/university is required.
- 140 hours of co-occurring specific education that includes a focus on both substance use and mental disorders and considers the interactive relationship between the disorders; including six hours of counselor specific ethics.
- Education is defined as formal, structured instruction in the form of workshops, seminars, institutes, in-services, college/university credit courses and RIBCCDP approved distance education.
- Education must be specifically related to the knowledge and skills necessary to perform the tasks within the seven domains.
- Education in CPR/First Aid and computer learning will be acceptable for a maximum of six hours each.
- Three college credits are equivalent to 45 hours.
- Education, as defined above, applicant provides to others may also be used providing it is verified in writing by sponsoring school or agency.

## Examination

- Pass the IC&RC Examination for Co-Occurring Disorders Professionals.

## Other

- Signed and dated Code of Ethical Conduct.
- Signed, dated and witnessed Release.
- Current job description dated and signed by supervisor and applicant.
- Applicant must either live or work in RI at time of application.

## Domains

1. Screening & Assessment
2. Crisis Prevention & Management
3. Treatment & Recovery Planning
4. Counseling
5. Management & Coordination of Care
6. Education of the Person, Their Support System & the Community
7. Professional Responsibility

## Fees

Certification:	\$250
<i>(fee must accompany application and materials)</i>	
Retest:	\$150
Exam Cancellation:	\$150

## **CERTIFICATION TIME PERIOD**

RIBCCDP certification encompasses two calendar years commencing on the date of passing the exam. Two dates, date of issue and valid through, will appear on the certificate along with a certification number

## **APPEAL PROCESS**

The purpose of appeal is to determine if RIBCCDP accurately, adequately and fairly reviewed applicant's file. A letter requesting an appeal must be made to RIBCCDP in writing within 30 days of the notification of the board's action. A person shall be considered notified three days after the relevant date of mailing. The written appeal will be sent to the Executive Committee who in turn will thoroughly review the entire application and materials to determine whether or not applicant should have been denied approval. Applicant will be notified in writing as to the findings of the Executive Committee.

## **RECERTIFICATION**

To maintain the high standards of this professional practice and to assure continuing awareness of new knowledge in the field, RIBCCDP requires recertification every two years.

To be recertified as a CCDPD, an individual must:

1. Hold a current and valid certificate issued by RIBCCDP;
2. Acquire 40 hours of RIBCCDP approved education relevant to co-occurring disorders, including 30 hours co-occurring disorders specific, and three hours in professional ethics and responsibilities received within the two year recertification cycle;
3. Verify that you have reviewed, read and will uphold by practice the RIBCCDP Code of Ethical Conduct for professional behavior;
4. Complete an application and pay the recertification fee.

## **LAPSED CERTIFICATION**

The completed recertification application should be received at RIBCCDP prior to the expiration date. If the application is incomplete, applicant will be notified by phone or email depending on what has been indicated by applicant.

There is no grace period. If the recertification is not completed by the expiration date, the individual will no longer hold a CCDPD and no further use of the CCDPD is permitted until the individual has recertified.

All certified professionals should review the recertification application well in advance of the expiration date. A Reinstatement Fee is due if the recertification is late between one day and five years. After five years, no recertification is possible and applicant would have to reapply for the credential, meeting all current requirements.

# APPLICATION FOR CCDP

Form can be completed and saved. You may then print the appropriate pages to submit to RIBCCDP.

Other past or current RIBCCDP credentials held:  SAC  ACDP  ACDP II  CCJP  RCS  CDCS  PCDP  PCCDP  
 CCDP  APS  CPS  ACPS  CPSS

Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  Male  Female

Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

County: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
*(required)*

Position/Title: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

County: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_

Dates Employed: \_\_\_\_\_ Hours per Week: \_\_\_\_\_

Immediate Supervisor: \_\_\_\_\_ Title: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

College/University: \_\_\_\_\_ Name on Transcript: \_\_\_\_\_

If RIBCCDP needs to contact you, please indicate your preference:  Email  Phone

Why are you pursuing certification? *(required)* \_\_\_\_\_

I hereby attest that the applicant is working in a position where a minimum of 51% of his/her time is spent providing direct, primary co-occurring disorders counseling OR that the applicant is working in a position where a minimum of 51% of his/her time is spent providing supervision of counseling.

The applicant has primary responsibility for providing or supervising co-occurring disorders counseling in individual and/or group settings, preparing treatment plans, documenting client progress and is clinically supervised by an individual who is knowledgeable in co-occurring disorders.

\_\_\_\_\_  
Supervisor's Signature

Have you ever received any disciplinary action from another certification or licensing authority?  Yes  No  
*If yes, please explain in full on a separate sheet.*

Have you ever been convicted of a felony violation in any state or federal law?  Yes  No  
*If yes, please explain in full on a separate sheet.*

Have you ever been licensed/certified in any other state?  Yes  No  
*If yes, please explain in full on a separate sheet.*

Fee of \$250 can be paid using one of the following:

- Check/MO (payable to RIBCCDP)
- PayPal – go to [www.ribccdp.com](http://www.ribccdp.com) and click on Fees.

**Please print your name as it should appear on your certificate:**

**PREVIOUS EMPLOYMENT, IF APPLICABLE**

*Include letter (on company letterhead) from previous employer verifying your duties and dates employed.*

Name of Employer: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Your Title: \_\_\_\_\_ Hours per Week: \_\_\_\_\_

Dates Employed: \_\_\_\_\_ Immediate Supervisor: \_\_\_\_\_

Primary Responsibilities: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Name of Employer: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Your Title: \_\_\_\_\_ Hours per Week: \_\_\_\_\_

Dates Employed: \_\_\_\_\_ Immediate Supervisor: \_\_\_\_\_

Primary Responsibilities: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Name of Employer: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Your Title: \_\_\_\_\_ Hours per Week: \_\_\_\_\_

Dates Employed: \_\_\_\_\_ Immediate Supervisor: \_\_\_\_\_

Primary Responsibilities: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

# SUPERVISION

To Supervisor: Please complete this form indicating applicant's on-the-job supervision. This form is not intended to document applicant's total number of hours worked but rather the hours of on-the-job supervision you have provided the applicant. Supervision is a formal or informal process that is administrative, evaluative, clinical, and supportive. It can be provided by more than one person, it ensures quality of clinical care, and extends over time. Supervision includes observation, mentoring, coaching, evaluating, inspiring, and creating an atmosphere that promotes self-motivation, learning, and professional development. In all aspects of the supervision process, ethical and diversity issues must be in the forefront.

Applicant's Name: \_\_\_\_\_

I hereby attest that a minimum of 100 hours of supervision in the domains have been attained by the above-named applicant. At least 10 hours in each of the domains were received as outlined below.

## CCDP DOMAINS

## # OF HOURS RECEIVED IN EACH

1. Screening & Assessment	_____
2. Crisis Prevention & Management	_____
3. Treatment & Recovery Planning	_____
4. Counseling	_____
5. Management & Coordination of Care	_____
6. Education of the Person, Their Support System & the Community	_____
7. Professional Responsibility	_____
<b>TOTAL MUST BE AT LEAST 100 HOURS</b>	_____

\_\_\_\_\_  
Supervisor's Signature

\_\_\_\_\_  
Date

## CLINICAL SUPERVISOR'S EVALUATION INFORMATION

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

Name of Employer: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

## PROFESSIONAL REFERENCES

I have requested the following individuals to forward their recommendations to RIBCCDP. List three people, other than your supervisors who know you professionally and can attest to your professional skills.

Name of Employer: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

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.

Photocopy all forms as needed.

## ASSURANCE AND RELEASE

I \_\_\_\_\_, of \_\_\_\_\_ do hereby submit the following information, assurances and release relating to my initial certification or renewal of certification/licensure with the Rhode Island Board for the Certification of Chemical Dependency Professionals (RIBCCDP), Rhode Island Board for Licensing of Chemical Dependency Professional (RIBLCDP) and the Rhode Island Department of Health (RIDOH).

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

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

Yes  No

*If the answer is Yes, please provide details on a separate sheet.*

Have you even been disciplined in any way by a certification/licensing board or professional organization?

Yes  No

*If the answer is Yes, please provide details on a separate sheet.*

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 statement or omissions shall result in the denial or revocation of my certification/license or renewal of my 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, RIBLCDP, and RIDOH, 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, RIBLCDP and RIDOH which information relates directly to my application and statements contained therein so long as said information remains confidential.

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

I further authorize RIBCCDP, RIBLCDP, and RIDOH 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 by the Department of Health, International Certification & Reciprocity Consortium (IC&RC) and the RIBLCDP. Furthermore, I understand and acknowledge that any sanctions imposed against my LCDP/LCDCS by the RIBLCDP/RIDOH will also be imposed against my RIBCCDP issued certification(s).

I have read and understand the above.

Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Witness: \_\_\_\_\_ Signature: \_\_\_\_\_

## **CLINICAL SUPERVISOR'S EVALUATION FORM**

*CONFIDENTIAL*

Dear Clinical Supervisor:

Your employee named on the accompanying form is applying to RIBCCDP for certification as a Co-Occurring Disorders Professional Diplomat. The information requested here is an essential part of RIBCCDP's evaluation of the competence of the applicant and must be on file before the application can be processed.

It is vital that you complete the Evaluation Form accurately. 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 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 RIBCCDP reserves the right to request further information from you concerning this applicant. Your cooperation will be very much appreciated in this effort.

Please return the completed evaluation along with documentation of the above clinical supervisor requirements.

Sincerely,

RIBCCDP

# CLINICAL SUPERVISOR'S EVALUATION FORM

Applicant Name: \_\_\_\_\_ Date: \_\_\_\_\_

Clinical Supervisor: \_\_\_\_\_ Credentials: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

The following items represent the skills needed by a CCDPD. 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. Applicants must earn an average of four on the rating scale to qualify for this certification.

## RATING SCALE:

- 1 is NOT APPLICABLE
- 2 is DON'T KNOW
- 3 is POOR
- 4 is AVERAGE
- 5 is ABOVE AVERAGE
- 6 is SUPERIOR

### \_\_\_\_ 1. Screening & Assessment

- Ability to engage client and establish rapport.
- Ability to gather and document client information.
- Ability to recognize signs and symptoms of substance abuse disorders and psychiatric disorders.
- Ability to recognize interactions between co-existing mental, substance-related and medical disorders.
- Develop diagnostic impressions and communicate results.

### \_\_\_\_ 2. Crisis Prevention & Management

- Ability to conduct an immediate risk assessment to determine the existence of an emergency or crisis situation.
- Ability to evaluate the nature and level of risk in a client's crisis situation by analyzing the elements of the crisis in order to implement and provide an appropriate intervention.
- Ability to implement an immediate course of action appropriate to the crisis.
- Ability to conduct an in-depth debriefing with all parties involved with the crisis.
- Develop and implement an individualized follow-up plan.

### \_\_\_\_ 3. Treatment & Recovery Planning

- Ability to interpret and evaluate clinically relevant data received from individual, significant others, assessments, and prior treatment sources to determine treatment needs.
- Engage the individual and others in a comprehensive treatment planning process.
- Ability to review data with the individual and others to collaboratively identify and prioritize treatment needs.
- Develop integrated treatment goals and measurable objectives with the individual and others.
- Ability to identify specific and measureable steps to achieve goals, utilizing the individual's strengths and resources.
- Ability to monitor and document individuals' progress in achieving treatment goals and modifying the treatment plan as necessary.

### \_\_\_\_ 4. Counseling

- Ability to provide a safe, empathetic environment in order to facilitate a collaborative relationship with the person and significant other.
- Develop an ongoing therapeutic alliance.
- Utilizes appropriate integrated counseling strategies and techniques.
- Ability to evaluate the effectiveness of counseling intervention strategies.
- Develop integrative discharge and aftercare plans.

\_\_\_ 5. Management & Coordination of Care

- Ability to collaborate with the individual and others to identify and prioritize strengths and needs and match to appropriate services.
- Develop treatment and service options in a collaborative manner.
- Ability to access, coordinate, and facilitate referrals, community, peer and natural support systems to maximize treatment and recovery opportunities as identified in the comprehensive integrated treatment plan.
- Ability to monitor and evaluate the delivery and coordination of services.

\_\_\_ 6. Education of the Person, their Support System & the Community

- Ability to educate the person and family about the symptoms of specific disorders, their interactive effects, and the relationship between symptoms and stressors.
- Ability to educate the person and family about the recovery process.
- Ability to educate the person and family about self-help and peer groups in the recovery process.
- Ability to educate the person and family about self-advocacy.
- Ability to educate the community about co-occurring disorders, the impact on the individual, family and community and the efficacy of treatment.

\_\_\_ 7. Professional Responsibility

- Behaves in an ethical manner by adhering to multi-disciplinary codes of ethics and standards of practice.
- Ability to follow appropriate policies and procedures by adhering to federal, state, and agency regulations regarding substance use and mental health treatment as they related to integrated care.
- Ability to recognize and maintain professional and personal boundaries.
- Ability to engage in continuing professional development based on an ongoing assessment of needs.
- Participation in clinical administrative supervision consultation.
- Ability to advocate for public policy and resources development in support of quality services.

Evaluators Statement

Where did you receive your training in co-occurring disorders? \_\_\_\_\_

How long have you been employed by this program? \_\_\_\_\_

Professional certificates/licenses you hold: \_\_\_\_\_

Are you involved in the administration/management of the program at which you are employed?

\_\_\_ No

\_\_\_ Yes, limited to clinical aspects (i.e. supervision of counselors)

\_\_\_ Yes, limited to administrative responsibilities such as budgeting

\_\_\_ Yes, both clinically and administratively

What is/was the overall size of applicants co-occurring caseload? \_\_\_\_\_

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

Average number of hours per week 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?

(Please describe) \_\_\_\_\_

\_\_\_\_\_

Total number of hours per week applicant spent providing co-occurring specific services? \_\_\_\_\_

For what period of time have you provided co-occurring specific supervision for this applicant? \_\_\_\_\_

Comments or additional information (optional):

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I hereby certify that I have been in a position to observe and have firsthand knowledge of the applicant's work and that all of the material is, to the best of my knowledge, true.

- \_\_\_\_ I recommend this applicant for certification.
- \_\_\_\_ I have some reservations in recommending this applicant.
- \_\_\_\_ I do not recommend this applicant.

Signature: \_\_\_\_\_ Agency: \_\_\_\_\_

Title: \_\_\_\_\_ Date: \_\_\_\_\_

Do not return this form to the applicant – please return to RIBCCDP.

## PROFESSIONAL REFERENCE FORM

Dear: \_\_\_\_\_

I am applying to the RIBCCDP for certification. References must be included as part of the application. Please complete the reference material enclosed and return it to RIBCCDP. Your prompt attention to this would be very much appreciated, as my application will not be processed until RIBCCDP 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 the 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 RIBCCDP. Your cooperation will be very much appreciated.

Sincerely,

RIBCCDP

Applicant name: \_\_\_\_\_

The following areas represent skills and knowledge needed by a co-occurring disorders 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.

### RATING SCALE:

- 1 is NOT APPLICABLE
- 2 is DON'T KNOW
- 3 is POOR
- 4 is AVERAGE
- 5 is ABOVE AVERAGE
- 6 is SUPERIOR

- \_\_\_\_ 1. Engage the client and establish rapport
- \_\_\_\_ 2. Respect for the client
- \_\_\_\_ 3. Empathy for the client
- \_\_\_\_ 4. Care and concern for the client
- \_\_\_\_ 5. Flexibility with the client
- \_\_\_\_ 6. Facilitate a collaborative relationship with client and significant other(s)
- \_\_\_\_ 7. Behave in an ethical manner
- \_\_\_\_ 8. Recognize and maintain professional and personal boundaries
- \_\_\_\_ 9. Engage in continuing professional development
- \_\_\_\_ 10. Ability to communicate effectively with client and co-workers
- \_\_\_\_ 12. Knowledge of co-occurring disorders
- \_\_\_\_ 13. Ability to receive clinical and administrative supervision and consultation

General Remarks (optional):

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Your name: \_\_\_\_\_

Email: \_\_\_\_\_ Telephone: \_\_\_\_\_

Position: \_\_\_\_\_

How long have you known the applicant? \_\_\_\_\_

My relationship with him/her is/was? \_\_\_\_\_

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 return this form to RIBCCDP.

## **CODE OF ETHICS AND DISCIPLINARY PROCEDURES**

The entire Code of Ethics can be found on our website at [www.ribccdp.com](http://www.ribccdp.com) or may be obtained from the office by calling 717-540-4456.

I have read and understand RIBCCDP Code of Ethics and Disciplinary Procedures in its entirety.

I do accept all of the principles of RIBCCDP's Code of Ethics and Disciplinary Procedures as prescribed by RIBCCDP.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_