(573) 616-2300 www.missouricb.com 428 E. Capitol, 3rd Floor
email: help@missouricb.com Jefferson City, MO 65101

Criteria For Missouri Associate Alcohol Drug Counselor I (MAADC I)

I. Criteria for those with an applicable Associate Degree or an applicable 1 year Addiction Certificate program

- An applicable Associate Degree or applicable 1 year Addiction Certificate program
- 3 contact hours of live ethics training (not online or home study)
- Signed Mentoring & Clinical Supervision Agreement by a MCB qualified supervisor
- Signed Professional Development Contract by a MCB qualified supervisor

II. Criteria for those with a HS Diploma/HSE

- HS Diploma/HSE
- 160 hours of applicable work experience within the last 10 years
- 3 contact hours of live ethics training (not online or home study)
- Signed Mentoring and Clinical Supervision Agreement by a MCB qualified supervisor
- Signed Professional Development Contract by a MCB qualified supervisor

APPLICABLE ASSOCIATE 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.*

APPLICABLE WORK EXPERIENCE

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 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.

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CHECK LIST FOR MAADC I APPLICATION

1. You have submitted a $110.00 check or money order with this application or have provided your credit/debit 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. You have signed the Code of Ethical Practice & Professional Conduct.
4. 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.
5. You and your MCB qualified supervisor have signed the Mentoring and Clinical Supervision Agreement.
6. You and your MCB qualified supervisor have signed the Professional Development Contract.
7. If needed, the appropriate person has completed and signed the Counselor Employment Verification Form and you have included the completed form with the application.
8. You have submitted proof of 3 contact hours of live ethics training.
9. The appropriate High School/HSE or College transcripts were included with the application.
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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<u>Application Instructions:</u>

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 MAADC I Fee is $110.00. You may pay either 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. 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. 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.
11. MAADC I credential expires one year from the issue date. The MAADC I credential does not renew. If a professional is not ready to upgrade his/her credential, he/she should reapply for a new MAADC I credential before the current credential expires.
12. 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 may have to pay a fee to have the material sent again.
13. **Please <u>mail</u> your application to the MCB. Please do <u>not</u> fax or e-mail your application.**

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

Missouri Associate Alcohol Drug Counselor I (MAADC I)

Appropriate fee must be submitted with application.

MISSOURI CREDENTIALING BOARD
428 E. Capitol, 3rd 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: ________________________________

<u>THIS APPLICATION MUST BE TYPED OR PRINTED NEATLY</u>
All Applications Become the Property of MCB

Please check if you are: ______ New MAADC-I Applicant ______Reapplying MAADC-I 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 Children's Division 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 Children's Division at 573-751-1013 and request a report of the incident to include with this application.

Education/Degree Information

Please mark your highest level of education completed:

1. High School Diploma/HSE: _____
2. Addiction Certificate Program: _____
3. Associate Degree: _____ Degree Program: ________________________
4. Bachelor Degree: _____ Degree Program: ________________________
5. Master Degree/Higher: _____ Degree Program: ________________________

An applicant may document High School Diploma or HSE or College/University Degree by:

1. ***Submitting copy of High School Diploma/HSE***
2. ***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

All applicants must submit proof of 3 hours of live ethics training.

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

Be sure to print, sign and date in all places on this page!

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 ($9.00) ☐ 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 ☐ MALE ☐ FEMALE	TELEPHONE NO. (OPTIONAL) ( )

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 / /
▶	

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

Missouri Credentialing Board

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MENTORING AND CLINICAL SUPERVISION AGREEMENT

Adapted from Stiehl, R. and Bessey, B. (1994)

THIS FORM MUST BE SIGNED 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)

Step 1: Agree to work together

- Agree on working together toward improving the supervisee's counseling skills

Step 2: Define and agree on learning goals

- The learning goals must be clearly defined, and there needs to be agreement to work together to help the supervisee attain proficiency in the skills chosen

Step 3: Understand the value of the goals

- The supervisee needs to understand the value of achieving the agreed upon goals

Step 4: Break goals into manageable parts

- The overall goals need to be broken down into parts such as: a) the knowledge, b) the skills, c) the attitudes necessary to attain proficiency

Step 5: Pick styles and methods of learning

- The supervisor needs to elicit from and negotiate with the supervisee his or her preferred styles and methods of learning

Step 6: Observe and evaluate

- How progress will be observed and evaluated needs to be discussed and agreed upon

Step 7: Provide feedback

- The supervisor needs to know how to give feedback, which guides, corrects, and at the same time encourages

Step 8: Demonstrate competency and celebrate

- An outcome demonstration of the newly acquired skill which confirms success needs to be designed, followed by a celebration of the accomplishment

We agree, to the best of our ability to uphold the agreement outlined above and to manage the supervisory relationship process according to the ethical principles and code of conduct of the MCB.

Applicant Printed Name: ______________________________ **Date:** __________________

Applicant Signature: ______________________________ **Date:** __________________

Supervisor Printed Name: ______________________________ **Date:** __________________

Supervisor Signature: ____

Clinical Supervision Training Certificate Number (not credential number): __________________

Missouri Credentialing Board

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PROFESSIONAL DEVELOPMENT CONTRACT

THIS FORM MUST BE SIGNED 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)

Purpose, Goals and Objectives of Supervision:

- Monitor and promote welfare of clients seen by Supervisee
- Promote development of Supervisee's professional identity and competence by using the tools learned in the Clinical Supervision: Building Chemical Dependency Counselor Skills Training
- Oversee Supervisee's entrance and advancement in the credentialing process
- Ensure ethical standards are maintained

Supervision Methods:

- Face to face sessions
- Supervisee attending trainings (both in-service/outside)
- File and documentation review
- Use of forms learned during clinical supervision training (Rubrics, Competency Rating Form, PDP, etc…)
- Preparing the case presentation when applying for certification

Evaluation of Supervisee:

- Feedback will be provided during each face to face session
- A formal evaluation will be conducted every 90 days using the Competency Rating Forms and Professional Development Plan to identify improvement areas

Supervisee Responsibilities:

- Maintain ethical guidelines and professional standards
- Improve personal knowledge, skills and attitude by following the Professional Development Plan and advice of supervisor
- Attend trainings to stay current in the field
- Perform all duties while keeping the client's best interest in mind

We agree, to the best of our ability to uphold the guidelines specified in the supervision contract and to manage the supervisory relationship process according to the ethical principles and code of conduct of the MCB.

Applicant Printed Name: ______________________________________ **Date:** _______________

Applicant Signature: ______________________________________**Date:** _______________

Supervisor Printed Name: _____________________________________ **Date:** _______________

Supervisor Signature: ____

Clinical Supervision Training Certificate Number (not credential number): _____________

Note: You do not need to fill this form out for an applicant that is applying at an appropriate Associate Degree level or higher or a 1 Year Addiction Certificate Program.

COUNSELOR EMPLOYMENT VERIFICATION FORM

An applicant is applying to the MCB for a Missouri Associate Alcohol Drug Counselor I 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: ______________________________

E-mail: ______________________________

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: __________

Counseling: __________

Treatment Planning, Collaboration & Referral: __________

Professional & Ethical Responsibilities: __________

Supervisor's Name (Printed): ______________________________

Supervisor's Signature: ______________________________

Date: ______________________________