



**Community Health Aide Program Certification Board  
Application for Initial BHA/P Certification**

**Requirements**

13. I am applying for certification as a:

  

Behavioral Health Aide I (BHA I)  
Behavioral Health Aide III (BHA III)

  

Behavioral Health Aide II (BHA II)  
Behavioral Health Practitioner (BHP)

14. I have been certified before as a:

  
  
  
  
  
  

Community Health Aide I (CHA I)  
Community Health Aide II (CHA II)  
Community Health Aide III (CHA III)  
Community Health Aide IV (CHA IV)  
Community Health Practitioner (CHP)  
Other Certification or Licensure (Please specify): \_\_\_\_\_  
Licensed Where: \_\_\_\_\_

  
  
  

Traditional Counselor (TC)  
Counselor Technician (CT)  
Chemical Dependency Counselor I (CDC I)  
Chemical Dependency Counselor II (CDC II)

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:

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

BHA/P Knowledge & Skills Checklist Signature Page (Form 10-09B).  
See [CHAPCB 2.10.010(b)(2)(C)]\*

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

# Community Health Aide Program Certification Board Application for Initial BHA/P Certification

## 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 10-01B, Application for Initial BHA/P 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
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28. _____ Supervising Clinician's Signature	_____ Date
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# Community Health Aide Program Certification Board Application for Initial BHA/P Certification

## 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 or a behavioral health professional who is familiar with the CHAP 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.

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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