

FOR OFFICE USE ONLY

ID Number: _____

40 HOUR HOME HEALTH AIDE (HHA) TRAINING PROGRAM APPLICATION

Date: _____

Name of Provider		Telephone Number		
Address (Number and Street or P.O. Box Number)	City	County	State	Zip Code

Provider: School Health Facility Home Health Agency

Program Director	Registered Nurse (RN) License Number
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Clinical Sites: Skilled Nursing Facility Home Health Agency Acute Care Hospital

A) Name		Telephone Number		
Address (Number and Street or P.O. Box Number)	City	County	State	Zip Code

B) Name		Telephone Number		
Address (Number and Street or P.O. Box Number)	City	County	State	Zip Code

Submit the following documents for the 40 Hour Program:

- _____ 1. Letter attesting that the school will use all components of classroom and clinical training (including assignments and tests) in accordance with the 40 Hour Model Curriculum for Home Health Aides, as developed by the California Community College Chancellor's Office. Free download at www.CA-hwi.org (see product ordering – CNA, Acute Care Nursing Assistant and HHA Curriculum).
- _____ 2. Copy of student record used to validate classroom and clinical curriculum, including evaluation. The student record will include the topic of instruction, the date and hours of instruction, date of skill demonstration and evaluation, and the name of the instructor performing the skill evaluation.
- _____ 3. Resume for RN instructor(s) verifying at least two (2) years of RN nursing experience, with one (1) year full time employment with the Home Health Agency or a Public Health Nurse certificate by the California Board of Registered Nursing. Resume must include: month/year to month/year of nursing experience, name/address/phone number of employer, including supervisor and phone number. Resumes that lack verifiable information will not be approved.
- _____ 4. Clinical site agreement with Skilled Nursing Facilities, Home Health/Hospice Agency or Acute Care Hospital (2 year duration) where students will receive supervised clinical training. The HHA Training Program has full responsibility of classroom/clinical training.
- _____ 5. CDPH 276D – Disclosure of Ownership and Control Interest Statement (for proprietary schools only).

California Department of Public Health Use Only	
Provider Identification #: _____	
Approved By: _____ <small>(CDPH, ATCS, Training Program Review Unit Representative)</small>	Date: _____