

Alaska Commission for Behavioral Health Certification

Application for CDC I Certification

CHEMICAL DEPENDENCY COUNSELOR I REQUIREMENTS & APPLICATION PROCEDURE

The Chemical Dependency Counselor I is “able to apply counseling knowledge, skills and attitudes with consistency and effectiveness in a variety of counseling interactions. They practice in a professional manner and utilize the clinical supervision they receive to enhance their skills in the field of addictions.” SAMHSA Tap 21

Experience:

Two (2) years full time work experience in chemical dependency treatment. A Master’s, Bachelor’s, or Associate’s degree from an accredited educational facility, in a relevant field (Social Services, Social Work, Addiction, Human Services, Psychiatric nursing, Psychology) may be submitted for consideration as a substitute for one (1) year of the two (2) years of required experience. The degree may also allow the applicant to take fewer required courses. This is considered by the Commission on a case by case basis.

Please note that the degree must be one of the degrees listed above under “experience,” and understand that the acceptance of the degree and the requirements for certification based on that degree are considered on a case by case basis. The degree must be from an accredited college.

Educational Requirements:

The following is a list of the coursework required for the non-degreed track for certification:

Ethics taken within last two years (3 hours)
Confidentiality taken within last two years (3 hours)
Infectious Diseases & HIV/AIDS (6 hours)
Intro to Addictive Behavior (8 hours)
Documentation (8 hours)
Crisis Intervention (8 hours)
Intro to Client Centered Counseling (12 hours)
Intro to Group Counseling (8 hours)
Working with Diverse Populations (12 hours)
Community Resources Use & Case Management (8 hours)
Recovery, Health, Wellness & Balance (8 hours)
Psycho-physiology (12 hours)
Motivational Interviewing (16 hours)
DSM Practice (12 hours)
ASAM Practice (12 hours)
Co-Occurring Disorders (12 hours)

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The following is a list of the coursework required for the degreed track for certification:

Ethics taken within last two years (3 hours)
Confidentiality taken within last two years (3 hours)
Infectious Diseases & HIV/AIDS (6 hours)
Intro to Addictive Behavior (8 hours)

Counselor Competency Practicum:

Completion of a 100-hour practicum is required for the CDC I, and **must be supervised by a certified chemical dependency counselor who has certification at least one level higher than that of applicant, in accordance with the criteria on the Counselor Competency practicum form.** If needed, the competencies for counselors at each level of certification can be found in the Counselor Competencies document, which can be obtained by emailing ACBHC or off the ACBHC website at akcertification.org.

Recertification:

Certification is for a period of two years. Application for re-certification must be made prior to expiration and may be done online at akcertification.org. The applicant should complete at least 40 hours of continuing education in the Behavioral Health field, to include 3 hours each of Ethics and Confidentiality, every two years. The certificates of completion for these classes are not required to be submitted for recertification, but the applicant should keep them and be prepared to submit them if asked.

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APPLICATION PROCEDURE

1. The applicant fills out pages 5-12, and gives pages 13-18 each to the person indicated on the form, to complete and mail to ACBHC. **Please do not print application on both sides because it goes into separate parts of the application file.**
2. Send copies of successfully completed training certificates and/or have the college mail the original college transcripts directly to ACBHC. Make certain that each completed course is listed on the “Training Hours Tally Sheet” including the syllabus or course description if the class content is not perfectly clear in the transcript or certificate of completion.
3. Use the forms provided for the Professional Affiliate Recommendation letters, Supervisor Recommendation form, Employer Verification, and Counselor Competency Practicum. These forms must be mailed directly to ACBHC by the person completing them. **The Counselor Competency Practicum form must be completed by a person certified at least one level above the applicant’s current certification.** It is the last two pages of the application and should be mailed directly to ACBHC by the person who completed the form. The Employer Verification form in the application should be completed by the applicant’s supervisor or the Human Resources person, to verify the candidate’s completion of the work experience requirement. The person filling out this form should include a job description for the applicant’s position if the title is not that of chemical dependency counselor.
4. Write your name at the top of Each and All of the tally sheet pages. List all of your training courses on the tally sheet pages. Total the number of training hours on the last page of the tally sheet. Sign and date the last page of the tally sheet. Make copies of all of your certificates and submit them to ACBHC along with your tally sheet and completed application.
5. All the forms in the application should be completed and submitted in their original form, no copies or faxes will be accepted for these pages. The course work certificates, a copy of candidate’s picture ID, and the current resume may be copies or faxes.
6. The initial certification fee is \$195.00, and the re-certification fee is \$180.00, renewable every two years. **These fees are non-refundable.**

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APPLICATION CHECK LIST FOR CHEMICAL DEPENDENCY COUNSELOR I (CDC I)

The application must include the following, **in original form, filled out by the applicant:**

- _____ Application General Information form
- _____ Training Tally Sheet - Please include all relevant trainings in chronological order, documenting dates, titles, and hours completed. Incomplete Tally Sheets will be returned to the applicant for proper completion except in the case of the applicant having taken the classes after submitting the application.
- _____ College transcripts if applicable, sent by college or university
- _____ Background Disclosure Sheet
- _____ ACBHC Ethical Standards - Code of Ethics - Initialed, signed and dated.
- _____ Authorization for Data Collection
- _____ Current Résumé
- _____ Clear, legible, and current copy of State or other valid picture identification
- _____ Payment in the amount of \$195.00 for initial certification (this may be paid online)

The following will each be submitted **directly to ACBHC by the person who completes them:**

- _____ Two (2) Professional Affiliate Recommendation forms
- _____ One Supervisor Recommendation form
- _____ Counselor Competency Practicum Form completed by a person certified at least one level above applicant's current certification level
- _____ Employer Verification Form completed by either the applicant's supervisor or Human Resources person at the agency where the applicant has gained required experience

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Alaska Commission for Behavioral Health Certification
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**APPLICATION FOR CERTIFICATION
GENERAL INFORMATION
(PLEASE PRINT)**

Name: _____

Mailing Address: _____

City, State Zip: _____

Home Phone: _____ Cell Phone: _____

Personal e-Mail: _____

Business e-Mail: _____

Employer: _____

Employer Address: _____

City, State Zip: _____

Business Phone: _____ Business Fax: _____

Date/State of past certification: _____

Would you accept a lower level of certification than you applied for?

Yes _____ No _____

I, (print name) _____ have provided accurate and truthful information on all the enclosed application material for certification and acknowledge that omission of the requested information as well as providing false information will result in denial of my certification or removal of my certification at a later date, as it becomes known.

Signature _____ Date _____

(form not complete without signature)

Mail the completed application to:

**ACBHC
P.O. Box 220109
Anchorage, AK 99522-0109**

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CDC I			
Category	Date	Course Title	Hours

Category	Date	Course Title	Hours
Ethics not more than two years old 3 Hours			
Total Hours			0.00

Category	Date	Course Title	Hours
Confidentiality not more than two years old 3 Hours			
Total Hours			0.00

Category	Date	Course Title	Hours
Introduction to Addictive Behavior 8 Hours			
Total Hours			0.00

Category	Date	Course Title	Hours
Infectious Diseases & HIV/AIDS 6 Hours			

Total Hours 0.00

Category	Date	Course Title	Hours
Documentation 8 Hours			
Total Hours			0.00

Category	Date	Course Title	Hours
Crisis Intervention 8 Hours			
Total Hours			0.00

Category	Date	Course Title	Hours
Introduction to Client Centered Counseling 12 Hours			
Total Hours			0.00

Category	Date	Course Title	Hours
Introduction to Group Counseling 8 Hours			
Total Hours			0.00

Category	Date	Course Title	Hours
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Working with Diverse Populations 12 Hours				
Total Hours				0.00

Category	Date	Course Title	Hours
Community Resource Use & Case Management 8 Hours			
Total Hours			0.00

Category	Date	Course Title	Hours
Recovery, Health & Wellness & Balance 8 Hours			
Total Hours			0.00

Category	Date	Course Title	Hours
Psycho-Physiology 12 Hours			
Total Hours			0.00

Category	Date	Course Title	Hours
Motivational Interviewing 16 Hours			

Total Hours **0.00**

Category	Date	Course Title	Hours
DSM Practice Application 12 Hours			

Total Hours **0.00**

Category	Date	Course Title	Hours
ASAM Practice 12 Hours			

Total Hours **0.00**

Category	Date	Course Title	Hours
Co-Occuring Disorders 12 Hours			

Total Hours **0.00**

Total CEU Hours **0.00**

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BACKGROUND DISCLOSURE FORM FOR APPLICATIONS

☐ **(For initial certification)** In my lifetime, I: _____
OR

☐ **(For recertification)** Since the issuance of my last certification on _____, I

1. Have had my professional certification or licensure revoked? ☐ Yes ☐ No
State: _____ Date: _____ Type: _____
2. Have been terminated or left from either a paid or volunteer position because of an ethics complaint? ☐ Yes ☐ No
3. Have been arrested or detained for anything other than misdemeanor traffic (not DUI or DWI related) charges? ☐ Yes ☐ No
4. Have been convicted of a misdemeanor or felony? ☐ Yes ☐ No
5. Have been convicted by any disciplinary board, city/state/federal/military/international court of law, of sexual assault, sexual abuse, sexual exploitation, physical abuse, or physical assault to any persons? ☐ Yes ☐ No
6. Have been found by an administrative office or court to have committed fraud related to Medicaid, Medicare, insurance entitlement (social security, temporary assistance, public assistance or other billing fraud)? ☐ Yes ☐ No
7. Have any civil or criminal charges pending? ☐ Yes ☐ No
8. Am currently incarcerated ** for any misdemeanor or felony? ☐ Yes ☐ No
9. Have a 1-year to 10-year or permanent barrier Crime? ☐ Yes ☐ No

* Answering “Yes” to any of the above questions does not automatically bar you from certification. **If you have answered “Yes” to any of the above items, please write a letter of explanation stating what happened in each case, what the outcome was in court, what you have done to correct the situation, and what you have done to ensure this will not happen again.** Explain (dates, case number(s), time, and places (s) of incarceration, special dispositions, and other related information) on separate attached sheet of paper.

** “Incarcerated” is defined as being in jail, halfway house, work release program or other form of court or corrections-imposed custody probation (to include misdemeanor, parole, furlough, SIS or deferred sentence).

*** If you have a Barrier Crime, please contact the DHSS Background Check Program via website (<http://dhss.alaska.gov/dhcs/Pages/cl/bgccheck/>) or in person to request a Variance for work. Once received, please e-mail it to (acbhc@akcertification.org).

I, (print name) _____ have provided accurate and truthful information on this form and acknowledge that omission of the requested information, as well as providing false information will result in denial of my certification or removal of my certification at a later date as it becomes known.

Signature _____ Date _____

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ACBHC ETHICAL STANDARDS
Adopted by ACBHC from the NAADAC Code of Ethics

**AS A PARTNER OF NAADAC, ACBHC ADOPTS AND ABIDES BY THE
CURRENT NAADAC CODE OF ETHICS**

**CLICK ON THIS [LINK](#) TO DOWNLOAD THE
CURRENT NAADAC CODE OF ETHICS**

Acknowledgment of NAADAC Code of Ethics

I acknowledge that I have received, read, and understand the *NAADAC Code of Ethics*. I recognize this document as the ethical framework guiding professional behavior in the field of addiction and behavioral health services.

I agree to conduct myself in a manner consistent with the standards outlined in the Code, and I understand that failure to do so may result in disciplinary action, including potential suspension or revocation of certification, as determined by the Alaska Commission for Behavioral Health Certification (ACBHC).

Name (Printed): _____

Signature: _____

Date: _____

Certification Number (if applicable): _____

Please submit this completed Ethics Acknowledgement with your application.

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AUTHORIZATION FOR DATA COLLECTION

I hereby authorize the Commission for Behavioral Health Certification to collect and maintain my name, application forms and other relevant personal information in the Counselor Registry. I further understand that I have access to my own personal information provided by me and may request and/or correct and/or secure a copy of any portion thereof.

Print Name: _____

Signature: _____ Date: _____
(form not complete without signature)

AUTHORIZATION FOR RELEASE TO STATE AND / OR NATIONAL REGISTERS

Name of Counselor: _____

Employer: _____

Address: _____

City, State Zip: _____

Business Telephone: _____ E-mail: _____

Alcoholism & Drug Abuse Counselor Level/Dates: _____

Highest Academic Degree: _____

Mailing Address: _____

City, State Zip: _____

Home Telephone: _____ e-mail: _____

Signature: _____ Date: _____

Mail the application to: **ACBHC**
P.O. Box 220109
Anchorage, AK 99522-0109

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PROFESSIONAL AFFILIATE RECOMMENDATION

Applicant Name: _____ is applying for CDC I certification in Alaska. I have known the applicant since _____.

A. Knowledge and Skills	Developing	Proficient	Exemplary
1. Understanding Addiction	☐	☐	☐
2. Treatment Knowledge	☐	☐	☐
3. Application to Practice	☐	☐	☐
4. Professional Readiness	☐	☐	☐
5. Clinical Evaluation	☐	☐	☐
6. Screening/Intake	☐	☐	☐
7. Assessment	☐	☐	☐
8. Treatment Planning	☐	☐	☐
9. Referral	☐	☐	☐
10. Service Coordination	☐	☐	☐
11. Implementing Treatment Plan	☐	☐	☐
12. Consulting	☐	☐	☐
13. Continuing Care (Assessment & Treatment Planning)	☐	☐	☐
14. Counseling	☐	☐	☐
15. Individual Counseling	☐	☐	☐
16. Group Counseling	☐	☐	☐
17. Family & Couple Counseling	☐	☐	☐
18. Client, Family and Community Education	☐	☐	☐

I understand that this form serves as a reference. I have attached _____ additional pages in order to address my knowledge of this applicant's competence and character. I hereby certify that the information provided is true and complete to the best of my knowledge.

Signature _____ Date _____
(form not complete without signature)

Printed Name: _____ Title _____

Agency _____

Address _____ Phone _____

City/State/Zip _____ e-mail _____

The person who completes this form must mail it directly to:

ACBHC

P.O. Box 220109

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PROFESSIONAL AFFILIATE RECOMMENDATION

Applicant Name: _____ **is applying for CDC I certification in**
Alaska. I have known the applicant since _____.

A. Knowledge and Skills	Developing	Proficient	Exemplary
1. Understanding Addiction	☐	☐	☐
2. Treatment Knowledge	☐	☐	☐
3. Application to Practice	☐	☐	☐
4. Professional Readiness	☐	☐	☐
5. Clinical Evaluation	☐	☐	☐
6. Screening/Intake	☐	☐	☐
7. Assessment	☐	☐	☐
8. Treatment Planning	☐	☐	☐
9. Referral	☐	☐	☐
10. Service Coordination	☐	☐	☐
11. Implementing Treatment Plan	☐	☐	☐
12. Consulting	☐	☐	☐
13. Continuing Care (Assessment & Treatment Planning)	☐	☐	☐
14. Counseling	☐	☐	☐
15. Individual Counseling	☐	☐	☐
16. Group Counseling	☐	☐	☐
17. Family & Couple Counseling	☐	☐	☐
18. Client, Family and Community Education	☐	☐	☐

I understand that this form serves as a reference. I have attached _____ additional pages in order to address my knowledge of this applicant's competence and character. I hereby certify that the information provided is true and complete to the best of my knowledge.

Signature _____ Date _____
(form not complete without signature)

Printed Name: _____ Title _____

Agency _____

Address _____ Phone _____

City/State/Zip _____ e-mail _____

The person who completes this form must mail it directly to:

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SUPERVISOR RECOMMENDATION FORM

For Applicant: _____

I, _____ have known the candidate for _____

years/months and can attest to the following qualifications for certified chemical dependency professional.

I understand that this form serves as a reference. I have attached _____ additional pages in order to address my knowledge of this applicant's competence in each of the twelve foundations and practice dimensions.

1. Understanding Addiction
2. Treatment Knowledge
3. Application to Practice
4. Professional Readiness
5. Clinical Evaluation
6. Treatment Planning
7. Referral
8. Service Coordination
9. Counseling
10. Client, Family, and Community Education
11. Documentation
12. Professional and Ethical Responsibilities

I recommend the applicant for certification as a chemical dependency counselor

☐ Yes ☐ No If no, explain: _____

I attest that the information provided above and in the attached pages is true and complete to the best of my knowledge.

Supervisor Signature, Title Date

Printed Name Name of Agency

Address City/State/Zip

e-mail Telephone

**The person who completes this form must mail it directly to:
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EMPLOYER VERIFICATION OF EXPERIENCE FORM

Applicant's Name: _____

The applicant is applying to the Alaska Commission for Behavioral Health Certification for certification as a Chemical Dependency Counselor I. Please fill out this form to document the applicant's employment in your agency and return it directly to ACBHC. **This information must be on file before the applicant's certification can be processed.** Your cooperation is very much appreciated.

Please complete the following:

Volunteered or Employed from: _____ to _____
(mo/day/yr) (mo/day/yr)

Number of hours worked per week _____

Number of weeks per year _____

Job Title: _____

If the employee's position changed, please describe here: _____

* If the job title is not that of a chemical dependency counselor, attach an official organizational job description to this Verification of Employment/Volunteer Experience. Average percentage of the duties that were chemical dependency related (Education, Prevention, Treatment or Aftercare)
_____ %

Agency: _____

Address: _____

City/State/Zip: _____

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

Signature: _____

Print Name: _____

Title: _____ Date: _____

The person who completes this form must mail it directly to:

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Chemical Dependency Counselor I Competency Practicum Evaluation Form

Applicant's Name _____

Practicum Site _____

Dates of fieldwork: (from) _____ (to) _____
(month/day/year) (month/day/year)

Competency Area	Hours Supervised	Rating		
		Developing	Proficient	Exemplary
Transdisciplinary Foundations				
1. Understanding Addiction				
2. Treatment Knowledge				
3. Application to Practice				
4. Professional Readiness				
Professional Practice Dimensions				
1. Clinical Evaluation				
1a. Screening				
1b. Assessment				
2. Treatment Planning				
3. Referral				
4. Service Coordination				
4a. Implementation of Treatment Plan				
4b. Consulting				
4c. Continuing Assessment & Treatment Planning				
5. Counseling				
5a. Individual				
5b. Group				
5c. Families & Significant Others				
6. Client, Family & Community Education				
7. Documentation				
8. Professional & Ethical Responsibilities				
OVERALL RATING				

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Total Practicum Hours (At least 100 Hours)		Please continue to next page
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**Chemical Dependency Counselor I
Competency Practicum Evaluation Form (page 2)**

Applicant Name: _____

Comments: (please be specific regarding competencies)

Supervisor Signature _____ Date _____

Certification Title: _____ Number: _____

Supervisor Name (print): _____ Title _____

Name of Agency _____

Street or Mailing Address _____

City/State/Zip Code _____

Telephone _____ Fax _____ e-mail _____

The person who completes this form must mail it directly to:

**ACBHC
P.O. Box 220109
Anchorage, AK 99522-0109**

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