

SAC Application

Student Assistance Counselor

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 \$200. May be paid by check/money order (payable to RIBCCDP) or with PayPal (by visiting www.ribccdp.com and clicking on Pay Fees. If paying through PayPal, fee must be paid prior to submission of 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.ribccdp.com Email: info@ribccdp.com

REQUIREMENTS FOR SAC

Knowledge & Skills

- Applicants must possess certain knowledge and skill commensurate with the needs of troubled and high risk youth in the State's school system. Issues related to substance abuse, child abuse and neglect, divorce and separation, domestic violence, sexual abuse, rape, suicide, eating disorders, stress management, and peer pressure should be familiar and addressed in the past. Further familiarity with the intricacies of clinical outreach work in the school environment is a key attribute.

Employment

- One year (2000 hours) in a recognized Student Assistance Counselor program. Employment must have been gained within the last five years.
- Supervised work experience must be in the Core Functions.
- Applicant must be currently employed.

Supervision

- 120 hours with a minimum of 10 hours in each Core Function.

Education

- Master's degree in Social Work, Psychology, Counseling or Education from an accredited college or university.
- 60 hours of training in Core Functions, of which 30 hours are from the Westchester County Student Assistance Counselor training, 12 hours are in confidentiality, six hours in chemical dependency counselor ethics, and six hours in communicable diseases.
- 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 eight domains.
- 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.

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.
- Two Supervisor Evaluations
- Three Professional References

Domains

1. Clinical Evaluation
2. Treatment Planning
3. Referral
4. Service Coordination
5. Counseling
6. Client, Family & Community Education
7. Documentation
8. Professional & Ethical Responsibilities

Fees

Certification: \$200
(fee must accompany application and materials)

CERTIFICATION TIME PERIOD

RIBCCDP certification encompasses two calendar years commencing on the date of approval of application. 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 SAC, an individual must:

1. Hold a current and valid certificate issued by RIBCCDP;
2. Acquire 40 hours of RIBCCDP approved education, including 30 hours substance abuse 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 SAC and no further use of the SAC 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 SAC

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

Other past or current RIBCCDP credentials held: PCDP ACDP ACDP II CCJP RCS CDCS PCCDP CCDP
 CCDPD 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 they are a Student Assistance Counselor. The applicant has primary responsibility for providing or supervising student assistance counseling in an individual and/or group and is supervised by an individual who is knowledgeable in student assistance counseling.

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 \$200 can be paid using one of the following:

Check/MO (payable to RIBCCDP)

PayPal – go to 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 120 hours of supervision in the core functions have been attained by the above-named applicant. At least 10 hours in each of the core functions were received as outlined below.

SAC CORE FUNCTIONS

OF HOURS RECEIVED IN EACH

1. Individual Assessment	_____
2. Clinical Intervention Skills	_____
3. Referral Skills	_____
4. Case Management Skills	_____
5. School Based Training/Prevention Programming	_____
6. Resource Development	_____
7. Networking	_____
8. Record Keeping/Monitoring	_____
9. Social Policy Impact	_____
10. Program Planning	_____
11. Program Delivery	_____
12. Program Evaluation	_____
TOTAL MUST BE AT LEAST 120 HOURS	_____

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: _____

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 Student Assistance Counselor. 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 SAC. 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 three on the rating scale to qualify for this certification.

RATING SCALE:

- 1 is UNACCEPTABLE
- 2 is NEEDS IMPROVEMENT
- 3 is ACCEPTABLE
- 4 is GOOD
- 5 is EXCELLENT

Attribute or Skill

- | | |
|---|-------|
| 1. Exhibits knowledge of chemical dependency | _____ |
| 2. Exhibits knowledge of human development | _____ |
| 3. Exhibits knowledge of basic helping skills | _____ |
| 4. Exhibits knowledge of prevention modalities and strategies | _____ |
| 5. Exhibits knowledge of special needs and high risk populations | _____ |
| 6. Exhibits knowledge of health promotion and wellness models | _____ |
| 7. Exhibits skill in developing prevention programs | _____ |
| 8. Exhibits skill in delivering prevention programs | _____ |
| 9. Exhibits skill in assessing school service needs | _____ |
| 10. Exhibits skill in engaging students and family members when appropriate | _____ |
| 11. Exhibits skill in running groups | _____ |
| 12. Exhibits ability to work cooperatively with school based colleagues and professionals | _____ |
| 13. Exhibits ability to maintain professional objectivity | _____ |
| 14. Exhibits ability to interact effectively with school administration and faculty | _____ |
| 15. Exhibits ability to exercise initiative | _____ |
| 16. Exhibits ability to network effectively with other agencies | _____ |
| 17. Exhibits ability to outreach with the local community | _____ |
| 18. Exhibits ability to interact with genuineness and respect | _____ |
| 19. Exhibits ability to utilized skills such as active listening, summarizing, reflecting | _____ |
| 20. Exhibits ability to engage in productive problem solving | _____ |
| 21. Exhibits responsibility with regard to work commitments | _____ |
| 22. Exhibits responsibility with regarding to making appropriate referrals | _____ |
| 23. Exhibits responsibility with regard to agency and federal confidentiality guidelines | _____ |

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 and that to the best of my knowledge, this accurately reflects this applicant's skills as I have observed them.

Signature: _____ Agency: _____

Title: _____ Date: _____

Please submit documentation of Clinical Supervisor requirements as noted on RIBCCDP's standards or a copy of your RCS certification. 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 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. Applicants must earn an average of three on the rating scale to qualify for this certification.

RATING SCALE:

- 1 is UNACCEPTABLE
- 2 is NEEDS IMPROVEMENT
- 3 is ACCEPTABLE
- 4 is GOOD
- 5 is EXCELLENT

Attribute or Skill

- | | |
|---|-------|
| 1. Exhibits knowledge of chemical dependency | _____ |
| 2. Exhibits knowledge of human development | _____ |
| 3. Exhibits knowledge of basic helping skills | _____ |
| 4. Exhibits knowledge of prevention modalities and strategies | _____ |
| 5. Exhibits knowledge of special needs and high risk populations | _____ |
| 6. Exhibits knowledge of health promotion and wellness models | _____ |
| 7. Exhibits skill in developing prevention programs | _____ |
| 8. Exhibits skill in delivering prevention programs | _____ |
| 9. Exhibits skill in assessing school service needs | _____ |
| 10. Exhibits skill in engaging students and family members when appropriate | _____ |

- 11. Exhibits skill in running groups _____
- 12. Exhibits ability to work cooperatively with school based colleagues and professionals _____
- 13. Exhibits ability to maintain professional objectivity _____
- 14. Exhibits ability to interact effectively with school administration and faculty _____
- 15. Exhibits ability to exercise initiative _____
- 16. Exhibits ability to network effectively with other agencies _____
- 17. Exhibits ability to outreach with the local community _____
- 18. Exhibits ability ot interact with genuineness and respect _____
- 19. Exhibits ability to utilize skills such as active listening, summarizing, reflecting _____
- 20. Exhibits ability to engage in productive problem solving _____
- 21. Exhibits responsibility with regard to work commitments _____
- 22. Exhibits responsibility with regard to making appropriate referrals _____
- 23. Exhibits responsibility with regard to agency and federal confidentiality guidelines _____

General Remarks (optional):

Your name: _____

Email: _____ Telephone: _____

Position: _____

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 and to the best of my knowledge, this accurately reflects this applicant's skill as I have observed them.

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 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: _____