



New Mexico Department of Health Office of Community Health Workers (OCHW)

Application for State Endorsement Renewal of Community Health Worker Training Programs

CHW Core Competencies: Generalist Training Application Instructions

Please read the Application Information thoroughly before beginning your application.

- This application consists of 4 Parts. Applicants must complete the following parts in their entirety:
 - ❖ **Part 1:** Overview of Training Program: Sections 1
 - ❖ **Part 2:** Instructor Requirements Section 1-3
 - ❖ **Part 3:** Designee Signature
 - ❖ **Part 4:** Renewal Endorsement Fee is \$200 and must be submitted with application with check or money order. Endorsement is good for one year.

Mail To: NM Department of Health | Public Health Division
Office of Community Health Workers
Attn: Devona Quam, Director
5300 Homestead Rd NE, Ste #300
Albuquerque, NM 87110
Account: XXXXXX7789

- Please keep a copy of all your application.
- Binders should be mailed or hand delivered to the point of contact indicated below:

Devona Quam, Director
NM Department of Health | Office of Community Health Workers
5300 Homestead Road NE, Ste #300
Albuquerque, NM 87110

CHW Core Competencies: Generalist Training Application Checklist

Part I: Overview of Training Program Information

Section 1: Contact Information

Part 2: Instructor Requirements

Section 1: Contact Information

Section 2: Education & Work Experience

Section 3: Training Experience

Part 3: Designee Signature Page

Application signed and dated

Part 4: Fee -Renewal Endorsement Fee of \$200.00

Check or Money Order submitted with application.

PART 1: Overview of Training Program

Section 1: Contact Information

Contact Name:		
<i>First</i>	<i>Middle</i>	<i>Last</i>
Job Title:		
Contact Telephone:	Contact Fax	Contact Email Address

Name of Sponsoring Organization:				
Physical Address: <i>Street Address/PO Box</i>		<i>City</i>	<i>State</i>	<i>Zip Code</i>
Mailing Address: <i>Street Address/PO Box</i>		<i>City</i>	<i>State</i>	<i>Zip Code</i>
Organization Telephone:	Organization Fax:	Website Address:		
Organization Type:				
<input type="checkbox"/> College or University	<input type="checkbox"/> Faith-based Organization	<input type="checkbox"/> Clinic or Hospital		
<input type="checkbox"/> Community College	<input type="checkbox"/> Government Agency	<input type="checkbox"/> IHS Clinic or Hospital		
<input type="checkbox"/> Community Based- Organization	<input type="checkbox"/> Local Health Department	<input type="checkbox"/> Other _____		
<input type="checkbox"/> Tribal Clinic or Hospital (638)	<input type="checkbox"/> Tribal Government			

Is your organization accredited by the Council for Higher Education Accreditation or similar accreditation body?				
<input type="radio"/> No		<input type="radio"/> Yes If yes, please fill in formation below.		
Name of Accrediting Organization:				
Contact Name in Accrediting Organization :	Title :	Telephone:	Email Address:	
Mailing Address: <i>Street Address/PO Box</i>		<i>City</i>	<i>State</i>	<i>Zip Code</i>
Status of Accreditation		Date of Last Accreditation		

PART 2: Instructor Requirements

Section 1: Contact Information

Please have each one of your core instructors/trainers complete the following questions.

- Instructors must have a bachelor's degree or higher from an accredited institution and at least three years of experience working with CHWs, or must be certified CHWs and have at least three years' experience working with CHWs.

Name:		(First)	(Last)
Job Title:			
Telephone:	Fax:	Email Address;	
Name of Sponsoring Organization:			
Physical Address: (Street Address/PO Box)		(City)	(State) (Zip Code)
Mailing Address: (Street Address/PO Box)		(City)	(State) (Zip Code)

Section 2: Education & Work Experience

1. Have you worked as a CHW?

- No (Skip to question #3)
 Yes

2. In what settings have you worked as a CHW? Check all that apply.

- | | |
|--|--|
| <input type="checkbox"/> Clinical | <input type="checkbox"/> State or local government |
| <input type="checkbox"/> Community | <input type="checkbox"/> School-based |
| <input type="checkbox"/> Non-profit organization | <input type="checkbox"/> Other |
| <input type="checkbox"/> College/University/learning institution | |

3. Have you worked with CHWs?

- No (Skip to question #5)
 Yes

4. In what settings have you worked with CHWs? Check all that apply.

- | | |
|--|--|
| <input type="checkbox"/> Clinical | <input type="checkbox"/> State or local government |
| <input type="checkbox"/> Community | <input type="checkbox"/> School-based |
| <input type="checkbox"/> Non-profit organization | <input type="checkbox"/> Other |
| <input type="checkbox"/> College/University/learning institution | |

Section 2: Education & Work Experience continued

5. Have you supervised CHWs? CHWs?

- No **(Skip to Section 3: Training Experiences)**
- Yes

6. Approximately how many CHWs have you supervised?

- 1-5
- 6-10
- 11-15
- More than 15

7. In what settings have you supervised CHWs? Check all that apply.

- Clinical
- Community
- Non-profit organization
- State or local government
- School-based
- Other
- College/University/learning institution _____

Section 3: Training Experience

1. In what capacity and/or profession have you provided trainings for CHWs? Check all that apply.

- | | | |
|--|---|--|
| <input type="checkbox"/> CHW | <input type="checkbox"/> Educator/trainer | <input type="checkbox"/> MD/ Physician |
| <input type="checkbox"/> Social Worker | <input type="checkbox"/> Health Educator | <input type="checkbox"/> Other |
| <input type="checkbox"/> Nurse | | |

2. Have you provided CHW training as an independent contractor?

- No
- Yes Please specify _____

3. Please list the organizations you have represented when providing trainings (Example Project ECHO, Navajo Nation CHR Program, or Southern Area Health Education Center).

4. In what kind of formats/settings have you trained CHWs?

- | | |
|---|---|
| <input type="checkbox"/> Continuing education | <input type="checkbox"/> Training center |
| <input type="checkbox"/> College class | <input type="checkbox"/> Conference setting |
| <input type="checkbox"/> Employer/On-the-Job | <input type="checkbox"/> Community setting |
| <input type="checkbox"/> Other _____ | |

5. How many years have you trained CHWs in New Mexico?

- | | |
|---|---|
| <input type="checkbox"/> Less than 1 year | <input type="checkbox"/> 6-10 years ago |
| <input type="checkbox"/> 1-3 years | <input type="checkbox"/> More than 10 years ago |
| <input type="checkbox"/> 4-5 years | |

6. When did you last provide trainings for CHWs?

- | | |
|---|---|
| <input type="checkbox"/> Less than 1 year | <input type="checkbox"/> 6-10 years ago |
| <input type="checkbox"/> 1-3 years ago | <input type="checkbox"/> More than 10 years ago |
| <input type="checkbox"/> 4-5 years ago | |

7. Which languages do you provide CHW training in? Check all that apply?

- | | |
|----------------------------------|--------------------------------------|
| <input type="checkbox"/> English | <input type="checkbox"/> Navajo |
| <input type="checkbox"/> Spanish | <input type="checkbox"/> Other _____ |



Standards and requirements for renewal of previously endorsed CHW Training Programs in New Mexico

Programs must adhere to the following:

- 1. Provide effective, equitable, understandable and respectful quality care and services that responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs;**
- 2. Meet the minimum number of contact hours for each of the Core Competencies for the total of 100 hours;**
- 3. Maintain instructors that have at a minimum a bachelor's degree or higher from an accredited institution and at least three years of experience working with CHW's, or must be a certified CHWs and have at least three years of experience working with CHWs;**
- 4. Retain accurate attendance records for all CHW core competency trainings;**
- 5. Provide a final student roster to OCHW upon course completion to include total number of those who completed the program, county residence, place of employment and student contact information;**
- 6. Hold attendance records for a period of five years;**
- 7. Provide opportunities for students to obtain 40 hours of field work within 9 months;**
- 8. Promote, support and encourage students to apply for certification;**
- 9. Recruit potential students through various types of outreach;**
- 10. Notify OCHW of each graduating class and total number of those who complete the program;**
- 11. The Office of Community Health Workers reserves the right to monitor or evaluate Core Competency Training programs which are approved and shall be conducted during scheduled and unannounced site visits to approved program site/s listed in the application.**

PART 4: Designee Signature

Note: This application must be signed and dated by the organization's Chief Executive Officer or designee.

- Please read the statement below and sign below to indicate your understanding and acceptance.

As an Authorized Representative of _____ I certify that the information provided in this application is true and complete. I understand and agree that curriculum does align with the New Mexico Department of Health Office of Community Health standards and requirements. I understand that providing false or misleading information may result in the voiding of this application or the revocation of any endorsement certificate issued.

The Office of Community Health Workers reserves the right to monitor or evaluate Core Competency Training programs which are approved and shall be conducted during scheduled and unannounced site visits to approved program site/s listed within the application.

Printed Name: _____

Title: _____

Signature: _____

Date: _____