Reset Form

HOME HEALTH AIDE REGISTRY APPLICATION

State Form 49560 (R4 / 5-11)
INDIANA STATE DEPARTMENT OF HEALTH-DIVISION OF ACUTE CARE

*Your Social Security number is requested in accordance with the provision of IC 4-1-8-1. Disclosure is mandatory and this record cannot be processed without it.

This form indicates that the supervisors of the licensed home health agency or hospice listed below have determined that this candidate has met the competency requirements listed in 42 CFR 484.36 and should be registered as a home health aide under Indiana Code 16-27-1.5.

I. Aide Identification

Full Name of Home Health Aide			
Residential Street Address *(number and street)*			
City		County	
State		ZIP code	
Aide Telephone Number		Date of Hire *(month, day, year)*	

Social Security Number*		Date of Birth *(month, day, year)*	
RHHA Registration Number			
CNA Registration Number			

II. Record Competency/Skills Check

Name of Organization Conducting Check	
City, State and ZIP code	
Facility Number	
Supervisor's Name Conducting Check	
Date Completed *(month, day, year)*	

III. Agency Identification

Program Director's Name					
Name of Home Health Agency					
Street Address *(number and street)*					
City		County		ZIP Code	
Facility Number					
Agency Telephone Number					

I, _____, swear and affirm under the penalties of perjury that the foregoing is true and accurate, and that I have read and understand 42 CFR 484.36 and have completed a competency evaluation program as required by this regulation.

_____ _____

Home Health Aide's Signature **Date** *(month, day, year)*

_____ _____

Program Director's Signature Date *(month, day, year)*