Behavioral Health Support Specialist Certification Application Packet

Contents:

Important Social Security Number Information:

If you have a Social Security Number, the law requires you to disclose it on your application for a professional or occupational license. 42 U.S.C. § 666(a)(13); RCW 26.23.150. It will be used under the state's child support enforcement program to locate individuals for purposes of establishing paternity and establishing, modifying, and enforcing support obligations. You are not required to have or obtain a Social Security Number to apply for or obtain a license from the Department of Health. If you do not have a Social Security Number, you are still eligible to apply for and obtain a credential if you meet the requirements. Please see the Declaration of No Social Security Number Form. Please call the Customer Service Center at 360-236-4700 if you have questions.

In order to process your request:

Mail your application with initial documentation and your check or money order payable to:

Department of Health
P.O. Box 1099
Olympia, WA 98507-1099

Send other documents not sent with initial application to:

Behavioral Health Support Specialist Credentialing
P.O. Box 47877
Olympia, WA 98504-7877

Contact us:

360-236-4700

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email doh.information@doh.wa.gov.

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Application Instructions Checklist

Important background check Information: Washington State law authorizes the Department of Health to obtain fingerprint-based background checks for licensing purposes. This check may be through the Washington State Patrol and the Federal Bureau of Investigation (FBI). This may be required if you have lived in another state or if you have a criminal record in Washington State. This would be at your own expense.

All information should be printed clearly in blue or black ink. It is your responsibility to submit the required forms.

☐ **Application Fee**. This fee is non-refundable. You can check the online **fee page** for current fees.

☐ **Select if the following applies:**
Spouse or Registered Domestic Partner of Military Personnel

☐ **1. Demographic Information:**
Social Security Number: You must list your social security number on your application. You are not required to have or obtain a Social Security Number to apply for or obtain a license from the Department of Health. Please see the Declaration of No Social Security Number Form. Please call the Customer Service Center at 360-236-4700 if you do not have one.

National Provider Identifier Number (NPI): The National Provider Identifier (NPI) is a standard unique identifier for health care professionals available from the Federal Centers for Medicare and Medicaid Services. The NPI is a 10 digit numeric identifier. If you have a NPI number, provide this on your application.

Legal Name: List your full name: first, middle, and last.

Definition of legal name: “Legal name” is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.

Birth date: Provide the month, day, and year of your birth.

Address: List the address we should use to send any information about your registration. Be sure to include the city, state, zip code, county, and country. This will be your permanent address with the Department of Health until we have been notified of a change. See **WAC 246-12-310**.

Phone, Fax, and Cell Numbers: Enter your phone, fax, and cell numbers, if you have them.

Email: Enter your email address, if you have one.

Other Name(s): Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include proof of this change. See **WAC 246-12-300**.

☐ **2. Personal Data Questions:**
All applicants must answer the same personal data questions. They are focused on your fitness to practice the essential skills of this profession.

If you answer “yes” to any questions in this section, you must provide an appropriate explanation. You must also provide the documentation listed in the note after the question. If you do not provide this, your application is incomplete and it will not be considered.

- Question 5 includes misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. You can get copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- If you have been granted certificate(s) of restoration of opportunity, please provide a certified copy of each certificate.
- Another jurisdiction means any other country, state, federal territory, or military authority.

☐ **3. Other License, Certification, or Registration:**
List all states, including Washington, where credentials are or were held. Attach additional pages if you need more space.

☐ **4. Education:**
To qualify for this credential, applicants must graduate from an approved Behavioral Health Support Specialist education program or approved and registered Behavioral Health Support Specialist apprenticeship program, and successfully complete a bachelor’s degree from an approved college or university. Please request official transcripts to be sent directly from your college or university to us.

☐ **5. Experience:**
List your practicum site, total hours, and dates of your required practicum included in the approved Behavioral Health Support Specialist education program (240-hour minimum over at least 5 months).

☐ **6. Applicant’s Attestation:**
You must sign and date this attestation for the department to process the application.

For Spouses and Registered Domestic Partners of Military Personnel Being Transferred or Stationed in Washington:

Under state law, if you are the spouse or state-registered domestic partner of a servicemember of any branch of the U.S. Military, to include Guard or Reserve, and are applying for a health care professional credential in this state, you may be eligible to have the processing of your application expedited to receive your credential more quickly.

Documents to submit with your application should include the following:

- A copy of your spouse's or registered domestic partner's military transfer orders to Washington State.
- One of the following:
  - A copy of your marriage certificate to show proof of marriage; or
  - A copy of a state's declaration or registration showing you are in a state registered domestic partnership with a member of the U.S. military.

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Credential Requirements

Thank you for applying for the Behavioral Health Support Specialist credential. To complete your application, please submit the following:

- Completed application and fee

Education:

- Provide official transcripts showing proof of completion of a bachelor's degree or higher from an approved school, **and**
- Documentation of completing an approved Behavioral Health Support Specialist Education program or approved and registered Behavioral Health Support Specialist Apprenticeship program. Transcripts must be submitted directly from the college or school.

Experience:

Applicants for Behavioral Health Support Specialist must complete a supervised practicum lasting at least 240 hours over at least five months as part of their approved educational program. All practicum experience must be under an approved supervisor.
See WAC 246-821-215 for approved supervisor requirements.
See WAC 246-821-200 for practicum requirements.

Jurisprudence Examination:

After all documents have been received and the application is complete, you will be approved to complete the jurisprudence examination online.

Your Behavioral Health Support Specialist certificate will be issued after successfully passing the jurisprudence examination with a minimum score of 95 percent.

Jurisprudence Examination Topics:

You should know and understand Washington State statutes and rules and how they relate to the practice of a Behavioral Health Support Specialist in this state. These areas of statute and rule include, but are not limited to:

RCW 18.227 Behavioral Health Support Specialist Laws
RCW 18.130 Uniforms Disciplinary Act
RCW 70.02 Health Care Information Act
RCW 26.44 Abuse of Children
RCW 71.05 Mental Illness Act
RCW 74.34 Abuse of Vulnerable Adults
WAC 246-15 Whistleblower Complaints
WAC 246-12 Administrative Procedures & Requirements for Credentialed Health Care Providers
WAC 246-16 Standards of Professional Conduct
WAC 246-821 Behavioral Health Support Specialist Rules

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Washington State Department of HEALTH

Date Stamp Here

Revenue 0597649550

Behavioral Health Support Specialist Certification Application

Please print clearly. It is the responsibility of the applicant to submit or request all required supporting documents be submitted. Failure to do so may result in a delay in processing your application.

Select if the following applies: ☐ Spouse or Registered Domestic Partner of Military Personnel

1. Demographic Information

Social Security Number (SSN) (If you do not have a SSN, see instructions)	**National Provider Identifier Number (NPI)** (Enter 10 digit number)	☐ Male ☐ Female ☐ Prefer Not to Answer ☐ X

Name First Middle Last

Birth date (mm/dd/yyyy)

Address

City	State	Zip Code	County

Country

Phone (enter 10 digit #)	Fax (enter 10 digit #)	Cell (enter 10 digit #)

Email address

Mailing address if different from above address of record

City	State	Zip Code	County

Country

Note: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information with the department.

Have you ever been known under any other name(s)? ☐ Yes ☐ No
If yes, list name(s):

Will documents be received in another name? ☐ Yes ☐ No
If yes, list name(s):

2. Personal Data Questions

Yes No

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation. ☐ ☐

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disabilities, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

If you answered yes to question 1, explain:

1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.

1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

Note: If you answered "yes" to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.

The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

"Currently" means within the past two years.

"Chemical substances" include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism? ☐ ☐

4. Are you currently engaged in the illegal use of controlled substances? ☐ ☐

"Currently" means within the past two years.

Illegal use of controlled substances is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? ☐ ☐

Note: If you answered "yes" to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.

If you have been granted certificate(s) of restoration of opportunity, please provide a certified copy of each certificate.

To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.

2. Personal Data Questions (cont.)

	Yes	No
6. Have you ever been found in any civil, administrative or criminal proceeding to have:		
a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes?	☐	☐
b. Diverted controlled substances or legend drugs?	☐	☐
c. Violated any drug law?	☐	☐
d. Prescribed controlled substances for yourself?	☐	☐
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", please attach an explanation and provide copies of all judgments, decisions, and agreements?	☐	☐
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority?	☐	☐
9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority?	☐	☐
10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession?	☐	☐
11. Have you ever been disqualified from working with vulnerable persons by the Department of Social and Health Services (DSHS)?	☐	☐

3. Other License, Certification, or Registration

List all states where credentials are or were held. Attach additional pages if you need more space.

State	License/Certification/ Registration Type	License/Certification/Registraton		Method of Licensure		
		Year Issued	Number	Exam	Endorse	Grandfathered

4. Education

List in date order all your post-secondary school(s) attended, major, month and year the degree was granted. Request your transcripts from the post-secondary school(s) you attended, and have the school send transcripts directly to the Department of Health.

School	Degree	Major	Date Degree Granted

5. Practicum Experience

List by date all practicum sites completed as part of your BHSS Educational Program.

Practicum Site	Total Hours	Dates Started	Date Completed

6. Applicant's Attestation

I, _____ , declare under penalty of perjury under the laws of
(Print applicant name clearly)
the state of Washington that the following is true and correct:

- I am the person described and identified in this application.
- I have read **RCW 18.130.170** and **RCW 18.130.180** of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.
- I have read all laws and rules related to my profession.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand that I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated _____ at _____
(mm/dd/yyyy) (City, state)

By: _____
(Signature of applicant)

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Washington State Department of HEALTH
Behavioral Health Support Specialist
CredentialingP.O. Box 47877
Olympia, WA 98504-7877
360-236-4700

Verification of Behavioral Health Support Specialist Supervision and Practicum Experience

Note: Use one form per supervisor for each practicum site.

Applicant

Name: Last	First	Middle	Birth Date (mm/dd/yyyy)

Address		

City	State	Zip Code

Phone (enter 10 digit #)	Business Phone (enter 10 digit #)

Direct Supervisor

The above applicant requires verification of supervised experience for certification as a Behavioral Health Support Specialist. Please complete the following.

Supervisor Name: Last	First	Middle	Credential #

Practicum Site Name	

Street Address	Phone (enter 10 digit #)

City	State	Zip Code

Supervised Practicum Experience (WAC 246-81-200) From (mm/dd/yyyy): To (mm/dd/yyyy):

I attest that the applicant named above was under my supervision for an approved Behavioral Health Support Specialist practicum. This applicant has achieved competency as a Behavioral Health Support Specialist and has demonstrated at least one clinical skill in each competency listed in WAC 246-821-110. This practicum site and my supervision met the requirements of WAC 246-821-210.

Signature of Supervisor _____ Date _____

Direct Supervisor Attestation	Total Hours	Initial
This applicant completed at least 60 hours in direct client contact, including the co-delivery of services alongside a supervisor or other certified or licensed behavioral health provider or substance use disorder professional.		
This applicant completed at least 240 total hours in this practicum.		
This applicant completed at least 12 hours of individual supervision in this practicum.		

Verification of Behavioral Health Support Specialist Supervision and Practicum Experience

Note to Supervisor:

To be considered an appropriate supervisor, you must be licensed in the state of Washington, with no license restrictions, as one of the following provider types:

(1) Independent clinical social worker or associate licensed under chapter 18.225 RCW;

(2) Marriage and family therapist or associate licensed under chapter 18.225 RCW;

(3) Mental health counselor or associate licensed under chapter 18.225 RCW;

(4) Psychiatric advanced practice registered nurse licensed under chapter 18.79 RCW;

(5) Psychologist or associate licensed under chapter 18.83 RCW; or

(6) Other credentialed provider listed in WAC 246-821-410 who is competent to assess, diagnose, and treat behavioral health conditions and support a student BHSS appropriately.

A practicum supervisor may not be a blood or legal relative, significant other, cohabitant of the student, or someone who has provided behavioral health counseling to the student in the last two years.

Do not sign this form verifying applicants' hours unless you meet the criteria and can provide documentation if called upon to do so.

My qualifications include: _____

_____

_____

_____

_____

_____

_____

_____

_____

I certify the above information is, to the best of my knowledge, accurate and complete. I understand the department may request additional information, if needed, to evaluate the application of the individual named on this document. I also attest that I meet or exceed the educational and supervision requirements for certification (as required by WAC 246-821-215)

_____ _____

Signature of Supervisor Date

Please return this form directly to the address above.

RCW/WAC and Online Website Links

RCW/WAC Links

Uniform Disciplinary Act, RCW 18.130

Administrative Procedure Act, RCW 34.05

Administrative Procedures and Requirements, WAC 246-12

Substance Use Disorder Professional Laws, RCW 18.205

Substance Use Disorder Professional Rules, WAC 246-811

Standards of Professional Conduct, WAC 246-16

Online

Behavioral Health Support Specialist Webpage

Get important information about your credential type by subscribing to email alerts.