Rev. 1-2021

Application for ***Approved Program Status*** with The Kentucky Department of Corrections For Facilitators of Reentry Programs

I. TYPE OF CLASS TO BE OFFERED *(Check all that apply.)*

- ☐ Portal New Direction (PND)
- ☐ MRT Mentor
- ☐ MRT Anger Management
- ☐ MRT Untangling Relationships
- ☐ Moral Reconation Therapy (MRT)
- ☐ MRT Thinking for Good
- ☐ MRT Staying Quit
- ☐ MRT Parenting and Family Values

II. TYPE OF AGENCY

- o Government Agency
- o Private Organization
- o Non-Profit Agency
- o Corporate Agency

III. IDENTIFICATION

Facilitator Name: _____

Name of Facility or Group Affiliation: _____

Physical Location for Class: _____
(Street) (City)

_____
(County) (State) (Zip Code)

Mailing Address: _____
(If different from above) (Street) (City)

_____
(County) (State) (Zip Code)

Telephone Number: _____

Email Address: _____
(Primary contact for correspondence)

Name of Supervisor: _____

IV. PRIMARY FACILITY/GROUP CONTACT (if different from section III)

Name: _____

Address: _____
(Street) (City)

_____
(County) (State) (Zip Code)

NOTE: Provide the following supporting documentation as an attachment to this application:

- The name, mailing address, email address, and phone number of each person or legal entity having an ownership interest in the facility.
- If owned by a corporation, the name, mailing address, email address, and phone number of each officer or director of the corporation.
- If owned by a partnership, the name, mailing address, email address, and phone number of each partner.

V. PROGRAM EXTENTION SITES (*If more than one extension site, please attach the following information to the application.)*

a. Number of existing location sites, excluding primary location: _____

b. Location information: (If more than one outpatient extension location exists, provide the following information as an attachment to this application.)

Name of Extension Site: _____

Physical Location: _____
(Street) (City)

_____
(County) (State) (Zip Code)

Telephone Number: _____
(Include Area Code)

Director/Administrator: _____

VI. EVIDENCE BASED CURRICULUM

(Please include information for each evidence-based curriculum used in the program. Attach additional curriculum information to this application.)

Name of Curriculum: _____

Who taught staff to facilitate the program: _____

When did staff receive training to facilitate the program: _____

Are staff required to receive training or become certified to facilitate? ☐ Yes ☐ No

If yes, how many staff have received the training and/or certified? _____

VII. GROUP DYNAMICS (*Check all that apply)*

Groups offered: ☐ AM ☐ Afternoon ☐ Evening

Gender Specific Groups: ☐ Yes ☐ No

VII. ADDITIONAL DOCUMENTATION CHECKLIST *(To be attached.)*

- Documentation of all program certificates obtained by staff relating to facilitating the program.
- List of all program staff, including administrative staff not involved in the provision of programming
- Other Information About Your Agency or Program

IX. SIGNATURE OF AUTHORIZED REPRESENTATIVE

An incomplete application may result in return of the application to the applicant. A completed application should be submitted to the Kentucky Department of Corrections at the address listed at the bottom of the document.

I understand that **any change** in the information provided within this application affecting the approval status of this agency or service will be reported to the Department of Corrections within three (3) business days, Division of Reentry Services and a new application will be completed or supplemental information will be provided. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application may result in denial or revocation of licensure.

_____

Signature of Authorized Representative **Title** **Date**

Submit the application and any supportive documentation to:

Kentucky Department of Corrections
Division of Reentry Services
275 East Main Street
Frankfort, KY 40601
KYDOC.ReentryServices@ky.gov