III.

V.

Application for <u>Approved Program Status</u> with The Kentucky Department of Corrections For Facilitators of Reentry Programs

I. TYPE OF C	TYPE OF CLASS TO BE OFFERED (Check all that apply.)					
MRT Men MRT Ang MRT Unta	 Portal New Direction (PND) MRT Mentor MRT Anger Management MRT Untangling Relationships MRT Breaking the Chains of Trauma 		 Moral Reconation Therapy (MRT) MRT Thinking for Good MRT Staying Quit MRT Parenting and Family Values 			
II. TYPE OF A	GENCY					
	ernment Agency te Organization	0 0	Non-Profit Agency Corporate Agency			
IDENTIFICATION						
Facilitator Name:						
Name of Facility or G	roup Affiliation:					
Physical Location for	Class:					
	(Street)	(City)				
Mailing Address:	(County)	(State)	(Zip Code)			
(If different from above)	(Street)	(City)				
	(County)	(State)	(Zip Code)			
Telephone Number: _						
Email Address:						
, , , , , , , , , , , , , , , , , , ,	ary contact for correspondence)					
Name of Supervisor:						

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

ddress:	(Street)	(City)		
	(County)	(State)	(Zip Code)	
			n as an attachment to this applicat	ion

PROGRAM EXTENSION 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 extension location exists, provide the following information as an attachment to this application.)

	Name of Extensior	n Site:			
	Physical Location:				
		(Street)	(City)		
		(County)	(State)	(Zip Code)	
	Telephone Numbe	r:			
		(Include Area Code)			
	Director/Administra	ator:			
VI.	application.)	each evidence-based curriculu	m used in the program. Attach addit		
	Name of Curriculum:				
	Who taught staff to facilitate the program:				
	When did staff receive training to facilitate the program:				
	Are staff required to rece	ive training or become ce	ertified to facilitate? \Box Yes	□ No	
	If yes, how many staff ha	ve received the training a	and/or certified?		
VII.	GROUP DYNAMICS (Check all that apply)			
	Groups offered:	AM 🗆 Afternoon	Evening		
	Gender Specific Groups:	🗆 Yes 🛛 No			
VII.	ADDITIONAL DOCUM		ST (To be attached.)		

- o 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
- o 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 applic	ation and any supportive o	locumentation to:			
Kent	Kentucky Department of Corrections				
	S				
	Frankfort, KY 40601				

Program.Approval@ky.gov