STATE OF MAINE
BOARD OF ALCOHOL AND DRUG COUNSELORS

Application for Licensure
Certified Clinical Supervisor
(CCS)

Department of Professional and Financial Regulation
Office of Professional and Occupational Regulation
(Mailing address) 35 State House Station, Augusta, ME 04333
(Physical Location) 76 Northern Avenue, Gardiner, Maine 04345

Office Telephone: (207) 624-8674
Office Facsimile: (207) 624-8637
TTY USERS CALL MAINE RELAY 711
Internet: www.maine.gov/professionallicensing

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35 STATE HOUSE STATION, AUGUSTA ME 04333 WEBSITE: WWW.MAINE.GOV/PROFESSIONALLICENSING

APPLICATION INSTRUCTIONS
FOR LICENSURE AS A CERTIFIED CLINICAL SUPERVISOR

Helping Tool: This is a checklist to help you identify the documents required with submission of your application. (This is an abbreviated checklist and does not replace the requirements outlined in the Alcohol and Drug Counseling Laws and Rules. Please review them carefully for more detailed and clarifying information.) You must submit a complete application and all required documents and information.

Fax submissions of applications and supporting documentation <u>will not be accepted.</u>

- **Completed Application** Complete and sign the application and submit with the appropriate fees and required documentation.
- If you have held a professional license of any kind in any other jurisdiction, you must submit verification of the license. If there has been discipline on the license, submit the disciplinary documentation.

- **Licensed Mental Health Professionals**

  If currently licensed as a Psychologist, Physician, Registered Clinical Nurse Specialist, Clinical Professional Counselor, Clinical Social Worker, Licensed or Certified Mental Health Professional, Marriage & Family Therapist or Licensed Pastoral Counselor who is qualified to provide alcohol and drug counseling services by virtue of the requirements for that profession, you must submit:

  1. Documented proof of 24 hours of training in clinical supervision including at least 6 hours of training in each of the following areas: skills assessment and evaluation, counselor development, management and administration and professional responsibility; **<u>and</u>**

  2. Documentation that you meet one of the following requirements:

     A. 1,000 hours of practice in alcohol and drug counseling under your qualifying license; or
     B. Work experience treating co-occurring mental health and substance use disorders with at least 3 years of experience supervising clinicians in a treatment program for co-occurring mental health and substance use disorders.

- **Licensed Alcohol & Drug Counselors**

  If currently licensed as an alcohol and drug counselor in Maine, you must submit:

  1. Documented proof of 24 hours of training in clinical supervision including at least 6 hours of training in each of the following areas: skills assessment and evaluation, counselor development, management and administration and professional responsibility.

Processing Time

- ✓ Your application has a greater chance of being processed expeditiously if it is complete and all supporting documents are attached. Action on this application is posted to the web in real time. Please visit our website if you wish to monitor progress. If the status appears as Pending, this means that your application was received by this office and it is pending or under review. Once reviewed and if everything about your application is complete and complies with requirements, the license will be issued and the status will show as ACTIVE. If incomplete you will receive written correspondence by email.

- ✓ Please refrain from calling our office to "check" on your application as these calls only serve to slow our ability to review and process applications. Information regarding the status of applications may be found at the Office of Professional and Occupational Regulation's website www.maine.gov/professionallicensing. We appreciate your thoughtful attention to this request.

- ✓ Once your license is issued it is immediately visible online with an "active" status. Licenses are emailed to the address provided by you by 6AM the following day.

STATE OF MAINE DEPARTMENT OF PROFESSIONAL & FINANCIAL REGULATION
OFFICE OF PROFESSIONAL AND OCCUPATIONAL REGULATION
Mailing Address: 35 State House Station, Augusta, Maine 04333 - TTY users call Maine relay 711 **Courier/Delivery address**: 76 Northern Avenue, Gardiner, Maine 04345

Frequently Asked Questions:

- **Where do I send my application?** Our mailing address is 35 State House Station, Augusta, Maine 04333-0035
- **Where are you located?** Gardiner Annex, 76 Northern Avenue, Gardiner, Maine.
- **What hours are you open?** Due to the Covid-19 pandemic, and until further notice, the Gardiner Annex that houses the Office of Professional and Occupational Regulation and other agencies is closed to the public. OPOR staff members work remotely from 8 am to 5 pm to review and process license applications. We advise you to mail paper applications to 35 State House Station, Augusta, ME 04333.
- **Can I come to Gardiner to drop off my application?** No, the Gardiner Annex is closed to the public until further notice due to the Covid-19 pandemic. Please mail your paper application to our mailing address—35 State House Station, Augusta, ME 04333.
- **Can I come to Gardiner to pick up my license?** No. Your license will be emailed to you.
- **How long does it take to process an application?** You can check our website: www.maine.gov/professionallicensing. Your license will show up as PENDING at first; as soon as your status is ACTIVE you are authorized to practice.

PLEASE ALSO SEE THE WEBSITE FOR THE OFFICE OF PROFESSIONAL AND OCCUPATIONAL REGULATION FOR ADDITIONAL QUESTIONS: https://www.maine.gov/pfr/professionallicensing/licensee_faq.html

NOTICES

BACKGROUND CHECK: Pursuant to 5 MRS §5301 - 5303, the State of Maine is granted the authority to take into consideration an applicant's criminal history record. The Office of Professional and Occupational Regulation requires a criminal history records check as part of the application process for all applicants.

PUBLIC RECORD: This application is a public record for purposes of the Maine Freedom of Access Law (1 MRS §401 et seq). Public records must be made available to any person upon request. This application for licensure is a public record and information supplied as part of the application (other than social security number and credit card information) is public information. Other licensing records to which this information may later be transferred will also be considered public records. Names, license numbers and mailing addresses listed on or submitted as part of this application will be available to the public and may be posted on our website.

SOCIAL SECURITY NUMBER: The following statement is made pursuant to the Privacy Act of 1974. Disclosure of your Social Security Number is mandatory. Solicitation of your Social Security Number is solely for tax administration purposes, pursuant to 36 MRS §175 as authorized by the Tax Reform Act of 1975 (42 USC §405(c)(2)(C)(i)). Your Social Security Number will be disclosed to the State Tax Assessor or an authorized agent for use in determining filing obligations and tax liability pursuant to Title 36 of the Maine Revised Statutes. No further use will be made of your Social Security Number and it shall be treated as confidential tax information pursuant to 36 MRS §191.

Before you seal the envelope, did you:

- Complete every item on the application (incomplete applications may be returned)
- Answer the disclosure question
- Sign and date your application
- Include correct amount (payable to Maine State Treasurer) *or* credit card information (plus signature)
- Include any required transcripts or exam results
- **Make a copy of your application to keep for your records**
- DO NOT SEND CASH.

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION
OFFICE OF PROFESSIONAL AND OCCUPATIONAL REGULATION
INDIVIDUAL LICENSE APPLICATION

APPLICANT INFORMATION (please print)			
FULL LEGAL NAME *FIRST* *MIDDLE INITIAL* *LAST*			
ANY OTHER NAMES EVER USED:			
DATE OF BIRTH *mm / dd / yyyy*		SOCIAL SECURITY NUMBER - -	
MAILING ADDRESS			
CITY	STATE	ZIP	COUNTY
PHONE # ( )	FAX # ( )	E-MAIL (for License)	

State Board of Alcohol and Drug Counselors

CCS License Application

LICENSE TYPE:

CCS—Certified Clinical Supervisor License

Required Fees: $61.00 (Non-Refundable)
(includes license and criminal records check fees)

Rev. 3/2022

Office Use Only:

CCS 1421 - $ 40.00
2619 - $ 21.00

Office Use Only:
Check #_____
Amount:_____
Cash #_____
Lic. #_____

PAYMENT OPTIONS:

Make checks payable to "Maine State Treasurer" – if you wish to pay by Mastercard, Visa, Discover or American Express fill out the following:

NAME OF CARDHOLDER (please print) *FIRST* *MIDDLE INITIAL* *LAST*

MAILING ADDRESS OF CARDHOLDER (please print)

I authorize the Department of Professional and Financial Regulation, Office of Professional & Occupational Regulation to charge my ☐ VISA ☐ MASTERCARD ☐ DISCOVER ☐ AMERICAN EXPRESS the following amount: $_____

☐ **I understand that fees are non-refundable**

Card number: *XXXX-XXXX-XXXX-XXXX* Expiration Date *mm / yyyy*

SIGNATURE **DATE**

SECTION 1: QUALIFYING LICENSE INFORMATION
List your qualifying license

License Type	License Number	Expiration Date

SECTION 2: LIST BELOW EVERY STATE OR JURISDICTION IN WHICH YOU HOLD OR HAVE EVER HELD A PROFESSIONAL LICENSE.

Has any state or jurisdiction taken disciplinary action against any professional license you hold or have held, or denied your application for licensure? (circle one) **NO** **YES**

If yes, enclose a signed detailed explanation and copies of all documents.

1. State, Territory, Country	License Number/Type	Date Issued	Expiration Date
2. State, Territory, Country	License Number/Type	Date Issued	Expiration Date
3. State, Territory, Country	License Number/Type	Date Issued	Expiration Date

SECTION 3: CHECK APPROPRIATE RESPONSE TO THE QUESTIONS BELOW. ANY YES RESPONSE MUST BE FULLY EXPLAINED BY WRITTEN STATEMENT ON A SEPARATE SHEET OF PAPER, SIGNED AND DATED, AND SUBMITTED WITH YOUR APPLICATION.

Have you had a hospital or similar health care institution privileges denied or suspended, restricted or withdrawn involuntarily; or have you ever voluntarily surrendered privileges or resigned from staff membership while under peer review?	□ Yes □ No
Have you ever received a sanction from Medicare or from a state Medicaid program? 1. □ Medicare OR □ Medicaid Program (State) _____ 2. Submit a copy of the official action by the entity. 3. Provide a detailed explanation in your own words on a separate sheet of paper. Clarification on programs: • Medicare – Health program administered by the United States government for people that are (1) ages 65 or older, (2) under the age of 65 with certain disabilities, and/or (3) all ages with end-stage renal disease. • Medicaid – Health program administered by the United States government for people with limited incomes. • MaineCare – Health program administered by the State of Maine with similar eligibility requirements as Medicaid.	□ Yes □ No

SECTION 4: APPLICANT'S CERTIFICATION AND SIGNATURE

Read the statement below and sign where indicated as your certification of the information provided on this application.

By my signature, I hereby certify that the information provided on this application is true and accurate to the best of my knowledge and belief. By submitting this application I understand that the Maine Board of Alcohol & Drug Counselors will rely upon this information for issuance of my license and that this information is truthful and factual. I further understand that sanctions may be imposed, including denial, suspension or revocation of my license, if this information is found to be false.

Alcohol & Drug Counseling Board:

Statute Reference: 32 MRSA Chapter 81 – Alcohol & Drug Counseling Board Link: http:// www.mainelegislature.org/legis/statutes/32/title32ch81sec0.html

Rules Reference: Alcohol & Drug Counseling Board (02 384) Chapters 1-9
http:// http://www.maine.gov/sos/cec/rules/02/chaps02.htm#384

Title 5 Administrative Procedures and Services Chapter 341
http://www.mainelegislature.org/legis/statutes/5/title5ch341sec0.html

Title 10 Department of Business Regulation Law §§8001-8011
http://legislature.maine.gov/statutes/10/title10ch901sec0.html

Office of Professional and Occupational Regulation Rules 02 041
http://www.maine.gov/sos/cec/rules/02/chaps02.htm#041
Chapter 10, Establishment of License Fees
Chapter 11, Late Renewals
Chapter 13, Uniform Rule for the Substantiation of Continuing Education Requirements

By my signature below, I Attest that I have read all of the above listed laws and rules and will keep current by periodically revisiting them for any changes and updates.

I agree to abide by the Maine Board of Alcohol & Drug Counselors Statutes, and Board Rules, as well as the Department of Professional and Financial Regulation's Laws and Rules, and the Office of Professional and Occupational Regulation's Laws and Rules. Above is a list of the relevant laws and rules and information to obtain these documents. This office cannot provide you with hardcopy documents, please visit the website(s) listed to obtain electronically available documents. These documents may be subject to change without notice and it is strongly advised that you periodically revisit these sites for any updates.

Printed Name of Applicant	Title
Signature of Applicant	Date

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
STATE BOARD OF ALCOHOL AND DRUG COUNSELORS
35 STATE HOUSE STATION
AUGUSTA, MAINE 04333-0035
TEL:(207)624-8674 – FAX:(207)624-8637

VERIFICATION OF EXPERIENCE PROVIDING ALCOHOL & DRUG COUNSELING SERVICES

Name of Applicant:		
Address:		
City:	State:	Zip:
Applicant's License Type:		License #:

Please indicate the type of experience you are applying with:

_____**1,000 hours of practice in alcohol and drug counseling with your qualifying license.**

- **Complete Supervisor's Affidavit Form with your Supervisor.**

_____**Experience treating co-occurring mental health and substance use disorders with at least 3 years of Experience supervising clinicians in a co-occurring mental health and substance use disorder treatment Program**

- **Submit a written statement that includes all of the information listed above.**

_____**Licensed Alcohol & Drug Counselor**

Maine Licensed Alcohol & Drug Counselor License Number: _____

By my signature, I hereby certify that the information provided on this form is true and accurate and I understand that the Maine Board of Alcohol & Drug Counselors will rely upon this information for issuance of my Certified Clinical Supervisor license. I further understand that sanctions may be imposed, including denial, suspension or revocation of my license, if this information is found to be false.

_____

Signature **Date**

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VERIFICATION OF CLINICALLY SUPERVISED EXPERIENCE

Name of Applicant:		
Address:		
City:	State:	Zip:
Applicant's Job Title:		Telephone #:

The following section is to be completed by employer or supervisor only

Name of Agency: _____

Address: _____

Clinically supervised work experience must be <u>obtained while licensed</u>. Please include applicant's valid license type and number.

Date of employment/ Dates worked to obtain hours (mm/yyyy)	Applicant's License Type	Applicant's License Number	Work area of practice that was Supervised in the practice of Alcohol and Drug Counseling (Check all that apply)	Number of Hours of Clinically Supervised Work Experience in the practice of Alcohol and Drug Counseling
From: _____ To: _____			☐ Screening ☐ Intake ☐ Orientation ☐ Assessment ☐ Client education ☐ Referral ☐ Case management ☐ Crisis intervention ☐ Reports and record keeping ☐ Treatment planning ☐ Individual, group & family counseling ☐ Consultation with other Professionals	
From: _____ To: _____			☐ Screening ☐ Intake ☐ Orientation ☐ Assessment ☐ Client education ☐ Referral ☐ Case management ☐ Crisis intervention ☐ Reports and record keeping ☐ Treatment planning ☐ Individual, group & family counseling ☐ Consultation with other Professionals	

VERIFICATION OF CLINICALLY SUPERVISED EXPERIENCE (Continued)

Date of employment/ Dates worked to obtain hours (mm/yyyy)	Applicant's License Type	Applicant's License Number	Type of Work Experience that was Supervised in the practice of Alcohol and Drug Counseling (Check all that apply)	Number of Hours of Clinically Supervised Work Experience in the practice of Alcohol and Drug Counseling
From: _____ To: _____			☐ Screening ☐ Intake ☐ Orientation ☐ Assessment ☐ Client education ☐ Referral ☐ Case management ☐ Crisis intervention ☐ Reports and record keeping ☐ Treatment planning ☐ Individual, group & family counseling ☐ Consultation with other Professionals	
From: _____ To: _____			☐ Screening ☐ Intake ☐ Orientation ☐ Assessment ☐ Client education ☐ Referral ☐ Case management ☐ Crisis intervention ☐ Reports and record keeping ☐ Treatment planning ☐ Individual, group & family counseling ☐ Consultation with other Professionals	
TOTAL NUMBER OF HOURS OF CLINICALLY SUPERVISED ALCOHOL AND DRUG COUNSELING WORK EXPERIENCE:				

Did you personally supervise the above named applicant during the time frame indicated on this form? ☐ **Yes** ☐ **No**

If no, describe your relationship with the applicant and include name and license number of Certified Clinical Supervisor: _____

_____

I, the _____ **of the above named applicant, certify that the information provided on this form is verifiable, factual and accurate.**

(i.e. supervisor, human resources, etc)

Print Name: _____ **License #:** _____

Title: _____

Signature: _____ **Date:** _____

TO SUPERVISOR COMPLETING THIS FORM: Return this completed form directly to the applicant; not the Board.