

Community Health Aide Program Certification Board Application for Behavioral Health Aide/Practitioner Certification

Requirements

13. Application 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 (BHA I)
- Behavioral Health Aide II (BHA II)
- Behavioral Health Aide III (BHA III)
- Behavioral Health Practitioner (BHP)

15. If previously certified, what is your certification number: _____

What is the level of practice: _____

What is the expiration date: _____

16. Based on level of certification and application type; Attach the following forms to this application. A full copy of the certification application should be kept in the employee file.

*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.

<p>BHA/P Training Certification</p> <p><input type="checkbox"/> BHA/P Training Log* (Form 14-16B or Form 14-17B)</p> <p><input type="checkbox"/> Clinical Practicum Log Signature Page (Form 12-11B, 12-12B, 12-13B, or 12-14B)</p> <p><input type="checkbox"/> BHA/P Knowledge & Skills Checklist Scoring Summary and Signature Pages (Form 10-09B)</p>

<p>BHA/P Change in Level</p> <p><input type="checkbox"/> BHA/P Training Log* (Form 14-16B or Form 14-17B)</p> <p><input type="checkbox"/> Clinical Practicum Log Signature Page (Form 12-11B, 12-12B, 12-13B, or 12-14B)</p> <p><input type="checkbox"/> BHA/P Knowledge & Skills Checklist Scoring Summary and Signature Pages (Form 10-09B)</p>

<p>BHA/P Renewal Certification</p> <p><input type="checkbox"/> BHA/P Certification Continuing Education Log (Form 10-08B)</p> <p><input type="checkbox"/> BHA/P Knowledge & Skills Checklist Scoring Summary and Signature Pages (Form 10-09B)</p>

**Community Health Aide Program Certification Board
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Employer Verification

17. I verify that _____ (print name of applicant):

Please **check** 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. _____ The applicant is currently employed by the Indian Health Service, a tribe, or tribal health program operating a community health aide program in Alaska under the Indian Self-Determination and Education Assistance Act [PL 93-638, 25 U.S.C. 450 et seq.].

20. _____ The application fee of \$750.00 is enclosed; or

21. _____ The application fee of \$750.00 will be sent separately.

New Application Fee of \$750.00 applies to all applications received on & after December 2, 2023.

Please make check payable to the Alaska Native Tribal Health Consortium – ATTN: CHAPCB.

22. _____ Supervisor's Name (Please Print)	23. _____ 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

Please **check** item 25.

25. _____ The applicant will only practice as a BHA/P under a behavioral health aide program in which clinical oversight is provided by a licensed behavioral health clinician, who is familiar with the BHA/P program, the Standards, and the BHAM; and is employed by the federal government or employed by or under contract with a tribal health program operating a community health aide program in Alaska under the ISDEAA. This requirement does not preclude other licensed behavioral health clinicians or behavioral health professionals, or other independently-licensed qualified healthcare professionals designated by the referral clinician directing the day-to-day activities of a behavioral health aide or behavioral health practitioner under the direction of the licensed behavioral health clinician providing clinical supervision. See [CHAPCB 2.40.010(a) Clinical Oversight.]

26. _____ Licensed Behavioral Health Professional's Name (Please Print)	27. _____ Credential
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28. _____ Signature	_____ Date
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Applicant Verification

29. I verify that _____ (print name of applicant):

Please **check** each item on lines 30 through 35.

30. _____ I have received a copy of *the Community Health Aide Program Certification Board Standards and Procedures, as amended*, and have read this document.

31. _____ I have not engaged in conduct that is grounds for imposing disciplinary sanctions under Chapter 4 of the document above.

32. _____ I have completed the training and education requirements for the level of certification being sought.

33. _____ I am currently employed by the Indian Health Service, a tribe, or tribal health program operating a community health aide program in Alaska under the ISDEAA [PL 93-638, 25 U.S.C. 450 et seq.].

34. _____ I will only practice as a BHA/P when employed by the Indian Health Service, a tribe, or tribal health program operating a community health aide program in Alaska under the ISDEAA [PL 93-638, 25 U.S.C. 450 et seq.].

35. _____ I will only practice as a BHA/P under the clinical supervision of a licensed behavioral health clinician who is familiar with the BHA/P program, the *Standards* and the BHAM; and is employed by the federal government or employed by or under contract with a tribal health program operating a community health aide program in Alaska under the ISDEAA. This requirement does not preclude other licensed behavioral health clinicians or behavioral health professionals directing the day-to-day activities of a behavioral health aide or behavioral health practitioner under the direction of the licensed behavioral health clinician providing clinical supervision.

I verify that I have considered each of the above responsibilities and have provided accurate information to the CHAP Certification Board. I understand that failure to comply with any of the above provisions or providing false information may result in disciplinary action by the Board and may result in the surrender of my certificate as a BHA/P.

36. _____
Signature of Applicant

Date

