Agency Affiliated Counselor License 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:

Agency Affiliated Counselor 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 civil.rights@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 forms required.

- ☐ **Are you currently employed or been offered employment by an agency identified in WAC 246-810-016?**
  If no, your application will be processed, however, a credential cannot be issued until you submit an **employment verification form**.

- ☐ **Check One: State Agency, agency on recognized list, or other/unknown**.
  In order to qualify to be an agency affiliated counselor, the facility where you work must be operated, licensed, or certified by the state of Washington, a federally recognized Indian tribe located within Washington State, or a county.

  WAC 246-810-017 describes the process to be a recognized agency or facility.
  A list of recognized agencies and facilities can be found **here**.

- ☐ **If you are currently employed, enter the start date you will begin working as an Agency Affiliated Counselor.**
  If you apply for your initial license to the Department of Health within thirty days of employment by an agency, you may work as an agency affiliated counselor while your application is being processed. See **RCW 18.19.210**

  You may not provide unsupervised counseling prior to completion of a criminal background check performed by either your employer or the Department of Health.

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

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

- ☐ **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 questions. 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. Counseling Services:**

Provide what type of counseling services you will be engaging in.
RCW 18.19.020(7)— Counseling means employing any therapeutic techniques, including but not limited to social work, mental health counseling, marriage and family therapy, and hypnotherapy, for a fee that offer, assist or attempt to assist an individual or individuals in the amelioration or adjustment of mental, emotional, or behavioral problems, and includes therapeutic techniques to achieve sensitivity and awareness of self and others and the development of human potential. For the purposes of this chapter, nothing may be construed to imply that the practice of hypnotherapy is necessarily limited to counseling.

☐ **4. Other License, Certification, or Registration:**
List all states, including Washington, where credentials are or were held. Specifically list credentials granted by examination, endorsement, or grandparented.

An Out-of-State Verification form is enclosed and must be sent to each state you listed. Enter your full name and birth date at the top of the form so the state can identify you. Also contact each state board listed for any fees they may charge for processing the verification.

☐ **5. Education:**
The Agency Affiliated Counselor License requires a master's degree or higher in counseling or social sciences. List in date order all college education. Please request official transcripts to be sent directly from your college or university to the Department of Health. Transcripts must indicate the degree and date conferred.

☐ **6. Experience:**
The Agency Affiliated Counselor License requires two (2) years of experience treating individuals with a mental disorder under the supervision of a mental health professional. List in date order all your experience.

☐ **7. Legacy Provision**
Applicants for licensed agency affiliated counselor are not required to meet the coursework requirement, prior to the effective date of rules being adopted, if the applicant held a mental health professional designation based on meeting the criteria established in **RCW 18.19**.

☐ **8. Applicant's Attestation:**
You must sign and date this for us to process the application.

We appreciate your interest in obtaining a credential. You will be notified if further documentation is required. If your application is incomplete, you will be mailed or emailed a letter regarding the deficiencies.

- The application is considered incomplete if requested information is left blank. Put N/A or place a line through a section instead of leaving it blank.
- The initial credential will expire on your birthday unless the credential is issued within 90 days of your next birthday. See **WAC 246-12-020(3)**.
- You must keep your address up to date in order to receive a courtesy renewal notice. Any renewal postmarked or presented to the department after midnight on the expiration date is late.

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.

Agency Affiliated Counselor
Credentialing
P.O. Box 1099
Olympia, WA 98507-1099

Date Stamp Here

Revenue: 0207070000

Agency Affiliated Counselor License Application

Are you currently employed or been offered employment by an agency identified in WAC 246-810-016?
Check One: ☐ Yes ☐ No
Check One: ☐ State Agency ☐ Agency on recognized list ☐ Other/unknown

If yes, start date you will begin working as an Agency Affiliated Counselor: _____

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

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 on file with the department.

Have you ever been known under any other name(s)?
If yes, list name(s):

Will documents be received in another name?
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. Counseling Services

Give a brief description of your therapeutic orientation, discipline, theory, or technique.

4. Other License, Certification, or Registration

List all states where licenses, certifications, or registrations are or were held.

State/ Jurisdiction	Credential Type	Credential		Method Licensed		
		Year Issued	Number	Exam	Endorse.	Grandparented

5. Education

The Agency Affiliated Counselor License requires a master's degree or higher in counseling or social sciences. List in date order all college education. Please request official transcripts to be sent directly from your college or university to the Department of Health. Transcripts must indicate the degree and date conferred. If you need more space, attach additional pages.

School	From (mm/dd/yyyy)	To (mm/dd/yyyy)	Degree and Major

6. Experience

The Agency Affiliated Counselor License requires two (2) years of experience treating individuals with a mental disorder under the supervision of a mental health professional. List in date order all your experience. If you need more space, attach additional pages.

Agency Name:	Start Date (mm/dd/yyyy)	End Date(mm/dd/yyyy)
Agency Location:	Supervisor Name:	
Job Title:		
Agency Name:	Start Date (mm/dd/yyyy)	End Date(mm/dd/yyyy)
Agency Location:	Supervisor Name:	
Job Title:		
Agency Name:	Start Date (mm/dd/yyyy)	End Date(mm/dd/yyyy)
Agency Location:	Supervisor Name:	
Job Title:		
Agency Name:	Start Date (mm/dd/yyyy)	End Date(mm/dd/yyyy)
Agency Location:	Supervisor Name:	
Job Title:		

7. Legacy Provision Attestation

Applicants for licensed agency affiliated counselor are not required to meet the coursework requirement, prior to the effective date of rules being adopted, if the applicant held a mental health professional designation based on meeting one of the following criteria.

Check box that applies:

☐ I have two years of experience in a direct treatment of persons with mental illness or emotional disturbance that was gained under the supervision of a mental health professional recognized by the department or attested to by a licensed behavioral health agency.

☐ I met the waiver criteria of RCW 71.24.260, and the waiver was granted prior to 1986.

☐ I had an approved waiver to perform duties of a mental health professional, that was requested by the behavioral health organization and granted by the mental health division prior to July 1, 2001.

I, _____, declare that I held a mental health professional desigation as
(Name of Applicant)
indicated above.

Applicant's Initials	Date

8. Applicant's Attestation

I,_____, declare under penalty of perjury under the laws of the state of
(Name of Applicant)

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 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 _____ By: _____
(mm/dd/yyyy) (Original Signature of Applicant)

Agency Affiliated Counselor
Credentialing
P.O. Box 47877
Olympia, WA 98504-7877
360-236-4700

Out-of-State Credential Verification

To Applicant:

Please complete this side of form and send it to the state(s) and/or jurisdiction(s) where you are or have been licensed, certified, or registered as a healthcare provider. Instruct them to return the form directly to the address listed above. Make a copy of this form if you need to send it to more than one state or jurisdiction. Agencies normally charge a fee for verification. Please check in advance to help expedite this process.

Name Last First Middle		
Mailing Address		
City	State	Zip Code
Any other names used		
Type of healthcare license, certification, or registration		
License, Certification, or Registration Number	Date Issued	

Have the licensing agency return this completed form to the address listed above.

If you have any questions, please call 360-236-4700.

(To be Completed by the Regulatory Agency)

Please complete this form regarding the applicant listed on the reverse. Submit the completed form and any other requested material directly to this office at the address on the reverse. We will not accept the form if submitted by the applicant. Thank you.

Name of license, certification, or registration holder:		
Authority providing verification: (state, name & title)		
Applicant was credentialed by: ☐ Written Examination	Date:	Score:
Name of examination:		
☐ Other Examination	Date: Score:	
Name of examination:		
Is credential current: ☐ Yes ☐ No	Expiration Date:	
Is this individual considered to be in good standing in your state? ☐ Yes ☐ No If "no," please attach explanation.		
Has this credential ever been denied? ☐ Yes ☐ No Suspended? ☐ Yes ☐ No Revoked? ☐ Yes ☐ No Surrendered? ☐ Yes ☐ No Reinstated? ☐ Yes ☐ No If "yes," please provide a copy of the final order or other documentation of action taken.		
If this credential holder has been disciplined, has he/she successfully completed all requirements and is currently in good standing? ☐ Yes ☐ No		

(SEAL)

Signature: _____

Title: _____

Date: _____

Agency Affiliated Counselor Credentialing
P.O. Box 47877
Olympia, WA 98504-7877
360-236-4700

Certified or Licensed Agency Affiliated Counselor Employment Verification Form

A certified or licensed agency affiliated counselor means a person who is employed by an agency as defined by the department.

Certified agency affiliated counselor may conduct mental health assessments and make mental health diagnoses which shall be reviewed by a clinical supervisor who is a mental health professional able to independently provide mental health assessments and diagnoses according to the scope of practice of the mental health professional's credential. A certified agency affiliated counselor may not provide clinical supervision.

Licensed agency affiliated counselor may independently conduct mental health assessments and make mental health diagnoses.

Check One: ☐ New Agency ☐ Update / Change Agency ☐ Additional Agency

Applicants may not provide unsupervised counseling prior to completion of a criminal background check performed by either the employer or the Department of Health.

Agency affiliated counselors shall notify the department if they are either no longer employed by the agency identified on their application or are now employed with another agency, or both. See RCW 18.19.210.

Agency Affiliated Applicant Name and Credential Number (Please Print) _____ Date of Hire (MM/DD/YYYY) _____

I verify that the above applicant is currently employed or will begin employment with the agency listed below as required by **WAC 246-810-015**.

Agency or Facility Employer Name _____

Agency or Facility Physical Address _____

City _____ State _____ Zip Code _____

My Agency is a county, state agency, federally recognized Indian tribe located within Washington State or has been recognized by the Secretary of Health to be able to employ agency affiliated counselors.
See **WAC 246-810-016** and **WAC 246-810-015**. Please see the **approved agency affiliated list**.

Signature of employer or designated/authorized employee _____ Date MM/DD/YYYY _____

Send this completed form to the address above.

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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

Agency Affiliated Counselor Laws, RCW 18.19

Agency Affiliated Counselor Rules, WAC 246-810

Online

Agency Affiliated Counselor Program, Web Page

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