

## **Criteria For Batterer Intervention Professional (BIP)**

### **I. BIP Criteria**

- HSE/HS Diploma or higher
- 24 hours of direct facilitation or co-facilitation of Batterer Intervention groups within the last 10 years
- 3 contact hours of ethics training
- Complete MCB TIP 25 Self-Study Course (Contact MCB Office to obtain course)
- 50 contact hours of Batterer Intervention related training (see P. 7)

## **CHECK LIST FOR BIP APPLICATION**

1. You have submitted a \$82.50 check or money order with this application or have provided your credit/debit card information on page 4 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 Ethics Code page of this application.
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. An appropriate person has completed and signed the BIP Verification Form.
6. You have included proof of 3 contact hours of ethics training.
7. You have included proof of completing the MCB TIP 25 Self-Study course.
8. You have included proof of 50 contact hours of Batterer Intervention related training. (See page 7)
9. You have included the completed BIP reference form.
10. The appropriate High School/HSE or College transcripts were included.
11. Check the Professional Search on the MCB web site homepage at [www.missouricb.com](http://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.

## **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 fee if applying for the BIP is \$82.50. You may pay either by check, money order, or by providing credit card information on page 4 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. The BIP credential renews every 2 years and requires 36 hours of relevant educational training with 6 of those hours being ethics. Depending on when you are issued your BIP credential and depending on other MCB credentials held, the first renewal period may be more or less than 2 years. **Please read your initial credential letter carefully.**
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 mail your application to the MCB. Please do not 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](http://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

## Batterer Intervention Professional (BIP)

**Appropriate fee must be submitted with application.**

### MISSOURI CREDENTIALING BOARD

**515 E. High St., Suite 202  
Jefferson City, MO 65101**

**TELEPHONE: (573) 616-2300**

**WEB SITE: [www.missouricb.com](http://www.missouricb.com)**

**EMAIL: [help@missouricb.com](mailto: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: \_\_\_\_\_

Credit Card Zip Code: \_\_\_\_\_



**Your Required Demographic Information Below (Please Type or Print Very Legibly)**

Gender:  Female;  Male;  Decline to State;  Other: \_\_\_\_\_

Ethnicity:  American Indian/Native Alaskan/Native American;  Asian;  Black/African American;  
 Decline to State;  Hispanic/Latino;  Multi-Racial/Ethnic;  Native Hawaiian/Pacific  
Islander  
 White;  Other: \_\_\_\_\_

Salary:  \$0-\$14,999;  \$15,000-\$24,999;  \$25,000-\$34,999;  \$35,000-\$44,999;  \$45,000-\$54,999  
 \$55,000-Over;  Decline to State

Military Service:  Never served in the military;  
 Active duty for training in the Reserves or National Guard;  
 On Active duty in the past, but not now for the Reserves or National Guard;  
 Now on active duty;  
 On active duty in the past, but not now;  
 Veteran

Primary Language:  English;  Spanish;  Chinese;  Tagalog;  Vietnamese;  Arabic;  
 French;  
 Korean;  Russian;  German;  Other: \_\_\_\_\_

Secondary Language:  N/A;  English;  Spanish;  Chinese;  Tagalog;  Vietnamese;  Arabic;  
 French;  Korean;  Russian;  German;  Other: \_\_\_\_\_

Highest Level of Education Completed:  Associates Arts/Science Degree;  Bachelor Arts/Science Degree;  
 Doctorate;  High School Diploma or HiSET;  Some College Credit;  
 No High School Diploma or HiSET;  Vocational Certificate;  Other: \_\_\_\_\_

## Education/Degree Information

Please mark your highest level of education completed:

- |                                  |       |                       |
|----------------------------------|-------|-----------------------|
| 1. High School Diploma/HSE:      | _____ |                       |
| 2. Addition 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 the following training/educational contact hours:

1. MCB TIP 25 Self-Study Course
2. 3 hours of ethics training
3. 50 hours of Batterer Intervention related training topics. The topics should be related to those listed below **but there must be a training certificate showing training regarding topic A – Survivor safety and sensitivity:**
  - A. Survivor safety and sensitivity
  - B. The history of the domestic violence movement
  - C. Cultural diversity
  - D. The nature and dynamics of domestic violence
  - E. The difference between batterer intervention and anger management
  - F. Domestic violence laws and legal issues
  - G. Responsibility versus denial
  - H. Sexism and oppression
  - I. Power and control
  - J. Facilitation and co-facilitation skills specific to groups
  - K. Characteristics of men who batter
  - L. Assessment of intake skills
  - M. Effects of a batterer’s abuse and violence on children and family
  - N. Alternate behaviors

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

**Applicant’s Agreement to the BIP Ethics Code:**

I have read the Current BIP Ethics Code as listed on the MCB web site [www.missouricb.com](http://www.missouricb.com), MCB Ethics Code Link and agree to abide by this code:

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Print Name \_\_\_\_\_ Date \_\_\_\_\_

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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.

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Print Name \_\_\_\_\_ Date \_\_\_\_\_

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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)			
<input type="checkbox"/> CHILD CARE WORKER (\$9.00) REGISTRANT	<input type="checkbox"/> PERSONAL CARE WORKER (\$9.00)	<input type="checkbox"/> xx VOLUNTARY	
<input type="checkbox"/> ELDER CARE WORKER (\$9.00) (NO FEE)	<input type="checkbox"/> RECIPIENT OF STATE OR FEDERAL FUNDS (0.00)		<input type="checkbox"/> FOSTER PARENT

SECTION B: IDENTIFYING DATA FOR BACKGROUND SCREENING		
LAST NAME	FIRST NAME	MIDDLE NAME

MAIDEN AND PRIOR NAMES USED
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SOCIAL SECURITY NUMBER (ATTACH COPY OF SOCIAL SECURITY CARD) - -	DATE OF BIRTH / /	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	TELEPHONE NO. (OPTIONAL) ( )
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**MAILING ADDRESS**

STREET ADDRESS OR POST OFFICE BOX	CITY	STATE	ZIP CODE	COUNTY
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**HOME ADDRESS (if different than mailing address)**

STREET ADDRESS	CITY	STATE	ZIP CODE	COUNTY
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**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. Furthermore, 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 / /
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***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 application process. By doing so, you give permission for your agency to share their FCSR results.***

## **Batterer Intervention Professional VERIFICATION FORM**

An applicant is applying to the MCB for a Batterer Intervention Professional credential. Please complete this form and provide a copy to the applicant to include with their application.

Applicant's Name: \_\_\_\_\_

Your 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 facilitating or co-facilitating Batterer Intervention Groups:

**BIP Group Facilitating Hours:** \_\_\_\_\_

Your Name (Printed): \_\_\_\_\_

Your Signature: \_\_\_\_\_

Date: \_\_\_\_\_

