Application for Batterer Intervention Provider Certification

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" (922 KAR 5:020) 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 Department for Community Based Services, Division of Protection and Permanency, Batterer Intervention Program Administrator. Applicants must include documentation of education, experience, training, and, for associate providers, a signed supervision contract. The cabinet 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 and submit it to:

Batterer Intervention Provider Certification Program Administrator
275 East Main Street 3 C-G
Frankfort, Kentucky 40621
(502) 564-9433
Fax (502) 564-9500

Application Checklist

Autonomous Applicants:

- ☐ Application for Certification as a BIP
- ☐ Required Affirmation as a BIP
- ☐ Documentation of Supervised Work Experience for Autonomous Providers
- ☐ Transcript of Master's Degree From an Accredited College or University
- ☐ Copy of Professional License(s)
- ☐ 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)
- ☐ Background Check Copy (current background check, if within one (1) year)
- ☐ An Outline of the Core Curriculum for Group Participation That Will be Used
- ☐ Biography of Provider

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 Two (2) Years and 4,000 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
- ☐ Biography of Provider

Applicant Information

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

First name: _____

Last name: _____

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

Home address: _____

City, state, zip code: _____

Email address: _____

Mobile phone number: _____

Is texting acceptable?

☐ Yes ☐ No

Application type:

☐ Associate Provider ☐ Autonomous Provider

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

_____

_____

_____

*List professional license(s) and certificate(s) held: _____

_____

_____

_____

**An applicant must attach verifiable documentary evidence of the qualifications required by 922 KAR 5:020, Section 4 (diploma, certificate, licensure, etc.).*

DVPR-001
Rev. 04/2021

Batterer Intervention Provider (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: _____

———————————————————————————————————————

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: _____

———————————————————————————————————————

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: _____

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: _____

DVPR-001
Rev. 04/2021

Documentation of Supervised Work Experience for Autonomous Providers

This form is to be completed and signed by your work supervisor and is for applicants seeking autonomous function.*

I certify that _____ has completed _____ hours of clinical work providing domestic violence services.

This experience was divided approximately as follows:

_____ hours working with domestic violence offenders

_____ hours working with domestic violence victims

I further certify that I provided _____ hours of clinical supervision to the applicant. As a result of my supervision and experience with the 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): _____

Date of signature: _____

Address: _____

City/state/zip: _____

Telephone: _____

Email address: _____

Make copies and submit separately if multiple supervisors.

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 (4,000 hours) of batterer intervention experience, I may recommend to the Coalition Against Domestic Violence that 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**