

Community Health Aide Program Certification Board Application for BHA/P Change in Level/Renewal of Certification

Requirements

14. I am applying for recertification and or upgrade as a (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. Education:

Undergraduate / Graduate:

School Name: _____

City/State: _____

Degree: _____ Major: _____ Graduation Date: _____

School Name: _____

City/State: _____

Degree: _____ Major: _____ Graduation Date: _____

School Name: _____

City/State: _____

Degree: _____ Major: _____ Graduation Date: _____

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Checklist

16. Please check each item:

BHA/P Knowledge & Skills Checklist (Form 10-09B) completed.
Do not submit - keep in BHA employee file.
See [CHAPCB 2.40.500]*

BHA/P Cultural Competency Checklist (Form 10-10B) completed.
Do not submit - keep in BHA employee file.
(Including the BHA/P Letter of Recommendation from a Tribal Endorser)
See [CHAPCB 2.40.510(b)(2)]*

Date Clinical Practicum was completed: _____

(This date signifies the applicant's completion of all required training, and satisfactory completion of 100 hours of clinical practicum for each level of certification.)

17. Attachments:

For **Renewal** application only:

BHA/P Continuing Education Log (Form 10-09B) documenting 40 contact hours of continuing education.
See [CHAPCB 3.10.070]*

For **Change in Level:**

BHA/P Training Log (Form 10-05B)
See [CHAPCB 2.40.500]*

BHA/P Knowledge & Skills Checklist Signature Page (Form 10-09B).
See [CHAPCB 2.40.500]

**Community Health Aide Program Certification Board Standards and Procedures, as amended.*

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Employer Verification

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

Please **check** each item on lines 19 through 21.

19. _____ 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 10-04B, Application for BHA/P Change in Level/Renewal of Certification, is accurate.

20. _____ 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.].

21. _____ The application fee of \$400.00 is enclosed; **or**
_____ The application fee of \$400.00 will be sent separately.

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 CHA/P program, the *Standards* and the CHAM; 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.

26. _____ Supervising Clinician's Name (Please Print)	27. _____ Supervising Clinician's Title
28. _____ Supervising Clinician's Signature	_____ Date

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