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| **Staff Name & Credential:** | | |  | | | | | | **Date of Hire:** | | |  | |
| **MHP/S request Directions:**  Complete MHP/MHS acknowledgement request form  Attach ALL supporting documentation as indicated  Email completed request with ALL supporting documentation to the Mental Health Program Administrator at DBHR  The review process of documentation could take as little as one or as much as four weeks to complete.  If as a result of the review, additional documentation or clarification of documentation is requested, you are asked to attach additional documentation to the initial email request or resend all documentation. | | | | | | | | | | | | | |
| **Mental Health Professional (MHP)**   1. **Check all qualifications that apply and attach supporting documentation** :   A psychiatrist, psychologist, psychiatric nurse or social worker as defined in chapters [71.05](http://app.leg.wa.gov/RCW/default.aspx?cite=71.05) and [71.34](http://app.leg.wa.gov/RCW/default.aspx?cite=71.34) RCW;  A person who is licensed by the department of health as a mental health counselor, mental health counselor associate, marriage and family therapist, or marriage and family therapist associate;  A person with a master’s degree or further advanced degree in counseling or one of the social sciences\* from an accredited college or university. Such person shall have, in addition, at least two years of experience in direct treatment of persons with mental illness or emotional disturbance, such experience gained under the supervision of a mental health professional;  A person who meets the waiver criteria of RCW [71.24.260](http://app.leg.wa.gov/RCW/default.aspx?cite=71.24.260), which was granted prior to 1986;  A person who had an approved waiver to perform the duties of a mental health profession that was requested by the behavioral health organization (BHO) and granted by the mental health division prior to July 1, 2001; or  A person who has been granted a time-limited exception of the minimum requirements of a mental health professional the division of behavioral health and recovery (DBHR). | | | | | | | | | | | | | |
| **\***For individuals with an Agency Affiliate Credential requesting MHP acknowledgement. Classes reviewed on transcripts are as indicated on DOH website, education criteria under Mental Health Counselors, which include:  Behavioral science in a field relating to mental health counseling includes a core of study relating to counseling theory and counseling philosophy.  Either a counseling practicum, or a counseling internship, or both, must be included in the core of study. Exclusive use of an internship or practicum used for qualification must have incorporated supervised direct client contact. | | | | | | | | | | | | | |
| This core of study must include **seven** content areas from the entire list in subsections **(1)** through **(17)** of this section, **five** of which must be from content areas in **subsections (1) through (8) of this subsection**.  Please check all that apply: | | | | | | | | | | | | | |
| 1. | Assessment/diagnosis | | | 2.  Ethics/law | | 3.  Counseling individuals | | | | | 4.  Counseling groups | | |
| 5. | Counseling couples | | | 6.  Developmental psychology (may be child adolescent, adult or life span | | | | | | | | | |
| 7. | Psychopathology/ abnormal psychology | | | | | 8.  Research and evaluation | | | | | | | |
| 9. | Career development counseling | | | | 10.  Multicultural concerns | | | | 11.  Substance/chemical abuse | | | | |
| 12. | Physiological psychology | | | | 13.  Organizational psychology | | | | 14.  Mental health consultation | | | | |
| 15. | Developmentally disabled persons | | | | 16.  Abusive relationships | | | | 17.  Chronically mentally ill | | | | |
| ***Required documentation attached for review for MHP:***  *DOH credential (LISCW, LICSW-A, LMHC, LMHC-A, LMFT, LFMT-A, ARNP, RN, Agency affiliated etc.)*  *College Diploma*  *College Transcript/s*  *Résumé* | | | | | | | | | | | | | |
| ***I (the applicant) certify that I meet the checked criteria above. I have attached the required documentation regarding my education, experience and supervision:*** | | | | | | | | | | | | | |
| ***Signature of applicant:*** | |  | | | | |  | ***Date signed:*** | |  | | |  |
| ***Print name and credential:*** | |  | | | | | | | | | | |  |
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| ***Confirmation of agency review of required documents for MHP request*** | | | | | | | | |
| ***I (agency representative)*** |  | | | ***, certify I have reviewed the MHP request and all*** | | | | |
| ***attached documentation, verified the experience above, and (staff)*** | | | |  | | | ***has*** | |
| ***the required credentials to be acknowledged as a Mental Health Professional as of this date of review.***  **.** | | | | | | | | |
| ***Signature/Credentials of agency representative (REQUIRED):*** | | |  | | ***Date*** |  | |  |
| ***Printed Name and credentials:*** | |  | | |  | | | |
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| **Mental Health Specialist (MHS)**   1. **Check all qualifications that apply and attach supporting documentation** :   A **"child mental health specialist"** is defined as a mental health professional with the following education and experience:   * A minimum of one hundred actual hours (not quarter or semester hours) of special training in child development and the treatment of children and youth with serious emotional disturbance and their families; and * The equivalent of one year of full-time experience in the treatment of seriously emotionally disturbed children and youth and their families under the supervision of a child mental health specialist.   A **"geriatric mental health specialist"** is defined as a mental health professional who has the following education and experience:   * A minimum of one hundred actual hours (not quarter or semester hours) of specialized training devoted to the mental health problems and treatment of persons sixty years of age or older; and * The equivalent of one year of full-time experience in the treatment of persons sixty years of age or older, under the supervision of a geriatric mental health specialist.   An **"ethnic minority mental health specialist"** is defined as a mental health professional who has demonstrated cultural competence attained through major commitment, ongoing training, experience and/or specialization in serving ethnic minorities, including:   * Evidence of one year of service specializing in serving the ethnic minority group under the supervision of an ethnic minority mental health specialist; ***and*** * Evidence of support from the ethnic minority community attesting to the person's commitment to that community; ***or*** * A minimum of one hundred actual hours (not quarter or semester hours) of specialized training devoted to ethnic minority issues and treatment of ethnic minority individuals. * Check the appropriate ethnic minority population for which you are seeking acknowledgement:   + **"Ethnic minority"** or **"racial/ethnic groups"** means, for the purposes of this chapter, any of the following general population groups:   African American;  An American Indian or Alaskan native, which includes: A person who is a member or considered to be a member in a federally recognized tribe; A person determined eligible to be found Indian by the secretary of interior; An Eskimo, Aleut, or other Alaskan native; and An unenrolled Indian meaning a person considered Indian by a federally or non-federally recognized Indian tribe or off-reservation Indian/Alaskan native community organization;  Asian/Pacific Islander; or  Hispanic.  A **"disability mental health specialist"** is defined as a mental health professional with special expertise in working with an identified disability group. For purposes of this chapter only, "disabled" means an individual with a disability other than a mental illness, including a developmental disability, serious physical handicap, or sensory impairment.  For acknowledgement as a deaf or developmental disabilities specialist, check the applicable box below and submit additional documentation supporting the request.  If the consumer is deaf, the specialist must be a mental health professional with:   * + Knowledge about the deaf culture and psychosocial problems faced by who are deaf; and   + Ability to communicate fluently in the preferred language system of the consumer.   The specialist for individuals with developmental disabilities must be a mental health professional who:   * + Has at least one year's experience working with people with developmental disabilities; or   + Is a developmental disabilities professional as defined in RCW 71.05.020. | | | | | | | | |

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| ***Required documentation attached for review for MHS:***  *DOH credential (LISCW, LICSW-A, LMHC, LMHC-A, LMFT, LFMT-A, ARNP, RN, Agency affiliated etc.)*  *College Diploma*  *College Transcript/s*  *Resume*  *Specialist training certificates and hours*  *Supervision*  Attestation in place of 100 hours of training (for Ethnic Minority Mental Health Specialist only) | | | | | | | | | | | | | | | | | | | |
| **List of specialized Training (Do not include school coursework which will be found on transcript(s))** | | | | | | | | | | | | | | | | | | | |
| **Training Completion Date** | | | | | | | **Subject** | | | | **Training Hours** | | | | | | | | |
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| **List Supervision received from Mental Health Specialist** | | | | | | | | | | | | | | | | | | | |
| **Date:** | **From** | **To** | | | | | **Supervisor name, credentials, and specialty/specialties** | | | | **Organization Name** | | | | | | | | |
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| ***I (the applicant) certify that I meet the checked criteria above. I have attached the required documentation regarding my education, experience and supervision.*** | | | | | | | | | | | | | | | | | | | |
| ***Signatures of applicant:*** | | |  | | | | | | | | | ***Date*** | | |  | | |  | |
| ***Printed Name and credentials:*** | | | | |  | | | | | | |  | | | | | | | |
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| ***Confirmation of agency review of required documents for MHS request*** | | | | | | | | | | | | | | | | | | | |
| ***I (agency representative)*** | | | |  | | | | | ***, certify I have reviewed the MHS application and*** | | | | | | | | | | |
| ***all attached documentation, verified the experience above, and (staff)*** | | | | | | | | | |  | | | | | | | ***has*** | | |
| ***the required credentials to be acknowledged as a Mental Health Specialist as of this date of review.*** | | | | | | | | | | | | | |  | | | | | |
| ***Signature/Credentials of agency representative (REQUIRED):*** | | | | | | | |  | | | | | ***Date*** | | |  | | |  |
| ***Printed Name and credentials:*** | | | | | |  | | | | | | |  | | | | | | |
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If you have any questions about the request or process please contact your

Mental Health Program Administrator:

Complete and sign this form, then scan it and e-mail the file to your Mental Health Program Administrator.