

**ADDICTIONS THERAPIST
RENEWAL DEADLINE:**

September 30, 2016

RENEWAL QUESTIONS:

Questions regarding renewal should be directed to:

DMH Division of PLACE staff at
place@dmh.ms.gov OR
(601) 359-1288.

**Addictions Therapist Renewal 2016
Renewal Instructions**

-SUBMITTING THE RENEWAL PACKET-

1. **COMPLETE** the applicable form(s) listed below, along with your renewal fee payment:
 - Renewal Application Form – (**Two-Pages; To be signed by the Renewal Applicant IN BLUE INK** and dated) – pages 4 and 5;
 - Renewal Verification of Employment Form (**IF REQUIRED-Refer to “Verifying Employment” below**) - pg. 6;
 - **\$100.00 Renewal Fee** - payable by check or money order; DO NOT send cash; **MAKE CHECK/MONEY ORDER PAYABLE TO: MS DEPARTMENT OF MENTAL HEALTH**
2. **SUBMIT** your completed renewal packet (**including the renewal fee**) to the following address:

Mississippi Department of Mental Health
Division of Professional Licensure & Certification (PLACE)
239 North Lamar Street
1101 Robert E. Lee Building
Jackson, MS 39201

Attn: Addictions Therapist Renewal

- The completed renewal packet should be submitted as soon as possible, but **NO LATER THAN 5:00 p.m. on September 30, 2016**. Postmark dates are not considered; **only the date of receipt counts towards meeting the renewal requirement.**
3. **SUCCESSFUL RENEWAL** - Once successfully renewed, **you will receive a confirmation email** containing a renewal document which indicates continued certification/licensure for the next two-year certification/licensure period; in order to receive this email, **please include an email address on the Renewal Application Form**. Your Staff Development Officer(s) (SDO) will also receive an email confirmation of your renewal.

-IMPORTANT RENEWAL INFORMATION; PLEASE READ-

Verifying Continuing Education (CEs):

- Renewal continuing education (CE) hours are **NOT REPORTED AT THE TIME OF RENEWAL**. Sufficient documentation to this effect (e.g., training records; computerized staff development printouts; official college transcripts, if utilizing college credit) **should be housed with the Staff Development Officer (SDO) at your current place of employment**. *You should also keep a personal copy of your continuing education (CE) records.*

- **If you are unsure who your program’s designated SDO is, please contact the DMH Division of PLACE for assistance.** (NOTE: *If you change employment during a renewal cycle, it is your responsibility to provide your current SDO a copy of any training records from your previous place of employment that are needed to fulfill your renewal continuing education (CE) requirement.*)
- **A minimum of 80 continuing education (CE) hours accrued between October 1, 2012, and September 30, 2016,** is required to renew. **Of the 80-hour CE renewal requirement, the following stipulations are included:**
 - 1) 48 of the 80 required hours must be related to the field of alcohol and other drug (A/D) abuse treatment (*may be inclusive of A/D prevention activities*).
 - 2) Of the remaining 32 required hours, 28 must be **behavioral health-related (*which may or may not include alcohol and other drug abuse prevention/treatment services-related topics*) **AND must also cover the requirements listed in numbers 5 and 6 below.** (**Relevant DMH-required training indicated in the current *DMH Operational Standards for Mental Health, Intellectual/Developmental Disabilities, and Substance Use Community Service Providers* may be counted as “behavioral health-related” CEs).
 - 3) Individuals may count up to four (4) hours in non-A/D or behavioral health-related areas, such as technology or administrative types of training, which they or their programs deem important or necessary for continued professional enhancement.
 - 4) Up to 16 of the total required 80 hours may be obtained by presenting applicable (alcohol and other drug abuse prevention/treatment-related) training events.
 - 5) At least two (2) of the required 80 hours **must be** in the area of cultural competency.
 - 6) At least two (2) of the required 80 hours **must be** in the area of ethics (related to the field of behavioral health).
 - 7) A minimum of 40 of the required 80 hours must be accrued through participation in live, face-to-face continuing education activities; thus, no more than 40 of the required 80 hours may be earned through online or distance learning educational activities.
 - 8) Two (2) three-semester hour (or equivalent) graduate-level behavioral health-related college courses from an approved educational institution, taken during the appropriate certification time period, will be accepted to fulfill the entire continuing education requirement. One (1) three semester hour (or equivalent) graduate-level behavioral health-related college course from an approved educational institution, taken during the appropriate certification time period, will be accepted to fulfill half (or 40 hours) of the continuing education requirement.
 - 9) Courses claimed for continuing education hours must be beyond the course work necessary to meet the educational requirement for DMH professional credentialing.
 - 10) Any activity completed for the purpose of achieving the DMH Addictions Therapist certification (such as DMH Addictions Therapist Web-Based Training Component courses) is not eligible for CE credit.
- **During the individual’s FIRST renewal cycle only, the CE renewal requirement may be prorated, if necessary, as requested by the renewal applicant. Renewing individuals for whom it is their FIRST renewal cycle are required to report a minimum of two (2) CE hours per month of credentialing, beginning with the month of full certification issuance and ending with the renewal deadline month (September 30th).** (One (1) of these two (2) hours per month must be related to the field of alcohol and other drug (A/D) abuse prevention/treatment, and the remaining one (1) of these two (2) CE hours per month of credentialing must be behavioral health-related (which may or may not include alcohol and other drug abuse prevention/treatment services-related topics). For example, an individual who first obtained his/her CAT credential in the month of January of a renewal year (which ends September 30th) would be required to report 18 CE hours; at least nine (9) of these 18 hours **MUST BE** alcohol and other drug (A/D) abuse prevention/treatment related, and the remaining nine (9) hours must be behavioral-health related, which may or may not include alcohol and other drug abuse

prevention/treatment services-related topics. This provision is only applicable to the individual’s first renewal cycle. **The renewal fee is not prorated.**

- ***If you obtained your CAT credential after the beginning of the current certification/licensure period (October 1, 2012), you can still count appropriate CE hours which were earned prior to having received your credential, as long as these appropriate CE hours fall within the aforementioned time frame.***
- For additional information regarding the CE reporting requirement, please refer to the *DMH Addictions Therapist Standards & Requirements document, effective date – January 1, 2012*; this document is available on the “PLACE” page of the DMH website: www.dmh.ms.gov.
- **The DMH Division of PLACE reserves the right to audit continuing education (CE) records of renewed individuals to determine compliance with the renewal continuing education (CE) requirement. If audited, you (in conjunction with your SDO) will be required to produce documentation to validate your completion of the renewal continuing education (CE) requirement. Your signature on the Renewal Application Form denotes your understanding of this requirement.**

Verifying Employment:

- **You only need to submit the Renewal Verification of Employment Form (page 6) with your renewal packet IF your place of employment has changed. If your place of employment has changed AND you have not already updated your employment information with the DMH Division of PLACE, then you need to include a completed Renewal Verification of Employment Form in your renewal packet.** Otherwise, you do not need to submit this form.
- A change in “place of employment” refers to a change in your overall employer (agency/organization) NOT your specific job title.

-SPECIAL SITUATIONS DURING RENEWAL-

NAME CHANGE?
If your legal name has changed, and you have not yet completed the name change process with the DMH Division of PLACE, please follow the name change instructions found in Chapter Nine of the Addictions Therapist Booklet and submit your name change information along with your completed renewal packet. *(The Addictions Therapist Booklet is available online at the DMH website: www.dmh.ms.gov. Once on this website, click “PROVIDERS” then “PLACE.” The booklet link is entitled, “DMH Addictions Therapist Standards & Requirements – Effective Date January 1, 2012.”* **Your renewal packet will not be processed without submission of the appropriate name change information.**

CHOOSING NOT TO RENEW?
If you do not wish to renew, complete the appropriate section on the enclosed Renewal Application Form and return it to the DMH Division of PLACE at the address listed on Page 1.

-CHANGE TO LAPSED STATUS-

Renewal of professional certification/licensure is required on or before the **September 30, 2016, renewal deadline** in order to maintain “Current” status. **Failure to meet renewal requirements in a timely manner** will result in a change of status from **Current to Lapsed on October 1, 2016.**

ADDICTIONS THERAPIST RENEWAL APPLICATION FORM - 2016

-Personal Information-

- Mr.
1. Name: Ms. _____ 2. Social Security #: XXX - XX - _____
Dr. _____ (Last 4 Digits)
3. Credential to be Renewed (check one):
Certified Addictions Therapist (CAT) Licensed Clinical Addictions Therapist (LCAT)
4. Email Address: _____
(Email address is required)

COMPLETE Items 5-7 ONLY IF A CHANGE from your present listing with the Division of PLACE is desired; **your email address is required.**

5. Mailing Address: _____
(Street or P.O. Box)
- _____
(City) (State) (Zip Code)
6. Home/Cell Phone #: _____ 7. Work Phone #: _____

-Employment Information-

8. My current job title/position is: _____
9. I am currently employed at the following overall program/mental health center/agency/organization:

List the name of your Current Employer Here

10. CHECK **ONE** of the two (2) options below **and follow the corresponding directions:**

I **DO NOT** need to report a change in my place of employment. ("Place" of employment refers to your employer (agency/organization) NOT your specific job title.)

DO NOT submit a Renewal Verification Employment Form with your renewal packet; this form is only required if you are reporting a change in your place of employment.

I **DO** need to report a change in my place of employment. ("Place" of employment refers to your employer (agency/organization) NOT your specific job title.)

SUBMIT an updated Renewal Verification of Employment Form (**Page 6**) with your renewal packet to denote your change in employment; be sure and follow the directions on the form.

This is a two-paged form.
Renewal Applicant Must Sign in BLUE INK & Date Page 5 

-Renewal Applicant's Statements of Assurance-

- RENEWAL APPLICANT MUST SIGN & DATE BELOW-

Directions: Read the "Renewal Applicant's Statements of Assurance" below. If you agree with the "Renewal Applicant's Statements of Assurance," print/type your full name and last four digits of your SSN in the designated space below, then sign below in BLUE INK and date the form. Failure to agree with these terms of renewal will delay and/or prohibit your ability to renew successfully.

-Renewal Applicant's Statements of Assurance-

I agree that I am the person who completed this application; that I am currently employed in the "state mental health system," as described in the *Addictions Therapist Booklet (Chapter One); that I have met all continuing education (CE) renewal requirements and understand that my renewal CE records may be audited by DMH for compliance and that documentation to this effect must be housed with my organization's designated Staff Development Officer(s) (SDO); I agree that the statements contained in this Renewal Application are true in every respect; and, that I will conform to the Principles of Ethical and Professional Conduct of the Mississippi Department of Mental Health. *(The Addictions Therapist Booklet is available online at the DMH website: www.dmh.ms.gov. Once on this website, click "PROVIDERS" then "PLACE." The booklet link is entitled, "DMH Addictions Therapist Standards & Requirements – Effective Date January 1, 2012."

Renewal Applicant's Printed/Typed Name: _____ **SSN:** xxx-xx-_____ (Last 4 Digits)

Signature of Renewal Applicant _____ ***** (Signature in Blue Ink) *****
Date _____

-Individuals Choosing NOT TO RENEW (or Requesting Inactive Status)-

I **DO NOT** wish to renew my Addictions Therapist credential. I am returning this notice and request **ONE** of the options below (check one):

- Retired Status;**
- Relinquished Status** (Request must be accompanied by original wall certificate.);
- Lapsed Status** (Your credential will automatically Lapse on October 1, 2016, if you do not renew.)

*For more information about Retired, Relinquished or Lapsed Status or to determine your eligibility, please consult the *Addictions Therapist Booklet OR contact the Division of PLACE. *(The Addictions Therapist Booklet is available online at the DMH website: www.dmh.ms.gov. Once on this website, click "PROVIDERS" then "PLACE." The booklet link is entitled "DMH Addictions Therapist Standards & Requirements – Effective Date January 1, 2012"*

CATs/LCATs interested in requesting Inactive Status should also consult this booklet or contact the Division of PLACE for more information; individuals granted Inactive Status must renew by the AT renewal deadline.

INCLUDE your Name and Social Security# on Page 4 of this form (along with any change of address, telephone number, etc.). SIGN IN BLUE INK and DATE this section only.

Signature **IN BLUE INK** (required)

Date

FOR OFFICE USE ONLY

Date Application Packet Received: _____ Last Four Digits of Applicant's SSN: _____
 Date Application Reviewed: _____ PLACE Reviewer Initials: _____
 Completed Renewal Application Form A Check/MO for \$100.00. Date Received (If Received Separately): _____
 AFTER September 30th Late Renewal Fee Received - Date Received: _____
 Date Renewal Email/Mail Confirm Sent: _____ Date Problem Letter/Request for More Information Sent: _____

RENEWAL VERIFICATION OF EMPLOYMENT FORM

(To be completed by the Personnel Officer at the Renewal Applicant's current place of employment)

Directions: This form is to be completed by the **Personnel Officer** at the **Renewal Applicant's current place of employment**. Please type or print **ALL INFORMATION**; fill in every blank or check the appropriate boxes. Upon completion, **the Personnel Officer should seal the form in an envelope and sign his/her name across the envelope's seal**. The signature on the envelope should match the signature on the enclosed form. The Personnel Officer should then **return the sealed envelope to the Renewal Applicant** for submission to the Division.

1. Employment:

Renewal Applicant/Employee's Name & SSN	Renewal Applicant/Employee Name:
	Social Security Number: XXX-XX- _____ (Last 4 Digits)
Renewal Applicant/Employee's <u>Current</u> Place of Employment & Place of Employment (Physical) <u>Street Address</u>	Overall Agency/Organization/Program Name:
	Place of Employment (Physical) <u>Street Address</u> (Information must be included):
Renewal Applicant/Employee's Date of Hire (Only Report a Single Date of Hire)	_____ / _____ / _____ Month Day Year
Renewal Applicant/Employee's Job Title	

2. Background Check: (No one will be credentialed without proof of criminal background checks.)

As appropriate to the Applicant's position and professional responsibilities, have background checks been conducted regarding this Applicant? YES NO (Provide explanation)

Explanation: _____

3. State Mental Health System Qualification: (Check the appropriate qualification).

a. This applicant/employee **currently** works for an agency/organization which is **certified and/or funded** by the Mississippi Department of Mental Health. YES NO (Provide explanation)

b. This applicant/employee **currently** works for a program which is **operated/administered** by the Mississippi Department of Mental Health. YES NO (Provide explanation)

4. **Personnel Officer's Name:** _____ **Email:** _____
(Printed or Typed)

Signature of Personnel Officer

Date