Alaska Commission for Behavioral Health Certification
Application for CDCS Certification

CHEMICAL DEPENDENCY CLINICAL SUPERVISOR REQUIREMENTS & APPLICATION PROCEDURE

The Chemical Dependency Clinical Supervisor has "by a combination of professional credentials and range of clinical experiences, reached the highest level of clinical competency. Additional to any direct clinical work, they provide leadership and serve as a role model and consultant to other clinical staff." *SAMHSA Tap 21*

Experience:

Six (6) 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 six (6) 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.

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)
Special Issues in Behavioral Health Services (16 hours)
Documentation Quality Assurance (12 hours)
Principles and Practices in Supervision (30 hours)

If information is omitted, the application will be considered incomplete and will not be processed. Only ORIGINALS of this document will be accepted and ALL errors must be initialed.

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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)
Special Issues in Behavioral Health Services (16 hours)
Documentation Quality Assurance (12 hours)
Principles and Practices in Supervision (30 hours)

Please note that the degree must be in a relevant field, such as Social Services, Social Work, Addiction, Human Services, Psychiatric nursing, Psychology, and may be submitted for consideration as a substitute for one (1) year of the six (6) years of required experience. Understand that the acceptance of the degree and the requirements for certification based on that degree are considered by the Commission on a case by case basis. The degree must be from an accredited college.

Required Qualifying Examination:

In order to be considered for the CDCS, the applicant must provide proof of having taken and passed the NCAC I, NCAC II, or MAC exam. This exam may not be administered to any person not yet certified by ACBHC as at least a CDC I.

Counselor Competency Practicum:

Completion of a 100-hour practicum is required for the CDCS, 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.** This is a two page form. If needed, the competencies for counselors at each level of certification may be found in the Counselor Competencies document, which is obtained by emailing ACBHC.

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.

Alaska Commission for Behavioral Health Certification
Application for CDCS Certification
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 directly 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 trainings and/or have the college mail the original educational 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.** The Counselor Competency Practicum form consists of 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, in order to verify the candidate's satisfaction 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 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 $230.00, and the re-certification fee is $215.00, renewable every two years. **These fees are non-refundable.**

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APPLICATION CHECK LIST FOR CHEMICAL DEPENDENCY CLINICAL SUPERVISOR (CDCS)

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. Training certificates may be copies.

_____ Original college transcripts if applicable, sent to ACBHC directly 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 $230.00 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 (100 hours) completed by a person certified at least one level above the 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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CDCS			
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
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**

Category	Date	Course Title	Hours
Special Issues in Behavioral Health Services 16 Hours			
		Total Hours	**0.00**

Category	Date	Course Title	Hours
Documentation and Quality Assurance 12 Hours			
		Total Hours	**0.00**

Category	Date	Course Title	Hours
Principles & Practices of Supervision 30 Hours			

Supervision 30 Hours			
		Total Hours	**0.00**

Total CEU Hours **0.00**

Alaska Commission for Behavioral Health Certification
Application for CDCS Certification

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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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/bgcheck/) 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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Alaska Commission for Behavioral Health Certification
Application for CDCS Certification

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 CDCS 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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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 _____

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SUPERVISOR RECOMMENDATION FORM

Applicant Name: _____

I, _____ have known the candidate for _____ years/months and attest to the following:

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 Clinical Supervisor

☐ 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

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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 Clinical Supervisor. 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 job title is not that of a chemical dependency counselor or clinical supervisor, attach an official organizational job description to this Verification of Employment/Volunteer Experience. Average percentage of the duties that were chemical dependency related (Supervision, 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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Alaska Commission for Behavioral Health Certification
Application for CDCS Certification
Chemical Dependency Clinical Supervisor Competency Practicum Form

Evaluation of Supervision, Knowledge, Skills and Attitudes

Applicant's Name _____

Practicum Site _____

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

This section is two pages long

	Rating		
	Developing	Proficient	Exemplary
Trans-disciplinary Foundations - Incorporates and uses all the skills and knowledge of the Counselor II, and provides clinical leadership and guidance regarding:			
1. **Understanding Addiction** - the provision of quality substance abuse and addiction services.			
2. **Treatment Knowledge** - treatment philosophies, practices, and policies,			
3. **Application to Practice** - diagnostic/placement criteria, treatment strategies, medical/pharmacological resources, client's personal budgeting, and outcome measures,			
4. **Professional Readiness** - client diversity, agency policy/procedure/ practice, professionalism, ethical/behavioral conduct, professional development, and prevention services, **for the provision of quality substance abuse and addiction services.**			

Professional Practice Dimensions - Incorporates and uses all the skills and knowledge of the Counselor II, and provides clinical leadership and guidance.	Supervised Hours	Developing	Proficient	Exemplary
1. Clinical Evaluation				
1a. Screening - the counselor, client, and available significant others, determining the most appropriate initial course of action, given the client's needs, characteristics, and available resources within the community				
1b. Assessment - the process through which the counselor collaborates with the client and others, to gather and interpret information necessary for planning treatment and evaluating client progress				
1c. Treatment Planning - the collaborative process through which the counselor and client develop desired treatment outcomes and identify strategies to achieve them				
1d. Referral - the process of facilitating the client's utilization of available support systems and community resources to meet needs identified in clinical evaluation and/or treatment planning				
2. Service Coordination				
2a. Implementation of Treatment Plan - all elements of treatment plan implementation				
2b. Consulting - all elements of the consultation process				
2c. Continuing Care - all elements of the continuing care process				

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Applicant Name:	**Hours**	**Developing**	**Proficient**	**Exemplary**
3. Counseling				
3a. Individual - demonstrates highest level of competence in counseling using methods that are sensitive to client characteristics, and to the influence of significant others, as well as the client's cultural and social context				
3b. Group - demonstrates highest level of competence in the methods of group counseling,				
3c. Families & Significant Others - demonstrates highest level of competence and provides leadership and guidance in the methods of family and significant other counseling				
4. Client, Family & Community Education - demonstrates highest level of competence and provides leadership and guidance in the process of providing client, families, significant others and community groups with information on risks related to psychoactive substance use as well as available prevention treatment and recovery resources				
5. Documentation - demonstrates highest level of competence and provides clinical leadership and guidance regarding the recording of screening and intake process, assessment, treatment plan, clinical reports, clinical progress notes, discharge summaries, and other client-related data				
6. Professional & Ethical Responsibilities - demonstrates highest level of competence and provides leadership and guidance regarding adherence to accepted ethical and behavioral standards of conduct and continuing professional development				
OVERALL RATING				
Total Practicum Hours (At least 100 Hours)				

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 _____

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

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