Missouri
Credentialing Board

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

Criteria For SATOP Qualified Professional or SATOP Qualified Professional with REACT (SQP or SQP-R)

I. Criteria for SQP

- Must hold one of the following: A current and active CADC, CRADC, CRAADC, CCJP, CCDP, CCDP-D, RADC, RADC-P, PLPC, LPC, LCSW, or Licensed Psychologist
- If you are applying for SATOP as a PLPC, LPC, LCSW or Licensed Psychologist, you must submit proof of a current license with your application
- Document 6 contact hours of live ethics training (not online or home study)
- Have the following items documented by a SATOP Qualified Professional (SQP) or SATOP Qualified Professional with REACT (SQP-R) who has attended the MCB Clinical Supervision Training:
  - Performed 10 Offender Management Unit (OMU) Assessments (This should be done under the direct supervision of a SQP or SQP-R)
  - Trained on the Adolescent Drug Education Program (ADEP) workbook
  - Observed 1 Offender Education Program (OEP) Class
  - Observed 1 Weekend Intervention Program (WIP) Class
  - Performed 2 Weekend Intervention Program (WIP) Individual Sessions (This should be done under the direct supervision of a SQP or SQP-R)
- Submit your current driving record with the application packet

II. Criteria for SQP with Required Educational Assessment and Community Treatment (REACT)

- Meet all of the criteria listed above for the SQP
- Have the following items documented by a SATOP Qualified Professional (SQP) or SATOP Qualified Professional with REACT (SQP-R) who has attended the MCB Clinical Supervision Training:
  - Performed 3 REACT Screening Unit (RSU) Assessments
  - Observed 1 REACT Educational Program (REP) Class

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CHECK LIST FOR SQP or SQP-R APPLICATION

1. You have submitted a $75.00 check with this application if applying for the SQP or SQP with REACT at the same time. If this is just to add the REACT addition to your existing SQP, the fee is $25.00. You may also provide your credit card information on page 5 of this application packet. **Applications will not be reviewed until payment is received.**
2. You have completely filled out the application.
3. If you are a licensed professional, you have included a copy of your current license certificate with the application.
4. You have signed the Code of Ethical Practice & Professional Conduct.
5. You have filled out the Family Care Safety Registry Worker Registration Form and included the form with your packet.
6. You have submitted proof of 6 contact hours of live ethics training.
7. You have submitted your current driving record.
8. A SQP/SQP-R who has attended the MCB Clinical Supervision training has completed the appropriate verification forms and you have included them with the application.
9. 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 after mailing your application to the MCB, call the MCB
10. 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 SATOP Fee for new applicants is $75.00. This fee is for either the SQP credential or the SQP-R credential. If you apply for the SQP at this time and add the REACT piece at a later date, the fee at that time will be $25.00. You may pay by check, money order, or by providing credit card information on page 5 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. If at any time during the credentialing 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.
10. 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.
11. 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.
12. **Please e-mail or <u>mail</u> your application to the MCB. Please do <u>not</u> 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. For instance, if you are already a SQP and are only adding the REACT piece, you only need to document the necessary requirements for the REACT portion of the credential. However, you must complete the application packet in its entirety.

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

SATOP Qualified Professional (SQP) or SATOP Qualified Professional with REACT (SQP-R)

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 applying for: ☐ SQP ☐ SQP-R

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 credentialed by the MCB or licensed within the state of Missouri? ☐ Yes ☐ No

If yes, which credential and/or license do you hold? _____

_____

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.

Where Do You 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 SQP-SQP-R is as follows:

6 contact hours of live ethics training (not online or home study)

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

☐ ELDER CARE WORKER ($9.☐) ☐ RECIPIENT OF STATE OR FEDERAL FUNDS (☐0) 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

- Individuals are required to register one time only.
- Contact 1-866-422-6872 (toll-free) if you have questions on how to complete this form
-
- ***Send this form in with your application and with a copy of your social security card.***

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OMU ASSESSMENTS VERIFICATION FORM

An applicant is applying to the MCB for a SATOP Qualified Professional or SATOP Qualified Professional-REACT 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: _____

Telephone: _____

E-mail: _____

Today's Date: _____

Please document the dates each of the 10 OMU Assessments were performed: (Each assessment should be performed under the direct supervision of a SQP or SQP-R.)

1. 1st OMU Assessment performed on: _____
2. 2nd OMU Assessment performed on: _____
3. 3rd OMU Assessment performed on: _____
4. 4th OMU Assessment performed on: _____
5. 5th OMU Assessment performed on: _____
6. 6th OMU Assessment performed on: _____
7. 7th OMU Assessment performed on: _____
8. 8th OMU Assessment performed on: _____
9. 9th OMU Assessment performed on: _____
10. 10th OMU Assessment performed on: _____

SQP or SQP-R Signature: _____

SQP or SQP-R Credential Certificate #: _____

SQP or SQP-R Clinical Supervision #: _____

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ADEP VERIFICATION FORM

An applicant is applying to the MCB for a SATOP Qualified Professional or SATOP Qualified Professional-REACT 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: _____

Telephone: _____

E-mail: _____

Today's Date: _____

Please document the following date the requirement was completed:

1. Applicant was trained on ADEP workbook: _____

The ADEP workbook can be ordered by calling The Change Company at 1-888-889-8866. You will need to speak to either Christy or Sherry and ask to order the "ADEP Training Journal."

SQP or SQP-R Signature: _____

SQP or SQP-R Credential Certificate #: _____

SQP or SQP-R Clinical Supervision #: _____

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OEP CLASS VERIFICATION FORM

An applicant is applying to the MCB for a SATOP Qualified Professional or SATOP Qualified Professional-REACT 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: _____

Telephone: _____

E-mail: _____

Today's Date: _____

Please document the date the requirement was observed:

1. OEP class observed on: _____

SQP or SQP-R Signature: _____

SQP or SQP-R Credential Certificate #: _____

SQP or SQP-R Clinical Supervision #: _____

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WIP CLASS VERIFICATION FORM

An applicant is applying to the MCB for a SATOP Qualified Professional or SATOP Qualified Professional-REACT 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: _____

Telephone: _____

E-mail: _____

Today's Date: _____

Please document the dates the requirements were observed/performed: (Each item should be performed under the direct supervision of a SQP or SQP-R.)

1. WIP class observed on: _____
2. 1st WIP Individual Session performed on: _____
3. 2nd WIP Individual Session performed on: _____

SQP or SQP-R Signature: _____

SQP or SQP-R Credential Certificate #: _____

SQP or SQP-R Clinical Supervision #: _____

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REACT VERIFICATION FORM

An applicant is applying to the MCB for a SATOP Qualified Professional-REACT 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: _____

Telephone: _____

Email: _____

Today's Date: _____

Please document the dates the requirements were observed/performed: (Each item should be performed under the direct supervision of a SQP or SQP-R.)

1. 1st RSU Assessment performed on: _____
2. 2nd RSU Assessment performed on: _____
3. 3rd RSU Assessment performed on: _____
4. REP class observed on: _____

SQP or SQP-R Signature: _____

SQP or SQP-R Credential Certificate #: _____

SQP or SQP-R Clinical Supervision #: _____