2022 Behavioral Health Board License Renewal Information Fields

Administered to: Bachelor Social Workers, Social Workers, Clinical Social Workers, Marriage and Family Therapist Associates, Marriage and Family Therapists, Mental Health Counselor Associates, Mental Health Counselors, Addiction Counselor, Addiction Counselor Associate, Clinical Addiction Counselor Clinical Addiction Counselor Associate

1. Sex
   DROP DOWN
   a. Female
   b. Male

2. Are you of Hispanic, Latina/o, or Spanish origin?
   RADIO BUTTONS
   a. Yes
   b. No

3. What is your race? Mark one or more boxes.
   MULTI CHECK BOX
   a. American Indian or Alaska Native
   b. Asian
   c. Black or African American
   d. Native Hawaiian/Pacific Islander
   e. White
   f. Some Other Race

4. What type of degree/credential qualified you for your first U.S. counselor license?
   DROP DOWN LIST
   a. High school diploma/GED - counseling or related field
   b. High school diploma/GED – other
   c. Vocational/Practical certificate – counseling or related field
   d. Vocational/Practical certificate – other
   e. Associate degree – counseling or related field
   f. Associate degree – other
   g. Bachelor's degree – counseling or related field
   h. Bachelor's degree – other
   i. Master's degree – counseling or related field
   j. Master's degree – other
   k. Doctoral degree – counseling or related field
   l. Doctoral degree – other

5. Where did you complete the degree that first qualified you for your license?
   DROP DOWN LIST
   a. Indiana
   b. Michigan
   c. Illinois
   d. Kentucky
   e. Ohio
   f. Another State (not listed)
   g. Another Country (not U.S.)

6. What is your highest level of education?
   DROP-DOWN LIST OR RADIO BUTTONS
   a. High school diploma/GED - counseling or related field
   b. High school diploma/GED – other
   c. Vocational/Practical certificate – counseling or related field
   d. Vocational/Practical certificate – other
   e. Associate degree – counseling or related field
   f. Associate degree – other
   g. Bachelor's degree – counseling or related field
   h. Bachelor's degree – other
   i. Master's degree – counseling or related field
   j. Master's degree – other
   k. Doctoral degree – counseling or related field
   l. Doctoral degree – other

7. What is your employment status?
   DROP-DOWN LIST OR RADIO BUTTONS
   a. Actively working in a position that requires this license
   b. Actively working in a related position that does not require this license
   c. Actively working in a field not related to this license
   d. Not currently working
   e. Retired

8. What best describes your employment plans for the next 12 months?
   DROP DOWN LIST
   a. Increase hours
   b. Decrease hours
   c. Transition to a non-direct service role
   d. Leave my current role to complete further training
   e. Leave my current role for family reasons/commitments
   f. Leave my current role due to physical demands
   g. Leave my current role due to stress/burnout
   h. Retire
   i. Continue as you are

9. If you hold more than one license that is overseen by the Behavioral Health and Human Services Licensing Board, under which license do you primarily practice? If this does not apply, please select "not applicable."
   RADIO BUTTON
   a. Bachelor Social Worker
   b. Social Worker
   c. Clinical Social Worker
   d. Marriage and Family Therapist Associate
   e. Marriage and Family Therapist
   f. Mental Health Counselor Associate
   g. Mental Health Counselor
   h. Addiction Counselor Associate
   i. Addiction Counselor
   j. Clinical Addiction Counselor Associate
   k. Clinical Addiction Counselor
   l. Not applicable

10. Do you use telehealth to deliver services to patients located in Indiana (as defined in IC 25-1-9.5-6; "telehealth" means the delivery of health care services using interactive electronic communications and information technology, in compliance with the federal Health Insurance Portability and Accountability Act (HIPAA), including: (1) secure videoconferencing; (2) interactive audio-using store and forward technology; or (3) remote patient monitoring technology; between a provider in one (1) location and a patient in another location)?)
    RADIO BUTTONS
    a. Yes
    b. No

11. Please indicate which of the following services you routinely provide as a part of your practice: (Note: The purposes of this services list is to gather information on key health issues in Indiana) Please check all that apply.
    CHECKBOXES
    a. Addiction counseling
    b. Case management
    c. Crisis counseling
    d. Dementia/Alzheimer's care
    e. General Counseling/Therapy
    f. Mental health diagnosis (as authorized under IC 25-23.6-1-5.6)
    g. School counseling
    h. Services via telehealth to patients/clients outside of Indiana
    i. None of the above

12. Please indicate the population groups to which you provide services:
    CHECKBOXES
    a. Newborns
    b. Children (ages 2-10)
    c. Adolescents (ages 11-19)
    d. Adults
    e. Geriatrics (ages 65+)
    f. Pregnant women
    g. Inmates
    h. Disabled individuals
    i. Individuals in recovery
    j. None of the above

13. What is the street address of your primary practice location (for telehealth providers: where the patient is located)? If this does not apply, please indicate "N/A"
    TEXT-BOX (64 CHARACTER LIMIT)

14. In what city is your primary practice location? If this does not apply, please indicate "N/A"
    TEXT-BOX (64 CHARACTER LIMIT)

15. In what state is your primary practice location? Please indicate state using 2-letter postal abbreviation. If this does not apply, please select "N/A"
    DROP-DOWN LIST
    Please include all states' 2-letter postal abbreviation along with an option for N/A

16. What is the 5-digit ZIP code of your primary practice location? If this does not apply, please indicate "N/A"
    TEXT-BOX (5 CHARACTER LIMIT)

17. How many hours do you spend in direct patient care at your principal practice location? If this does not apply, please select "not applicable."
    DROP-DOWN LIST OR RADIO BUTTONS
    a. 0 hours per week
    b. 1 – 4 hours per week

c. 5 – 8 hours per week
d. 9 – 12 hours per week
e. 13 – 16 hours per week
f. 17 – 20 hours per week
g. 21 – 24 hours per week
h. 25 – 28 hours per week
i. 29 – 32 hours per week
j. 33 – 36 hours per week
k. 37 – 40 hours per week
l. 41 or more hours per week
m. Not applicable

18. Which best describes the type of setting that most closely corresponds to your principal direct patient care practice location(s). If this does not apply, please select "not applicable.":
DROP DOWN LIST
a. Child Welfare
b. Community Health Center (RHC, FQHC, Look-alike)
c. Community Mental Health Center (CMHC)
d. Mental Health Clinic (Not a CMHC)
e. Criminal Justice
f. Detox
g. Faith-Based Setting
h. Federal Government Hospital
i. In-Home Setting
j. Methadone Clinic
k. Non-Federal Hospital: General Medicine
l. Non-Federal Hospital: Inpatient
m. Non-Federal Hospital: Other- e.g. nursing home unit
n. Non-Federal Hospital: Psychiatric
o. Primary or Specialist Medical Care (Non-behavioral health setting)
p. Private Practice
q. Recovery Support Services
r. Rehabilitation
s. Residential Setting
t. School Health Service
u. Specialized Substance Abuse Outpatient Treatment Facility
v. Telehealth
w. Other
x. Not applicable

19. Which best describes the field of practice for your principal practice location? If this does not apply, please select "not applicable."
RADIO BUTTONS
a. Addictions
b. Administration
c. Community Development
d. Developmental and Other Disabilities
e. Family and Children Services
f. Gerontological Services
g. Health and Rehabilitation
h. Income Maintenance
i. Information and Retrieval
j. Juvenile and/or Adult Corrections
k. Mental Health
l. Occupational

m. Violence and Abuse Services
n. Other
o. Not applicable

20. What is the street address of your secondary practice location (for telemedicine providers: where the patient is located)? If this does not apply, please indicate “N/A”.
TEXT-BOX (64 CHARACTER LIMIT)

21. In what city is your secondary practice location? If this does not apply, please indicate “N/A”.
TEXT-BOX (64 CHARACTER LIMIT)

22. In what state is your secondary practice location? Please indicate state using 2-letter postal abbreviation. If this does not apply, please select “N/A”
DROP-DOWN LIST
Please include all states’ 2-letter postal abbreviation along with an option for N/A

23. What is the 5-digit ZIP code of your secondary practice location? If this does not apply, please indicate “N/A”.
TEXT-BOX (5 CHARACTER LIMIT)

24. How many hours do you spend in direct patient care per week at your secondary practice location? If this does not apply, please select “not applicable.”
DROP-DOWN LIST OR RADIO BUTTONS
a. 0 hours per week
b. 1 – 4 hours per week
c. 5 – 8 hours per week
d. 9 – 12 hours per week
e. 13 – 16 hours per week
f. 17 – 20 hours per week
g. 21 – 24 hours per week
h. 25 – 28 hours per week
i. 29 – 32 hours per week
j. 33 – 36 hours per week
k. 37 – 40 hours per week
l. 41 or more hours per week
m. Not applicable

25. Which best describes the type of setting that most closely corresponds to your secondary direct patient care practice location(s): If this does not apply, please select “not applicable.”
DROP-DOWN LIST OR RADIO BUTTONS
a. Child Welfare
b. Community Health Center (RHC, FQHC, Look-alike)
c. Community Mental Health Center (CMHC)
d. Mental Health Clinic (Not a CMHC)
e. Criminal Justice
f. Detox
g. Faith-Based Setting
h. Federal Government Hospital
i. In-Home Setting
j. Methadone Clinic
k. Non-Federal Hospital: General Medicine
l. Non-Federal Hospital: Inpatient
m. Non-Federal Hospital: Other- e.g. nursing home unit
n. Non-Federal Hospital: Psychiatric

o. Primary or Specialist Medical Care (Non-behavioral health setting)
p. Private Practice
q. Recovery Support Services
r. Rehabilitation
s. Residential Setting
t. School Health Service
u. Specialized Substance Abuse Outpatient Treatment Facility
v. Telehealth
w. Other
x. Not applicable

26. Which best describes the field of practice for your secondary practice location? If this does not apply, please select “not applicable.”
RADIO BUTTONS
    a. Addictions
    b. Administration
    c. Community Development
    d. Developmental and Other Disabilities
    e. Family and Children Services
    f. Gerontological Services
    g. Health and Rehabilitation
    h. Income Maintenance
    i. Information and Retrieval
    j. Juvenile and/or Adult Corrections
    k. Mental Health
    l. Occupational
    m. Violence and Abuse Services
    n. Other
    o. Not applicable