#### **SUBMIT APPLICATION TO:**

Alaska Native Tribal Health Consortium

Community Health Aide Program Certification Board
4115 Ambassador Drive, 3rd Floor
Anchorage, Alaska 99508

Phone: 907-729-3624, Fax: 907-729-3629, Email: chapcb@anthc.org

**INSTRUCTIONS:** Please print or type information and <u>do not use white out</u>. Use a black or blue pen. If there is an error, please cross it out, write the correct information, initial and date any changes. This document requires the signatures of the applicant, employer and supervising clinician.

1.	Applicant Name:				FOR OFFICIAL USE ONLY
	(Full Legal Name)	Last	First	MI	
2.	Other Names Used:				Received
		Last	First	MI	
3.	Date of Birth:				Action
•		Month	Day	Year	-
4.	Social Security Numb	er (last 4 digits):			
5.	Gender (optional):	Female	Male		
6.	Ethnic Origin: (Optional)	Alaska Native American Indian Other	Asian or Pacific Islar African American	nder Caucasian Hispanic	
7.	Home Address:				
	City:		State:	Zip:	
8.	Employment Status:	Full Time	Part Time Itiner	rant Intermittent	
9.	Employer:				
10.	Employer Address: _				
	City:		State:	Zip:	
11.	Work Phone #:		Fax #:		
12.	Work E-Mail:				

## Requirements

13. Ap	plication type (check one):					
	Initial Certification					
	Renewal (every 2 years)					
	Change in level					
	· ·					
14. Applicant is applying for the following level of certification (check one):						
	Behavioral Health Aide I (BH	Α	l) □ Behavioral Health A	۸ide	e III (BHA III)	
	Behavioral Health Aide II (BF	łΑ	II) ☐ Behavioral Health P	ra	ctitioner (BHP)	
15. If previously certified, what is your certification number:						
	Wh	at	is the level of practice:			
What is the expiration date:						
	•					
*If the training program was completed more than two years prior to the application date, attach BHA/P Certification Continuing Education Log (Form 10-08B) documenting 40 hours of Continuing Education in the two years prior to the application date.						
	BHA/P Training Certification		BHA/P Change in Level		BHA/P Renewal Certification	
	BHA/P Training Log* (Form 14-16B or Form 14-17B)		BHA/P Training Log* (Form 14-16B or Form 14-17B)		BHA/P Certification Continuing Education Log (Form 10-08B)	
	Clinical Practicum Log Signature Page (Form 12-11B, 12-12B, 12-13B, or 12-14B)		Clinical Practicum Log Signature Page (Form 12-11B, 12-12B, 12-13B, or 12-14B)		BHA/P Knowledge & Skills Checklist Scoring Summary and Signature Pages (Form 10-09B)	
	☐ BHA/P Knowledge & Skills Checklist Scoring Summary and Signature Pages (Form 10-09B)		BHA/P Knowledge & Skills Checklist Scoring Summary and Signature Pages (Form 10-09B)			

## **Employer Verification**

17.	I verify that		(print name of applicant):		
Pleas	e <b>check</b> each item on lines 19 through 21.				
18.	The applicant has completed the training and education requirements and is competent to practice at the level of certification being sought. The information provided on Form 14-15B, Application for Behavioral Health Aide/Practitioner Certification, is accurate.				
19.	program operating a community	heaĺth a	e Indian Health Service, a tribe, or tribal health ide program in Alaska under the Indian Selfct [PL 93-638, 25 U.S.C. 450 et seq.].		
20.	The application fee of \$750.00 is e	nclosed;	or		
21.	The application fee of \$750.00 will	be sent	separately.		
New A	Application Fee of \$750.00 applies to all application	ons recei	ved on & after December 2, 2023.		
Please	e make check payable to the Alaska Native Tribal	Health C	Consortium - ATTN: CHAPCB.		
22.		23.			
	Supervisor's Name (Please Print)		Supervisor's Title (i.e.: BHA/P Director, Medical Director, Chief Executive Officer or other person authorized to sign on behalf of the organization)		
24.					
	Supervisor's Signature		Date		
Pleas	e <b>check</b> item 25.				
25.	clinical oversight is provided by a li BHA/P program, the Standards, ar or employed by or under contract vaide program in Alaska under the IS behavioral health clinicians or be licensed qualified healthcare profet day-to-day activities of a behavior	censed I nd the BI with a tri SDEAA. chavioral essionals ral health I health	under a behavioral health aide program in which behavioral health clinician, who is familiar with the HAM; and is employed by the federal government bal health program operating a community health This requirement does not preclude other licensed health professionals, or other independently-designated by the referral clinician directing the aide or behavioral health practitioner under the clinician providing clinical supervision.		
26.		27.			
	Licensed Behavioral Health Professional's Name (Please Print)		Credential		
28.	Oi-mark mark		Duta		
	Signature		Date		

## **Applicant Verification**

29.	I verify th	nat	(print name of applica	ınt):
Pleas	se <b>check</b> e	each item on lines 30 through 35.		
30.		, ,	mmunity Health Aide Program Certification Eended, and have read this document.	}oard
31.		I have not engaged in conduct the under Chapter 4 of the document a	at is grounds for imposing disciplinary sand bove.	tions
32.		I have completed the training and e being sought.	education requirements for the level of certific	ation
33.		, , , ,	ian Health Service, a tribe, or tribal health prop program in Alaska under the ISDEAA [PL 93	_
34.			en employed by the Indian Health Service, a a community health aide program in Alaska u 450 et seq.].	
35.		health clinician who is familiar with tand is employed by the federal governibal health program operating a constraint of ISDEAA. This requirement does clinicians or behavioral health professional security.	er the clinical supervision of a licensed behave the BHA/P program, the <i>Standards</i> and the Bhavernment or employed by or under contract wommunity health aide program in Alaska under not preclude other licensed behavioral has fessionals directing the day-to-day activities aral health practitioner under the direction of providing clinical supervision.	HAM; vith a er the ealth of a
inforr provi	nation to tl sions or pr	he CHAP Certification Board. I under	ve responsibilities and have provided acc rstand that failure to comply with any of the a in disciplinary action by the Board and may r	bove
36.	Signatur	e of Applicant	 Date	
	Signatur	c oi Applicatit	שמוכ	

#### RELEASE OF INFORMATION AND VERIFYING SIGNATURE

37.	I, (name of applicant), authorize the Indian Health Service,					
	Community Health Aide Program Certification Board (CHAPCB administered by Alaska Native Tribal					
	Health Consortium), to examine my education records and any law enforcement records pertaining to					
	me and to discuss them with persons having possession of them. I also expressly permit and authorize release of such records pertaining to me to the Indian Health Service, CHAPCB.					
	I authorize the IHS, CHAPCB to discuss my records with persons or organizations, which are considered					
	appropriate by the IHS, CHAPCB in connection with an official investigation, and to provide copies of my records to those persons or organizations, if appropriate.					
	I understand that records disclosed to the IHS, CHAPCB may become part of a public record and may not be protected from further disclosure by law.					
	This authorization is given expressly in connection with my application for certification as a Behavioral Health Aide/Practitioner. This authorization expires at the expiration of my certification.					
	I consent to the release of information described above and I certify under penalty of perjury that the foregoing is true and accurate.					
38.						
	Signature of Applicant Date					

#### Important Notes Regarding This Application

The information contained in this application for certification and in your permanent Community Health Aide Program Certification Board (CHAPCB) certification record at the ANTHC CHAP Office is considered a "Public Record" and is not protected from disclosure by law. By completing this application and signing it, you are confirming the accuracy of the information entered on the application.

Your CHAPCB certification records may be kept in electronic, paper, and microfilm formats. You have a right to request a copy of your records at any time. Any individual has the right to inspect and copy public records under reasonable rules and during regular office hours. All requests must be made in writing. Information, which is non-disclosable, will not be made available.

The \$750.00 application fee will provide operational support for the CHAPCB for two years. Should operating costs be lower than anticipated, fees for future periods will be reduced accordingly.

It is the responsibility of the applicant to keep the CHAPCB informed of his or her current mailing address. The department will send correspondence, including applications for recertification, to the address on file.

If any individual believes information contained in his or her certification records is incorrect, the individual should notify the ANTHC, CHAPCB in writing, of the perceived error. The address of the Board is:

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