Reset Form

RECIPROCITY HOME HEALTH AIDE REGISTRY APPLICATION

State Form 57884 (R / 7-26)
INDIANA DEPARTMENT OF HEALTH - DIVISION OF HOME & COMMUNITY BASED 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.

Please type or print legibly.

SECTION I – AIDE IDENTIFICATION

Full Name of Home Health Aide *(first, middle, last)*			Date of Birth *(month, day, year)*
Residential Street Address *(number and street)*			
City	State	County	ZIP Code
Aide Telephone Number	Aide E-mail Address		
Aide Social Security Number*		Sex ☐ Male ☐ Female	

SECTION II – VERIFICATION OF CERTIFICATION

List all state(s) are you certified as a Home Health Aide:

List your Home Health Aide certification number(s) from other state(s):

SECTION III – STATE(S) VERIFICATION OF CURRENT STANDING

I understand I must attach letter(s) with this application from the state(s) listed above verifying no complaints or disciplinary action have been taken on my certification(s).

SECTION IV – NATIONAL CRIMINAL BACKGROUND CHECK

I understand I must submit a national criminal background check with this application. The background check must be dated within thirty (30) days of this application.

SECTION V– SIGNATURE AND CERTIFICATION OF APPLICATION

Home Health Aide Applicant:

I, _____, swear and affirm under the penalties of perjury that the foregoing is true and accurate, and that I have read and understood 42 CFR 484.80 and have completed a competency evaluation program in another state, as required by this regulation.

_____ _____

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