Community Health Aide Program Certification Board

Application for Behavioral Health Aide/Practitioner Certification

**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**](mailto:chapcb@anthc.org)

**INSTRUCTIONS:** Please print or type information and do not use white out. 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 physician.

**FOR OFFICIAL**

**USE ONLY**

#### Received

#### Action

1. Applicant Name:

(Full Legal Name) Last First MI

1. Other Names Used:

Last First MI

1. Date of Birth:

Month Day Year

4. Social Security Number (last 4 digits):

|  |  |  |  |
| --- | --- | --- | --- |
|  | Female |  | Male |

5. Gender (optional):

6. Ethnic Origin:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Alaska Native |  | Asian or Pacific Islander |  | Caucasian |
|  | American Indian |  | African American |  | Hispanic |
|  | Other | | | | | |

(Optional)

1. Home Address:

City: State: Zip: \_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Full Time |  | Part Time |  | Itinerant |  | Intermittent |

8. Employment Status:

9. Employer:

10. Employer Address:

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_

11. Work Phone #: Fax #:

12. Work E-Mail:

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**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 III (BHA III)
* Behavioral Health Aide II (BHA II) 🗆 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.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 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) |

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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 $500.00 is enclosed; or

21. The application fee of $500.00 will be sent separately.

Please make check payable to the Alaska Native Tribal Health 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 |

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. |  | 27. |  |
|  | Licensed Behavioral Health Professional’s Name (Please Print) |  | Credential |
| 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

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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 $500.00 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:

Community Health Aide Program Certification Board

c/o Alaska Native Tribal Health Consortium

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Anchorage, Alaska 99508

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Email: chapcb@anthc.org