Arkansas Substance Abuse Certification Board

Application Review Checklist for ADC and AADC

This page will be the first page of your certification packet. Please attach the documentation IN THE ORDER LISTED BELOW. It is the responsibility of the applicant to submit complete documentation (i.e. certificates, transcripts). Incomplete or disorganized packets WILL be returned to you. Testing Fees are nonrefundable.

Name of Applicant:_____ Date:_____
Valid email Address:_____
Daytime Phone: _____
I am applying to test for the ADC_____ or AADC_____

CIT Registration

1. Registration Application (Mail upon initial registration)
2. Statement of Disclosure (Mail upon initial registration)
3. Release of Information (Mail upon initial registration)
4. Code of Ethics Signature Page (Mail upon initial registration)
5. Arkansas State Police Individual Record Check: (**Provide one upon Initial registration and a second current one with testing packet**)
6. Official **sealed** college transcripts: (Have them mailed directly from the college or university to the ASACB office at any time)

Testing Packet (to be completed by CIT and mailed in with testing packet)

7. Informal Education Training Profile: (**Mail with testing packet with documentation or certificates attached**)
8. Formal Education Training Profile: (**Mail with testing packet with certificates attached**)
9. Experience Profile: (Submit with testing packet)
10. **Second** background check (**as noted in #5**).
11. Personal Philosophy of Counseling: (**Mail with testing packet**)
12. Current Testing Fee Payment of **$250.00**

Supervisor Forms (CS) (**Mailed separately by Clinical Supervisor**)

14. Verification of Employment form(s)
15. Counselor Evaluation Form
16. Letter of approval for candidate case study submission
17. Supervised Practicum Verification
18. I, _____ have reviewed this packet and verify that all required documentation is included.

_____ _____
Signature of Clinical Supervisor Date Signed

REVIEWED BY:
Approved_____ Disapproved_____ Education Committee Initials:_____ Date_____

Approved_____ Disapproved_____ Education Committee Initials:_____ Date_____

Payment Received_____ -for _____ Exam on _____ Date_____ Receipt Number____

Arkansas Substance Abuse Certification Board

Formal Education/Training Hours Profile

Name:_____Daytime Phone_____
Mailing Address:_____

_____

NOTE: You may duplicate this form as needed. List the course/ workshops that you have attended **and <u>attach the matching certificates for each page you complete</u>**. You may have <u>up to</u> seventy (**70**) informal or in-service hours. Those hours are to be documented by appropriate certificates or dated sign-in sheets on *the Informal Education Training Hours form.*

Name of Course:_____ **Hours Earned:**_____

Name of Presenter:_____ **Dates:**_____

Facility Where Offered:_____

Course Content or Objectives:

_____

_____

Name of Course:_____ **Hours Earned:**_____

Name of Presenter:_____ **Dates:**_____

Facility Where Offered:_____

Course Content or Objectives:_____

_____

Name of Course:_____ **Hours Earned:**_____

Name of Presenter:_____ **Dates:**_____

Facility Where Offered:_____

Course Content or Objectives:_____

_____

TOTAL HOURS THIS PAGE_____

Arkansas Substance Abuse Certification Board

Informal Education/Training Hours Profile

Name:_____Daytime Phone_____
Mailing Address:_____

NOTE: You may duplicate this form as needed. List the in-service and informal hours you have attended and attach matching certificates for each page you complete. You may have **up to** seventy (**70**) informal or in-service hours. These hours must be documented by appropriate certificates or dated sign-in sheets on this form.

Name of Course:_____ **Hours Earned:**_____

Name of Presenter:_____ **Dates:**_____

Facility Where Offered:_____
Course Content or Objectives:

Name of Course:_____ **Hours Earned:**_____

Name of Presenter:_____ **Dates:**_____

Facility Where Offered:_____

Course Content or Objectives:

Name of Course:_____ **Hours Earned:**_____

Name of Presenter:_____ **Dates:**_____

Facility Where Offered:_____

Course Content or Objectives:

TOTAL HOURS THIS PAGE_____

Arkansas Substance Abuse Certification Board

Work Experience Profile

Name_____Daytime Phone_____
Mailing Address_____

Name of Facility_____

Statement by Verifying Party:

I hereby verify that the above named applicant has completed hours of work experience in an alcohol and other drug abuse counseling facility.

Name of Facility_____

Mailing Address_____
_____ Phone number_____
Dates of Employment_____ to_____
Day Month Year Day Month Year

Chief Job Responsibilities_____

_____
_____
_____
_____
_____

_____ _____
Signature and Title of Person Verifying Date Signed

_____ _____
Signature of Certification Applicant Date Signed

Arkansas Substance Abuse Certification Board

Counselor Evaluation Form

This documentation is to be mailed by an applicant's supervisor. You may duplicate this form if you need documentation from more than one supervisor.

Name of Applicant ----------Daytime Phone----------
Agency or Facility----------Daytime Phone----------
Clinical Supervisor----------Date Signed----------

The applicant listed above is applying to the Arkansas Substance Abuse Certification Board for the credential of Alcohol Drug Counselor (ADC) or Advanced Alcohol Drug Counselor (AADC). The information requested on the following pages is an essential part of the Board's evaluation process of determining knowledge, skills and competency of the applicant.

Your evaluation from direct observation and supervision of the applicant's work will assist the evaluation committee in determining the applicant's eligibility for testing. This form is confidential and will not be made available to the applicant at any time.

Please return the completed form by mail to:
Arkansas Substance Abuse Certification Board
Evergreen Place
1100 N. University Ave. Ste. 35
Little Rock, AR 72207
(501) 749-4040

INSTRUCTIONS: The following items represent the skills needed by a substance abuse counselor. Evaluate the applicant's abilities in each area and mark the rating which most nearly describes the counselor's skills.

RATING CODE:

N/A- Not applicable
N/K- Not known
1. Poor
2. Fair
3. Average
4. Above Average
5. Superior

Arkansas Substance Abuse Certification Board

Name of Applicant----------Daytime Phone----------

Mailing Address:----------

--------1. Client Intake: The process of collecting client information at the beginning of treatment that is used in assessment of a client for treatment.

_____2. Client Assessment: The process by which a counselor evaluates the intake information collected in order to determine appropriate services.

_____3. Alcohol/Drug Abuse Evaluation: Knowledge and application of the major theories and stages of addiction and the symptomatology of alcoholism or drug dependency in assessing the client's use of chemical substances.

_____4. Triage: Determining appropriate and timely services for the client with knowledge of his/her problems and their intensity.

_____5. Client Orientation: Individual or group sessions to familiarize clients with program services, expectations, regulations and goals.

_____6. Client Education: Activities which have the major goal of increasing the client's recognition of significant symptoms and patterns of problematic behavior.

_____7. Outreach: Direct contact by a counselor with persons in a community setting to identify and/or counsel persons with problems related to alcoholism or drug abuse.

_____8. Individual Counseling: A one-to-one counselor/client process for the purpose of assessing a client's problems and facilitating appropriate changes.

_____9. Group Counseling: A process involving clients for the purpose of jointly exploring the client's problems and facilitating change.

____10. Family Counseling: A process of exploring the dynamics of the family system and facilitating appropriate changes.

Arkansas Substance Abuse Certification Board

Name of Applicant---------- Daytime Phone:----------

11. Crisis Intervention: Quickly assessing and defining the nature of a client's crisis situation and using appropriate methods of intervention.

____12. Treatment Planning: Defining areas of problems and needs, establishing short and long term goals, and developing appropriate strategies for reaching these goals within a time frame.

____13. Consultation: Establishing contacts with other professionals in support of the client's treatment.

INSTRUCTIONS: The following items represent the skills needed by a substance abuse counselor. Evaluate the applicant as you feel he/she demonstrates abilities in each area. Mark the rating code which most nearly describes the counselor's demonstrated skills.

RATING CODE:
N/A- Not applicable
N/K Not known
1. Poor
2. Fair
3. Average
4. Above Average
5. Superior

_____1. Common sense in dealing with clients

_____2. Respect for client

_____3. Care and concern for client

_____4. Empathy with client

_____5. Flexibility with clients. Ability to recognize individual client's needs.

_____6. Spontaneity with clients

_____7. Capacity for confrontation with client

_____8. Capacity for appropriate self-disclosure

_____9. Concreteness

Arkansas Substance Abuse Certification Board

Name of Applicant:----------Daytime Phone:----------

____10. Ability to communicate effectively with clients and coworkers

____11. Ability to treat client information in accordance with state and federal confidentiality regulations

____12. Knowledge of alcoholism and drug abuse and/or addictions

____13. Capacity to act in an ethical manner with clients and coworkers.

____14. Problem recognition and evaluation: Ability to apply knowledge of physical, behavioral, attitudinal, and affective manifestations of alcoholism and drug abuse to determine the existence and degree of progression.

____15. Ability to set appropriate limits with clients and the families.

____16. Ability to supervise other counselors.

EVALUATOR'S STATEMENT:

(1)Please list the name and address of the facility where you supervised this applicant.----------
---

(2) What are the beginning and ending dates you have supervised this applicant?
From:----------To:----------
Month Day Year Month Day Year

(3) Did the applicant work under your supervision part-time or full-time? If both part-time and full-time, please specify the number of hours and the dates.----------
---
(4) What was the average caseload the applicant carried per month?-----

(5) What was the average number of hours per month the counselor worked in individual counseling? ----------In group counseling?----------

Arkansas Substance Abuse Certification Board
Evergreen Place
1100 N. University Ave.
Ste. 35, Little Rock, AR
72207

Name of Applicant----------Daytime Phone----------

I HEREBY CERTIFY THAT I HAVE BEEN IN A POSITION TO OBSERVE THE APPLICANT, TO SUPERVISE THE APPLICANT AND THAT I HAVE FIRST–HAND KNOWLEDGE OF THEIR WORK AS A COUNSELOR. I CERTIFY THAT ALL OF THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE.

---------- ----------

Clinical Supervisor's Signature Date

Please use this space to add comments, explanations or recommendations regarding this applicant which you feel may be helpful to the board.

Arkansas Substance Abuse Certification Board
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1100 N. University Ave.
Ste. 35, Little Rock, AR
72207

Supervised Practicum

Name of Applicant:---------- Daytime Phone:----------
Mailing Address:----------

This document is to verify that the applicant listed above has received **300 hours** of direct supervision with a **minimum of ten (10)** hours in obtaining/developing the knowledge and skills necessary to perform each of the Twelve Core Functions as defined by the IC & RC/AODA. **An additional 180 hours of direct supervision will be required to meet the 300 hour requirement if only the 10 hour minimum is met in each core function**. Direct supervision is defined as one-on-one supervision or direct observation of skills within the Core functions. The practicum may occur as part of eligible work experience, and may be completed under more than one Clinical Supervisor or in more than one agency.

I have supervised the above named applicant for the period of

---------- to ---------- at ----------.
month/year month/year name of agency

During this period, I have supervised the above named applicant for the hours specified in each Core Function.

Screening	Hours supervised in this Core Function _____
Intake	Hours supervised in this Core Function _____
Orientation	Hours supervised in this Core Function _____
Assessment	Hours supervised in this Core Function _____
Treatment Planning	Hours supervised in this Core Function _____
Counseling	Hours supervised in this Core Function _____
Case Management	Hours supervised in this Core Function _____
Crisis Intervention	Hours supervised in this Core Function _____
Client Education	Hours supervised in this Core Function _____
Referral	Hours supervised in this Core Function _____
Report & Record Keeping	Hours supervised in this Core Function _____
Consultation	Hours supervised in this Core Function _____

I have directly supervised the above named applicant for a total of _____hours.

_____
Name of Clinical Supervisor

_____ _____
Signature of Clinical Supervisor Date Signed

Arkansas Substance Abuse Certification Board
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1100 N. University Ave.
Ste. 35, Little Rock, AR
72207

Verification of Employment

Name of Applicant: _____Daytime Phone:_____

Mailing Address:_____

_____

_____

(**Please circle or write in the amount of hours verified**)

This form is used to document and verify the 2,000, 4,000 or 6,000 hours of work experience_____. You may duplicate this form if you have worked in more than one agency. This document is to verify that the above named applicant has been employed at

_____ in

Name of Agency

In the position of _____

from _____ to _____.
Month/Year Month/ Year

_____ _____
Signature and Title of Verifying Party Date Signed

_____ _____
_____ Daytime Phone
Mailing Address

Arkansas Substance Abuse Certification Board
Evergreen Place
1100 N. University Ave.
Ste. 35, Little Rock, AR
72207

Personal Philosophy of Counseling

Please type your philosophy of counseling in not more than 1 page and submit it with your testing packet. Submit your case study to your Clinical Supervisor for review. If they determine your case study is acceptable, they will attach the verification letter below stating their acceptance to your testing packet. **You NO LONGER have to submit your case study to the ASACB, only the verification letter of acceptance from your CS**.

The Written Case

Mechanics

1. Is the presentation typed?
2. Does the portfolio include the original case study?
3. Does the fact sheet contain the appropriate information and signatures?
4. Did the applicant address all sections of the format and content outline, in the proper sequence?

Format and Content

I. Substance Abuse History

1. Substances Used
2. Frequency
3. Progression
4. Severity/Amount Used
5. Onset — When Started
6. Primary Substance
7. Route of Administration
8. Effects — Blackouts, Tremors, Tolerance, DTs, Seizures, Other Medical Complications. Some of these can be included in the Physical History

II. Psychological Functioning

1. Mental Status – Oriented, Hallucinations*, Delusions*, Suicidal*, Homicidal* Judgment, Insight*to include both present and past

III. Educational/Vocational/Financial

1. Educational and Work History
2. Educational Level
3. Disciplinary Action (at school or work)
4. Reasons for Termination
5. Current and Past Financial Status

IV. Legal History (associated with, or not associated with, mood altering chemicals)

1. Charges, Arrests, Convictions
2. Current Status
3. Pending

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V. Social History

1. Parents
2. Siblings/Rank
3. Psychological Functioning in Family
4. Substance Use in Family
5. History of Social Functioning from Childhood to Present
6. Family Functioning — Including Physical, Sexual, and Emotional Abuse
7. Relationship History
8. Children

VI. Physical History

1. Both Alcohol and Drug and Non-alcohol and Drug Problems
2. Past and Present Major Medical Problems – i.e., Disabilities, Pregnancy and Related Issues, STD, Alcohol and Drug-Related Problems

VII. Treatment History (both alcohol and drug and psychological history)

VIII. Assessment

1. Identifying and evaluating an individual's strengths, weaknesses, problems, and needs for the development of the treatment plan

IX. Treatment Plan

1. Identifying and ranking problems needing resolution; establishing agreed upon immediate and long-term goals; deciding on a treatment process and the resources to be utilized

X. Course of Treatment

1. Describe the counseling approaches you used, your rationale for their use and any revisions you made based on the client's unique problems and responses to treatment

XI. Discharge Summary

1. Concise description of the client's overall response to treatment, including alcohol/drug status at discharge

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72207

Candidate Case Study Submission

Presented for the Arkansas Substance Abuse Certification Board Testing Procedure

Submitted by: _____

Applicant for Certification as an Alcohol and Drug Counselor

Counselor's Statement

I, _____, do submit the attached written case study as being prepared in accordance with all applicable standards of the professional code of ethics and rules of confidentiality.

Clinical Supervisor's Statement

I, _____, do submit this form as verification that the above applicant has adhered to the Arkansas Substance Abuse Certification Board written case study guidelines regarding mechanics, format and content and it is accepted as such.

_____ _____

Signature of Certification Applicant Date Signed

_____ _____

Signature of Clinical Supervisor Date Signed

Arkansas Substance Abuse Certification Board
Evergreen Place
1100 N. University Ave.
Ste. 35, Little Rock, AR
72207

ARKANSAS STATE POLICE

ASP-122
 # 1 STATE POLICE PLAZA DRIVE
LITTLE ROCK, AR 72209
(501) 618-8500

Identification Bureau Individual Record Check Form

Required:
1. This form properly completed and notarized.
2. $ 25.00 check or money order payable to "Arkansas State Police".
3. Stamped envelope addressed to:
   ASACB
   Evergreen Place
   1100 N. University Ave. Ste. 35
   Little Rock, AR 72207
4. Mail required items 1-3 to the State Police

Full Name:_____
First Middle Last Name / Maiden/Other
Date of Birth:_____Race:_____Sex:_____

Social Security #:_____Driver's License #:_____
State
Mailing
Address:_____
Street City State Zip

I GIVE MY CONSENT FOR THE ARKANSAS STATE POLICE TO CONDUCT A CRIMINAL RECORD SEARCH ON MYSELF AND RELEASE ANY RESULTS TO THE FOLLOWING PERSON OR ENTITY.

Name: Arkansas Substance Abuse Certification Board
Mailing Address: ASACB, Evergreen Place
1100 N. University Ave. Ste. 35
Little Rock, AR 72207
(501) 749-4040

Signature_____**Date**_____
First Middle Last Name Month Day Year

REQUESTS <u>WILL NOT</u> BE PROCESSED WITHOUT A NOTARY STAMP
STATE OF_____
COUNTY OF_____
Subscribed and sworn before me a Notary Public in and for the county and state aforesaid, this_____day of_____20____.

Notary Public Signature _____