

Addiction Certification Preparation Program Application

Date of Application: _____

Applicant's Name: _____ Position: _____

Phone #: _____ Fax #: _____

Email Address: _____

Facility Name: _____

Supervisor's Name: _____ Phone #: _____

Location Address: _____

Mailing Address: _____

APPLICANT SECTION

Education:

(Please provide a copy of an **unofficial transcript** from each college/university.)

College/University	Type of Degree (Associate's, Bachelor's, Master's, etc.)	Major
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

GDC Counseling Training:

(Examples: Initial Correctional Counselor Training, Motivational Interviewing, M4C, MRT, Matrix, T4C, Anger Management, Problem Solving Skills in Action, etc.) Attach additional page if necessary.

Training	Provider	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Addiction Certification Preparation Program Application

Professional Conferences /Workshops:

Title of Workshop	Provider	Date

Professional Certifications/Licensures:

Type	Awarded By	Date	Current Yes/No

Have you ever been denied a certification or licensure? If so, what type of certification or licensure, when, and why?

Are you currently working toward a certification or licensure? What? What are your remaining requirements?

Addiction Certification Preparation Program Application

SOP 107.17

Attachment 1

3/31/22

Page 3 of 6

Work History:

All:

Please list any employers, **including your current employer**, for whom you have worked where you provided Direct Services to an identified substance abusing population. **If you have worked at multiple GDC facilities, please list each facility separately.** Please indicate below if you received Clinical Supervision while you were there.

Employer	Date of Services	# Hours per week of Direct S.A. Services
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>

Hrs. of Clinical Supervision

Supervisor's Name

Current:

Please list current job responsibilities that you perform directly to a substance abusing population who has been identified by a formal assessment and/or an official override.

Responsibility	# of Hrs Weekly
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

Addiction Certification Preparation Program Application

Please initial next to each of the following statements indicating your commitment:

- _____ I must obtain 4,000 hours (approximately two (2) years of working 40 hours per week) of experience with an identified substance abusing population.
- _____ I must attend the year-long training, in which sessions occur once a month, until I meet the required 300 hours of training in all Twelve (12) Core Functions (Screening, Intake, Orientation, Assessment, Treatment Planning, Counseling, Case Management, Crisis Intervention, Client Education, Referral, Reports and Record Keeping, and Consultation). I also know other training may be involved. I recognize that I might have to pay out-of-pocket for additional training.
- _____ I must obtain 200 hours of Clinical Supervision with a minimum of ten (10) hours in each of the 12 Core Functions. A supervisor should have a good clinical background in substance abuse, chemical dependencies, and co-occurring disorders. The **preferred credential** for a Clinical Supervisor is the **Alcohol and Drug Abuse Certification Board of Georgia's (ADACBGA) Certified Clinical Supervisor (CCS)** and/or the IC&RC International Certified Clinical Supervisor (**ICCS**). Other acceptable credentials for Clinical Supervisors, which will require case-by-case approval by the ADACBGA ahead of the provision of Clinical Supervision, are:
- Licensed Professional Counselor (**LPC**) *who also holds* the Certified Professional Counselor Supervisor (**CPCS**) through LPCA of Georgia *and/or* the Approved Clinical Supervisor (**ACS**) through the Center for Credentialing & Education (**CCE**) of the National Board for Certified Counselors (**NBCC**),
 - Licensed Clinical Social Worker (**LCSW**) *who also holds board certification in Clinical Supervision* through the American Board of Examiners in Clinical Social Work (**ABE**) *or* otherwise qualifies to offer Clinical Supervision under the rules of the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists,
 - Licensed Marriage and Family Therapist (**LMFT**) *who also holds* the **Approved Supervisor** designation through the American Association for Marriage and Family Therapy (**AAMFT**),
 - Certified Clinical Supervisor (**CCS**) through the Georgia Addiction Counselors Association (**GACA**) *including* proof of having taken and passed the NCC AP's written Clinical Supervisor examination ("Grandfathered" individuals who did not take an exam shall not be approved for the provision of Clinical Supervision), and/or
 - National Clinical Supervision Endorsement (**NCSE**) through the National Association of Alcohol & Drug Abuse Counselors (**NAADAC**).

Addiction Certification Preparation Program Application

If the Clinical Supervisor does not hold the ADACBGA CCS and/or IC&RC ICCS but instead holds one of the other acceptable credentials for Clinical Supervisors listed above, the Clinical Supervisor must first be approved by the board ahead of the provision of Clinical Supervision to the candidate, provide documentation of a minimum of two (2) years practice and supervisory experience specific to substance use treatment and/or the treatment of co-occurring disorders, and must document a minimum of five (5) hours of co-occurring- or substance use- specific continuing education hours each year.

_____ **I also recognize that I may have to pay out-of-pocket for Clinical Supervision.**

_____ I must apply to the certification board and take a computerized test in order to become certified.

I plan to obtain Clinical Supervision from _____

Do you have any questions regarding the program requirements?

Applicant's Signature: _____ Date: _____

Addiction Certification Preparation Program Application

LEADERSHIP SECTION

(WARDEN, DEPUTY WARDEN OF CARE AND TREATMENT, SUPERINTENDENT,
ASSISTANT SUPERINTENDENT, OR CHIEF COUNSELOR)

This section must be completed by one of the Staff listed above.

___Yes ___No In your opinion, is this Applicant sufficiently motivated to complete this lengthy and demanding program?

___Yes ___No Is this Applicant adequately performing his/her assigned duties on the job?

___Yes ___No Is it feasible for this Applicant to attend training every month for at least three (3) consecutive days, as well as possible other trainings as needed, to complete the 300 hours of training required to obtain certification?

___Yes ___No Will this Applicant be able to provide 4,000 hours (approximately two (2)years) of specific Direct Services (screening, intake, orientation, assessment, case management, crisis intervention, counseling, consultation, client education, treatment planning, referral, reports, and record-keeping) to a substance abusing population that has been identified through a formal assessment and/or an official override?

___Yes ___No Will this Applicant be able to receive the required minimum of 10 hours of Clinical Supervision in each of the 12 Core Functions as part of the 200 hours needed to obtain certification?

___Yes ___No Does this Applicant have your endorsement to participate in this program?

Leader's Signature: _____ Date: _____

**Please contact the Office of Reentry Services for further clarification of the Addiction Certification Preparation Program (ACPP) requirements.*