



12. Employer Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
13. Work Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_
14. Work E-Mail: \_\_\_\_\_ Alternate email: \_\_\_\_\_

**Portland Area Community Health Aide Program Certification Board  
 Application for Behavioral Health Aide/Practitioner Certification**

**Requirements**

15. Application type (check one):

- Initial Certification
- Renewal (every 2 years)
- Change in level

16. 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)

17. If previously certified: Level of practice: \_\_\_\_\_

Certification expiration date: \_\_\_\_\_

Board providing certification/license: \_\_\_\_\_

18. 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.

<p><b>BHAP Training Certification</b></p> <p><input type="checkbox"/> Copy of ATA degree/BHA Certificate from NWIC/HU.</p> <p><input type="checkbox"/> <b>(For Alaska Level BHP only)</b> AK BHA/P Training Log</p> <p><input type="checkbox"/> Clinical Practicum Log &amp; Signature Page</p> <p><input type="checkbox"/> BHA/P Knowledge &amp; Skills Checklist Scoring Summary and Signature Pages</p>
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<p><b>BHA/P Change in Level</b></p> <p><input type="checkbox"/> Copy of ATA degree/BHA Certificate from NIWC/HU.</p> <p><input type="checkbox"/> <b>(For Alaska Level BHP only)</b> AK BHA/P Training Log</p> <p><input type="checkbox"/> Clinical Practicum &amp; Log Signature Page</p> <p><input type="checkbox"/> BHA/P Knowledge &amp; Skills Checklist Scoring Summary and Signature Pages</p>
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<p><b>BHA/P Renewal Certification</b></p> <p><input type="checkbox"/> BHA/P Certification Continuing Education Log</p> <p><input type="checkbox"/> BHA/P Knowledge &amp; Skills Checklist Scoring Summary and Signature Pages</p>
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**Portland Area Community Health Aide Program Certification Board  
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**Employer Verification**

19. I verify that \_\_\_\_\_ (print name of applicant):

Please **check** each item on lines 20 through 21.

20. \_\_\_\_\_ 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 21/11-01b, Application for Behavioral Health Aide/Practitioner Certification, is accurate.

21. \_\_\_\_\_ The applicant is currently employed by the Indian Health Service, a tribe, or tribal health program operating a community health aide program in Oregon, Washington, or Idaho, or other IHS area.

22. \_\_\_\_\_  
Supervisor Name (Please Print)

23. \_\_\_\_\_  
Title  
(i.e.: Behavioral Health Director, Medical Director, Chief Executive Officer or other person authorized to sign on behalf of the organization)

24. \_\_\_\_\_  
Supervisor 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 or behavioral health professional, 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 Oregon, Washington, or Idaho, or other IHS area. 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 or behavioral health professional providing clinical supervision. See [PACCB 2.40.010(a) Clinical Oversight.]

26. \_\_\_\_\_  
Licensed Behavioral Health Clinician or Professional's Name (Please Print)

27. \_\_\_\_\_  
Credential

28. \_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



