Application for Certification as a Batterer Intervention Provider

Name: ____

Business Address: ____

____

Business Phone: ____

Home Address: ____

____

Personal Phone: Cell: ______________________

Home: ______________________

Email Address(es): Business: ____

Personal: ____

Certification Request: Associate Autonomous

List College Degree(s) and granting institution(s):

List attachments included with this application*:

An applicant must attach verifiable documentary evidence of the qualifications required by 920 KAR 2:020 Section 4. (Diploma, Certificate, Licensure, etc.)

<u>Please include a copy of your current resume with your application.</u>

DOCUMENTATION OF SUPERVISED WORK EXPERIENCE FOR AUTONOMOUS PROVIDERS

This form is to be completed and signed by a Work Supervisor*, and is for applicants seeking autonomous function as a Batterer Intervention Provider.

I certify that ____ (Applicant's Name)

has completed ___________ clock hours of clinical work providing domestic violence services.

The experience was divided approximately as follows:

___________ clock hours working with domestic violence batterers

___________ clock hours working with domestic violence victims

I further certify that I provided ___________ clock hours of clinical supervision to the applicant.

As a result of my supervised experience with that applicant, I:

Recommend him/her for certification
Do not recommend him/her for certification
Will not offer a recommendation

____
Printed Name of Supervisor

____
Signature of Supervisor

____
Degree of Supervisor (including license or certificate number)

____
Street Address

____
City, State, Zip

_____________________________________ _______________________________
Telephone Number Date

***Make copies and submit separately for multiple supervisors.**

APPLICATION FOR CERTIFICATION AS A BATTERER INTERVENTION PROVIDER REQUIRED AFFIRMATION.

I agree and comply with all the requirements established in 920 KAR 2:020. I understand that if I violate any of those requirements my certification as an associate or autonomous provider may be denied or revoked. I also understand that certification is granted for a two (2) year period and renewal of certification requires that I receive and be able to provide documentary evidence of twelve (12) hours of continuing education related to domestic violence during the period of renewal.

I certify that the information given in this application and attachments hereto are correct and complete to the best of my knowledge. I acknowledge and agree that falsification of information in this application or an attachment hereto constitutes sufficient grounds for denial or revocation of certification. I hereby authorize the Cabinet to inquire of any institution, agency, organization or person it deems necessary to verify the contents of this application and attachments hereto. I hereby authorize any institution, agency, organization or person to disclose to the Cabinet any information contained in this application.

I hereby certify that I have not been convicted of or pled guilty to any offense listed in 920 KAR 2:020 Section 3(3)(a) within the past ten (10) year period; I have not had a domestic violence protective order issued against me in the past five (5) years; I am not currently subject to a court order restraining or enjoining me from providing services pursuant to any professional license or certification I hold; and I do not presently have and have no had an alcohol or other substance abuse problem as defined in KRS 222.005 within the two (2) years immediately prior to the date of this application.

____ ____________________

Signature of Applicant Date

Required Attachments for an Associate Provider

1. Copy of Bachelor's Degree conferred by an accredited college or university;
2. A curriculum vitae or other documentation that demonstrates two (2) years and 4000 hours of relevant work experience and;
3. Completion of specialty training in domestic violence (must equal or exceed twenty-four (24) clock hours);
4. Supervision agreement (must be signed by the applicant and the supervisor);
5. Letters of recommendation from two (2) victim advocates (one of whom must work for an agency separate from the applicant) and;
6. A copy of the core curriculum for group participation that will be used.

Required Attachments for an Autonomous Provider

1. A copy of a Master's degree or higher degree from an accredited college or university;
2. A copy of each professional license or certification held by the applicant;
3. Completion of specialty training in domestic violence (must equal or exceed twenty-four (24) clock hours);
4. Documentation of one hundred fifty (150) clock hours of supervised domestic violence work experience;
5. A letter of recommendation for certification as an autonomous provider from the professional who provided the required clinical supervision;
6. Letters of recommendation from two (2) victim advocates (one of whom must work for an agency separate from the applicant) and;
7. A copy of the core curriculum for group participation that will be used.

Certified Batterers Intervention Provider
Clinical Supervision Agreement for Associate Providers

I am an autonomous Batterer Intervention Provider and I agree to provide one hour per week of clinical supervision to:

___

This supervision will include case discussion, review of reading assignments, skill building, direct observation, or review of audio or video recording of assessment or intervention performed by the associate Batterer Intervention Provider.

This supervision will continue until such time that the provider listed above achieves autonomous functioning, no longer works with batterers, or we agree for supervision to end.

After the Associate Provider completes two (2) years (4000 hours) of batterer intervention experience I may recommend to the Cabinet that he/she be granted autonomous function.

____
Printed Name of Supervisor

____ ____________
Signature of Supervisor Date

____ (Address)

____ (City, State, Zip)

____ (Telephone)

____
Signature of Associate Batterer Intervention Provider Applicant

*Make copies and submit separately if multiple supervisors

BATTERER INTERVENTION PROVIDER RECIPROCITY FORM

Pursuant to KAR 2:020 Section 4(4)(f) an applicant meeting or exceeding standards set forth in the regulation and holding a current certification from another state and being in good standing with that certifying agency, may be granted reciprocity upon proof of certification from that state agency.

____ (Name of Applicant)

____ (Address)

____ (City, State, Zip)

____

Phone Number(s)

____ (State where you are currently certified)

**** Please provide standards for certification in the state where you are currently certified. This can be in the form of legislation, an application for certification, or direction to a website where this information may be obtained.***

____ (Contact Person)

____

Address of Certification State

___________________________ ____

Phone Number Email Address

____

Website

Send or fax completed form and a copy of current certification to:

Jeanne Keen, Program Administrator
Division of Violence Prevention Resources
275 East Main Street, 3 E-A
Frankfort, KY 40621
(502) 564-0433 (Phone) (502) 564-9500 (FAX)

ASSOCIATE TO AUTONOMOUS PROVIDER REQUEST FORM

Pursuant to KAR 2:020 Section4(4)(g) an associate provider may apply for autonomous function after two (2) years of full time supervised batterer intervention work experience with a supervisor's recommendation. It is the associate provider's responsibility to request, in writing, to become an autonomous provider. This form must be included with the written request.

I, ____________________________________ have provided clinical supervision
Supervisor's Name

to _______________________________________ from ___________________
Associate Provider's Name Beginning date of supervision

_________________________.
Ending date of supervision

I recommend that the above named Associate Provider be granted the status of an Autonomous Provider at this time.

____ ______________
Signature of Supervisor Date

____ ______________
Signature of Applicant Date

Official Use Only

____

The applicant listed above is approved/not approved for Autonomous/Associate Provider.

____ ______________
Signature of Program Administrator Date