Introduction

Introduction and Purpose of the Program

KRS 403.7505 authorizes the Cabinet for Health and Family Services to promulgate administrative regulations to create a batterer intervention certification program for mental health professionals. The program is specifically designed to certify those professionals who provide court-ordered batterer intervention; it does not regulate services to victims except with respect to how collateral contacts with victims are to be made by batterer intervention providers. This program is also limited in scope to court-mandated services to domestic violence batterers.

The purpose of the program is to ensure victim safety through the provision of quality intervention services to domestic violence batterers. The program is also intended to provide for an organized referral resource for the Kentucky court system.

Qualifications of Certified Providers

The administrative regulation entitled "Batterer Intervention Provider Certification Standards" (920 KAR 2:020) establishes the requirements for certification as an autonomous provider who shall be a licensed or certified mental health professional; and certification as an associate provider who may only operate under the supervision of an autonomous provider. Certain credentials, clinical experience, baseline training, and continuing education are required.

Procedures for Certification

Mental health professionals interested in becoming certified batterer intervention providers for their local court system shall make written application to the Kentucky Coalition Against Domestic Violence, Batterer Intervention Program Coordinator. Applicants must include documentation of education, experience, training, and, for associate providers, a signed supervision contract. The Coalition shall respond to the applicant in writing no later than sixty (60) days after receiving a complete request for certification. Certification lasts for two (2) years.

You must complete this application, including the required attachments specified, and submit it to:

Isela Arras, Program Director
iarras@kcadv.org
Kentucky Coalition Against Domestic Violence
111 Darby Shire Circle
Frankfort, Kentucky 40601
(502) 209-5382
Fax (502) 229-5382

Application Checklist

Associate Applicants:

- [ ] Application for Certification as a BIP
- [ ] Required Affirmation as a BIP
- [ ] Supervision agreement (must be signed by the applicant and the supervisor)
- [ ] Transcript of Bachelor's degree from an accredited college or university
- [ ] Letters of recommendation from two (2) victim advocates (one of whom must work for an agency separate from the applicant)
- [ ] Completion of BIP Certification Training (24 hours)
- [ ] Current resume/curriculum vitae or other documentation that demonstrates (2) two years and 4000 hours of relevant work experience
- [ ] Background check copy (current background check, if within one (1) year)
- [ ] Outline of the core curriculum for group participation that will be used
- [ ] Bio of provider

Required Affirmation

I agree to 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 for renewal.

I certify that the information given in this application and attachments hereto is correct and complete to the best of my knowledge. I acknowledge and agree that falsification of information given in this application or an attachment hereto constitutes sufficient grounds for denial or revocation of certification. I hereby authorize the Kentucky Coalition Against Domestic Violence 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 Kentucky Coalition Against Domestic Violence any information contained in this application.

I hereby certify that I have not been convicted of pleaded guilty to any offense listed in 920 KAR 2:020 Section 3(3)(a) within the past ten year period; I have not had a domestic violence protective order issued against me in the last 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 not had an alcohol or other drug abuse problem as defined in KRS 222.005 within the two years immediately prior to the date of this application.

Signature of Applicant :____

Printed Applicant Name: ____

Date: ____________________

Kentucky Coalition Against Domestic Violence
KCADV

Associate Applicant Information

NOTE: BIP certification follows person, not organization. Applicant personal information is for admin purposes only

Name: ____

Last Name: ____

Title (LPCA, LCSW, LPC, etc.): ____

Home address: ____

City, State, Zip Code: ____

Email address: ____

Mobile phone number: ____

Is texting acceptable?

☐ Yes ☐ No

*List college degree(s) and granting institution(s): ____

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*List professional License(s) and Certificate(s) held: ____

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**An applicant must attach verifiable documentary evidence of the qualifications required by 920 KAR 2:020 Section 4(diploma, certificate, licensure, etc.).*

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Kentucky Coalition Against Domestic Violence
KCADV

BIP Service Provision Information

**Please list address/contact information where services/groups will be provided. This information is what courts, referring agencies and your clients will see.*

Practice/Organization Name: ____

Address: ____

City, State, Zip Code: ____

County: ____

Phone number: ____

Fax number: ____

Email address: ____

Website address: ____

Organizational Facebook page: ____

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Organizational Contact Information

**if different than Service Provision Information*

Practice/Organization Name: ____

Address: ____

City, State, Zip Code: ____

County: ____

Phone number: ____

Fax number: ____

Email address: ____

Website address: ____

Organizational Facebook page: ____

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Satellite Office Information

**Please list all locations and addresses where you will provide services. Use additional forms, if necessary*

Practice/Organization Name: ____

Address: ____

City, State, Zip Code: ____

County: ____

Phone number: ____

Fax number: ____

Email address: ____

Website address: ____

Organizational Facebook page: ____

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County: ____

Phone number: ____

Fax number: ____

Email address: ____

Website address: ____

Organizational Facebook page: ____

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 years (4000 hours) of batterer intervention experience, I may recommend to the Coalition Against Domestic Violence that the they be granted autonomous function.

Signature of Supervisor: ____

Printed Name of Supervisor: ____

Date Signed: ____

Address: ____

City/State/Zip: ____

Telephone: ____

Email Address: ____

Signature of Applicant: ____

Printed Name of Supervisor: ____

***Make copies of this form and submit separately if multiple supervisors**