Missouri
Credentialing Board

(573) 616-2300 www.missouricb.com email: help@missouricb.com 428 E. Capitol, 2nd Floor Jefferson City, MO 65101

Criteria for Certified Reciprocal Advanced Alcohol & Drug Counselor (CRAADC)

I. Criteria for those with an applicable Masters Degree

- Applicable Masters Degree with Clinical Application
- 2000 hours of applicable work experience within the last 10 years
- 300 hours of a Supervised Practicum in the Performance Domains
- Signed Competency Rating Form from MCB qualified supervisor
- 180 Contact Hours of Education to include the following:
  - 6 live ethics hours (not from online or home study)
  - 20 of the 180 hours obtained within the prior 12 months of applying
- Pass IC&RC International AADC Examination

APPLICABLE DEGREES

(A degree must be from a college or university found in the US Dept. of Education's database of accredited schools. The database can be found at http://ope.ed.gov/accreditation.)

1. Psychology
2. Social Work
3. Criminal Justice
4. Family Studies
5. Communication
6. Sociology
7. Chemical Dependency
8. Counseling
9. Nursing
10. Human Services
11. Art Therapy
12. Applied Behavioral Science
13. Education

** If your Related Field Degree (Major) is in one of the above areas but has a different transcript title, please contact the MCB office at 573-616-2300 to verify it will be accepted as an applicable degree.*

DEFINITIONS

A. **CONTACT HOURS of EDUCATION/TRAINING** is defined as workshops, seminars, institutes, accredited college/university courses, home study or on-line courses as pre-approved by the MCB and in-services. One (1) contact hour of education is equal to sixty (60) minutes of continuous instruction. 15 contact hours are given for each college credit. Therefore, a college course of three (3) credits is equal to 45 contact hours.

In order to be considered a valid training experience for the purpose of credentialing, education/trainings must be related to the knowledge and skill base associated with the performance domains of a substance use disorders advanced professional.

All education taking place outside the applicant's place of employment must be documented through proof of attendance including transcripts from an accredited college, letters and/or certificates of completion. Supporting documentation in the form of brochures, flyers, syllabus, course description, etc. may also be required to review content for acceptability.

All education taking place within the applicant's place of employment must be documented by title, date and length of presentation, as well as the name and title of presenter. The training must be verified by the employee's supervisor who attests the training took place and the employee was a participant in the entire training.

B. **APPLICABLE WORK EXPERIENCE** is defined as supervised work experience in a position with job duties that assist clients in the recovery process by performing the substance use disorder advanced counselor performance domains. Experience as a volunteer, intern and/or payment of a stipend qualifies as work experience if the same work is performed that a paid employee would perform.

All qualifying work experience must have been accrued during the ten (10) years immediately prior to application being made.

Work experience must be verified by an employment verification form from the agency(s) in which the applicant has been employed.

C. **SUPERVISED PRACTICUM IN THE PERFORMANCE DOMAINS** is defined as performance of the advanced counselor performance domains while under supervision.

Supervision must be provided by someone who holds a CRADC, CRAADC, CCJP, CCDP, CCDP-D, RADC, RADC-P, LPC, LCSW, LMFT or Licensed Psychologist and who has attended the MCB Clinical Supervision Training.

The supervision of the performance domains may take place within an academic setting and/or within a supervised work setting. The goal is to receive supervised experience in all of the domains. Applicants must complete a minimum of 10 hours performing each of the domains with a total supervised practicum of 300 hours.

D. PERFORMANCE DOMAINS DEFINITIONS: Refer to the AADC Candidate Guide on the MCB web site at www.missouricb.com under the Education Box/Candidate Guide link.

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CHECK LIST FOR CRAADC APPLICATION

1. You have submitted either the $400.00 with this application if you are a new applicant or $325.00 if you are an upgrade applicant.
2. You have paid by check or money order, or have provided your credit/debit card information on page 7 of this application packet. **Applications will not be reviewed until payment is received.**
3. You have completely filled out the application.
4. You have signed the Code of Ethical Practice and Professional Conduct.
5. You have filled out the Family Care Safety Registry Worker Registration Form and included the form with your packet. If your agency has conducted a FCSR background check on you within the last 30 days, you may submit the results to help expedite the application process.
6. You have submitted proof of 180 total hours of education/training with 20 of those hours being obtained within the 12 months prior to application.
7. The appropriate person has completed and signed the Counselor Employment Verification Form and you have included the completed form with the application.
8. The Supervised Practicum Form was completed by a MCB approved supervisor and you have included the completed form with the application.
9. The Competency Rating Form was completed by a MCB approved supervisor and you have included the completed form with the application.
10. The appropriate College transcript(s) were included with the application.
11. Typically, applications are reviewed within two weeks of receipt in the MCB office. If you have not received written correspondence from the MCB 3 weeks <u>after</u> mailing your application to the MCB, call the MCB.
12. If you took and passed the examination and you have not received correspondence from the MCB, check the Professional Search on the MCB web site homepage at www.missouricb.com. Type in your last name. If your application is complete, your credential information will be displayed and you should have received your welcome letter and certificates by e-mail.

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Application Instructions:

1. Requirements to receive this credential are subject to change without notice. Please make sure you are submitting the most recent application packet. If you are unsure, contact the MCB office.
2. The application must be typed or neatly printed.
3. Please keep a copy of all materials submitted for your records.
4. FEES: The total CRAADC Fee for a new applicant is $400.00. The total CRAADC Fee for those upgrading from any other credential is $325.00. You may pay by check, money order, or by providing credit card information on page 7 of this application packet. **Applications will not be reviewed until payment is received.**
5. Please be aware that should your application be reviewed and additional information is requested, you will have 90 days to provide the requested information. Failure to do so will result in your application expiring without being approved.
6. **All fees are non refundable.** If your application is denied or expires, fees will not be refunded.
7. If your application is denied, you may contact the MCB office staff for instructions on how to appeal the denial of your application.
8. All materials submitted to the MCB office become property of the MCB.
9. The applicant must currently reside and/or be employed in the State of Missouri at least 51% of the time. The only exception to this is applicants living and working in a state that is not a member of the International Certification and Reciprocity Consortium.
10. Please remember that it is your responsibility to keep the MCB office informed of any personal informational changes such as address and phone number changes. If you fail to notify us of changes, you will be responsible for any material that is mailed to the wrong address and will have to pay a fee to have the material sent again.
11. **Please mail your application to the MCB. Please do not fax or e-mail your application.**

Special Instructions For Those Applicants Upgrading

1. Your application is a continuation from your previous application(s). Therefore, you do not need to submit duplicate information from previous applications such as transcripts, training certificates sent with previous applications, etc. However, you must completely fill out the application packet.

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Useful Information:

1. If at any time during the application process, a question arises about an applicant's moral character, reputation for honesty, integrity, or professionalism, the Board may either deny the application at that time or place the application on hold until an investigation has been done and a decision made regarding the question brought up.
2. Once your application has been accepted and has final approval, you will receive an e-mail and/or letter from our office with further instructions on how to continue the application/testing process. With this letter, you will also receive information on obtaining a free Candidate Guide. This guide provides you sample questions for the exam. In addition, additional study materials can be purchased. The companies that sell study guides are listed on our web site www.missouricb.com under the "Education Box/Study Guide Information" link. The exam you are taking is called the AADC Exam.
3. The CRAADC credential is a reciprocal credential with other IC&RC member boards that offer this credential. You can contact the MCB office for more information on reciprocity.

Important Notice To Applicants

According to Missouri Credentialing Board (MCB) Policies and Procedures, the following rules apply to those seeking a MCB credential.

1. No individual currently under any type of court supervision can apply for a MCB credential. Please wait until you are completely free from court supervision before applying.
2. The following items disqualify an individual from ever being credentialed with the MCB:
   A. Is listed on the Department of Mental Health disqualification registry
   B. Is listed on the employee disqualification list of the Dept. Health and Senior Services or Dept. of Social Services
   C. Any crime against a minor
   D. A person who has been convicted of, found guilty to, plead guilty to or nolo contendere to any of the Disqualifying Crime (s) Pursuant to Section 630.170, RSMo. The crime (s) will only disqualify an applicant if the crime (s) were a felony. Please view information about Section 630.170, RSMo on the MCB web site www.missouricb.com under the Disqualifying Crimes Link.
3. If an individual has applied for and been given an exception from the Department of Mental Health, the individual may apply for a MCB credential. Please send in proof of exception with your application.

APPLICATION

FOR

Certified Reciprocal Advanced Alcohol & Drug Counselor (CRAADC)

Appropriate fee must be submitted with application.

MISSOURI CREDENTIALING BOARD
428 E. Capitol, 2nd Floor
JEFFERSON CITY, MISSOURI 65101

TELEPHONE: (573) 616-2300

WEB SITE: www.missouricb.com

EMAIL: help@missouricb.com

Please Mark Credit Card Type:

1. Visa _____
2. MC _____
3. Discover _____

CC Expiration Date: _____/_____

Credit Card #**:** _____-_____-_____-_____

Credit Card 3 Digit Verification Code: _____

THIS APPLICATION MUST BE TYPED OR PRINTED NEATLY

All Applications Become the Property of MCB

Please check if you are: ☐ New Applicant ☐ Upgrade Applicant

Applicant's Name: _____
First Middle Last Name Suffix (Jr., II)

_____
Maiden Other Names Used

Current Home Address: _____
Street/PO Box Apt. #

_____
City State Zip County

Home Telephone: _____/_____ SSN: _____-_____-_____

Work Telephone: _____/_____, Ext. _____ Cell Number: _____/_____

E-mail Address: _____

SEX: ☐ M ☐ F BIRTH DATE:____/____/_____

Are you currently or have you been credentialed or licensed as a Substance Use Disorder Professional by the MCB or any other state or organization? ☐ Yes ☐ No

If yes, which state/organization and when? _____

What is the type of credential/license held with the other state/organization?

_____

Have you ever been **ARRESTED** and/or **CONVICTED** of a felony? ☐ Yes ☐ No

If yes, please go to the www.missouricb.com website, print off the "Felony Offense Form", fill out the form and submit with your application. If you were convicted of a felony listed in Section 630.170 RSMo (view www.missouricb.com; Disqualifying Crimes link), you may not apply for this credential without an exception from the Department of Mental Health.

Have you ever knowingly been contacted by a Division of Family Services employee regarding a **CHILD ABUSE** and/or **CHILD NEGLECT** incident involving you? ☐ Yes ☐ No

If yes, please go to the www.missouricb.com website, print off the "Child Abuse/Neglect Statement", fill out the form and submit with your application. In addition, please contact the Division of Family Services at 573-751-2330 and request a report of the incident to include with this application.

Education/Degree Information

1. Master Degree/Higher Program: _____
2. Master Degree/Higher Conferred Date: _____
3. College/University Name: _____

An applicant may document a College/University degree by:

1. Submitting official or unofficial College/University transcripts. Please ensure the transcript shows the applicable degree being conferred.

Where Does the Applicant Currently Work?

Name of Employer:					
Mailing Address of Employer	Street	City	State	Zip Code	County
Name & Title of Immediate Supervisor:					
Your Business Phone: Area Code/Telephone Number		Extension		Fax #	Area Code/Telephone Number

TRAININGS/EDUCATIONAL HOURS

The number of educational hours needed for the CRAADC is as follows:

1. 180 Hours Total
   - 6 contact hours of live ethics training (not online or home study)
   - 20 of the 180 hours obtained within the prior 12 months of applying

All training hours must be documented by transcripts, certificates, in-service logs or other means of qualifying documentation.

Applicant's Agreement to the Code of Ethical Practice and Professional Conduct

I have read the Current Treatment Code of Ethical Practice and Professional Conduct as listed on the MCB web site www.missouricb.com, MCB Ethics Code Link and agree to abide by this code:

Print Name Date

Signature Date

AUTHORIZATION AND RELEASE

I hereby certify all of the information given herein is true and complete to the best of my knowledge and belief. I also authorize any relevant investigations, or the release of personal information to the Missouri Credentialing Board, its agents, or contractors pursuant to this application/renewal procedure. I understand falsification of any portion of this application/renewal will result in my being denied credentialing, or revocation of same upon discovery.

I further agree to hold the Missouri Credentialing Board and its Board Members, officers, agents, staff, peer evaluators and examiners, free from any civil liability for damages or complaints by reason of any action that is within the scope and arise out of the performance of their duties which they, or any of them, may take in connection with this application/renewal, any examination, the grades with respect to any examination, and/or the failure of the MCB to issue me said credential or renewal.

This Authorization and Release shall also apply to personal information requested by the Board at any time following credentialing in connection with any investigation concerning allegations that could lead to disciplinary action against me.

Print Name Date

Signature Date

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
FAMILY CARE SAFETY REGISTRY
WORKER REGISTRATION

PLEASE TYPE OR PRINT CLEARLY

SECTION A: WORKER TYPE (CHECK ONE BOX ONLY)

☐ CHILD CARE WORKER ($9.00) ☐ PERSONAL CARE WORKER ($9.00) ☐ XX VOLUNTARY REGISTRANT

☐ ELDER CARE WORKER ($9.00) ☐ RECIPIENT OF STATE OR FEDERAL FUNDS ($ .00) FOSTER PARENT (NO FEE)

SECTION B: IDENTIFYING DATA FOR BACKGROUND SCREENING

LAST NAME	FIRST NAME	MIDDLE NAME

MAIDEN AND PRIOR NAMES USED

SOCIAL SECURITY NUMBER *(ATTACH COPY OF SOCIAL SECURITY CARD)*	DATE OF BIRTH	GENDER	TELEPHONE NO. (OPTIONAL)
- -	/ /	☐ MALE ☐ FEMALE	( )

MAILING ADDRESS

STREET ADDRESS OR POST OFFICE BOX	CITY	STATE	ZIP CODE	COUNTY

HOME ADDRESS (if different than mailing address)

STREET ADDRESS	CITY	STATE	ZIP CODE	COUNTY

SECTION C: CURRENT EMPLOYER INFORMATION (IF APPLICABLE)

EMPLOYER NAME	CONTACT PERSON	PHONE NUMBER
		( )

ADDRESS	CITY	STATE	ZIP CODE

SECTION D: AUTHORIZATION TO RELEASE BACKGROUND SCREENING INFORMATION

The information provided is complete and accurate to the best of my knowledge. I understand it is unlawful to withhold or falsify information required on this form. I grant my permission for the Missouri Department of Health and Senior Services (DHSS) to obtain any and all background information authorized by law to process this request. Futhermore, I authorized the Missouri Department of Health and Senior Services to release the fact that I am a registrant in the Family Care Safety Registry (FCSR) and any related background information to the requestor of the FCSR for employment purposes only, as provided in 210.921, subsection 1 subdivision (1) and (2), RSMo. For purposes of the FCSR, "employment purposes" includes direct employer/employee relationships, prospective employer/employee relationships, and screening and interviewing of persons or facilities by those persons contemplating the placement of an individual in a child care, elder care or personal care setting. I understand that if I dispute the information contained in the FCSR I have the right to appeal the accuracy in the transfer of information to the FCSR within thirty (30) days of receiving the results of the background screening determination.

NOTICE: The FCSR may choose to deposit the check enclosed electronically as an ACH debit entry to your designated bank account. I understand that my signature below authorized my Financial Institution to deduct this payment from my account. In the event that DHSS or its subcontractor, is unable to secure funds from your account or you provide insufficient or inaccurate information regarding your account, your obligation to the DHSS will remain unpaid and further collection action may be taken by the DHSS or its subcontractor, including, but not limited to, returned check fees.

SIGNATURE OF APPLICANT (REQUIRED IN INK)	DATE
	/ /

IMPORTANT

Submit this form with your application and a copy of your SS card. If your agency has ran a FCSR check within the last 30 days, you can submit the results with this form which may speed up the application process. By doing so, you give permission for your agency to share their FCSR results.

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CRAADC COUNSELOR EMPLOYMENT VERIFICATION FORM

An applicant is applying to the MCB for a Certified Reciprocal Advanced Alcohol Drug Counselor credential. Please complete this form and provide a copy to the applicant to include with their application.

Applicant's Name: _____

Supervisor's Name (Print):_____

Agency: _____

Address: _____

_____

Telephone: _____

Email: _____

Today's Date: _____

Within the last 10 years from the date listed above, please list the **composite total** number of hours the applicant spent working with substance use disorder clients in the following domains: **(Please list all hours worked as this form replaces any previous employment forms submitted with prior applications)**

The formula for computing hours is to take the total number of months worked within the last 10 years and multiply that by 167 hours per month to get the total number of hours. Then divide that total number as appropriate into the 4 domains below.

Screening, Assessment & Engagement: _____

Treatment Planning, Collaboration, & Referral: _____

Counseling & Education: _____

Ethical & Professional Responsibilities: _____

Supervisor's Name (Printed): _____

Supervisor's Signature: _____

Date: _____

CRAADC SUPERVISED PRACTICUM OF THE PERFORMANCE DOMAINS FORM

INSTRUCTIONS: On this form document the number of supervised hours performed in each domain. **The applicant must have completed a total of 300 hours. The applicant must perform a minimum of 10 hours in each domain.** The remaining number of hours needed for credentialing can be in any of the domains.

This form must be filled out by a MCB qualified supervisor

(MCB qualified supervisor includes an individual who holds a CRADC, CRAADC, CCJP, CCDP, CCDP-D, RADC, RADC-P, LPC, LCSW, LMFT or Licensed Psychologist and who has completed the MCB Clinical Supervision Training. This cannot be an immediate family member)

Applicant's Name(Print):_____

MCB Qualified Supervisor (Print):_____

Agency:_____ Clinical Supervision Number:_____

Total # Supervised Work Hours (Must be a minimum of 300 hours):_____

Please indicate on the domain lines below how many of the Total # Supervised Work Hours listed above were in each domain. The total listed on the line above should equal the sum total of the 4 domains (Must be a minimum of 10 hours listed for each domain):

Screening, Assessment & Engagement: _____ **Hours**

Treatment Planning, Collaboration, & Referral: _____ **Hours**

Counseling & Education: _____ **Hours**

Ethical & Professional Responsibilities: _____ **Hours**

MCB Qualified Supervisor's Signature:_____ Today's Date: _____

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COMPETENCY RATING FORM

1=Understands; 2=Developing; 3=Competent; 4=Skilled; 5=Master

INSTRUCTIONS FOR SUPERVISOR: On this form, a MCB qualified supervisor should rate the competency of the applicant in the 10 listed areas using the **rating scale 1-5** given above. For help in determining a rating for a particular area use the competency rating forms found in your clinical supervision manual and/or the TAP 21.

(MCB qualified supervisor includes an individual who holds a CRADC, CRAADC, CCJP, CCDP, CCDP-D, RADC, RADC-P, LPC, LCSW, LMFT or Licensed Psychologist and who has completed the MCB Clinical Supervision Training. This cannot be an immediate family member)

Practice Dimension	**Rating**
Clinical Evaluation – Screening	_____
Clinical Evaluation – Assessment	_____
Treatment Planning	_____
Referral	_____
Individual Counseling	_____
Group Counseling	_____
Family Counseling	_____
Client, Family, and Community Education	_____
Documentation	_____
Professional/Ethical Responsibilities	_____
Total Rating Score	0

(Please add the scores together for each of the above practice dimensions to get a total rating score)

Applicant's Name: _____

Name of Supervisor (Print): _____

Title: _____

Agency:_____ Clinical Supervision Certificate#:_____

Address:_____

Supervisor's Signature:_____ Today's Date: _____

DOCUMENTATION OF DISABILITY-RELATED NEEDS

Please have this section completed by an appropriate professional (physician, psychologist, psychiatrist) to ensure that your board is able to provide the required exam accommodations. Submitted documentation must follow ADA guidelines in that psychological or psychiatric evaluations must have been conducted within the last **three years**. All medical/physical conditions require documentation of the treating physician's examination conducted within the previous **three months**.

Professional Documentation:

I have known _____ since _____/_____/_____ in my
Exam Candidate Date
capacity as a _____.
Professional Title

The candidate discussed with me the nature of the exam to be administered. It is my professional opinion that, because of this candidate's disability described below, he/she should be accommodated by providing the special arrangements listed below:

Description of Disability:

_____
_____
_____
_____
_____

Signed: _____ Title: _____

Printed Name: _____

Address: _____

City/State/Zip: _____

Telephone Number: _____ Email: _____

License Number: _____ Date: _____
(if applicable)

REQUEST FOR SPECIAL ACCOMMODATIONS

If you have a disability that requires special testing accommodations, please complete this form and the Documentation of Disability-Related Needs and return it to your IC&RC member board for processing. The information you provide and any documentation regarding your disability and your need for accommodations in testing will be treated with strict confidentiality. Submitted documentation must follow ADA guidelines in that psychological or psychiatric evaluations must have been conducted within the last **three years**. All medical/physical conditions require documentation of the treating physician's examination conducted within the previous **three months**.

Preferred Exam Date: _____ Preferred Exam Location: _____

Name: _____

Home Address: _____

City/State/Zip: _____

Daytime Telephone Number: _____

Email: _____

Special Accommodations:

I request special accommodations for the following IC&RC ADC examination

Please provide (check all that apply):

___☐___ Special seating or other physical accommodations
___☐___ Reader
___☐___ Large print exam
___☐___ Extended testing time (time and a half)
___☐___ Distraction-free room
___☐___ Other special accommodations (please specify)

Comments:

_____
_____
_____
_____

Print Name: _____

Signature: _____

Date: _____