



## RECIPROCITY HOME HEALTH AIDE REGISTRY APPLICATION

State Form 57884 (9-25)

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.

<b>SECTION I – AIDE IDENTIFICATION</b>			
Full Name of Home Health Aide ( <i>first, middle, last</i> )		Date of Birth ( <i>month, day, year</i> )	
Residential Street Address ( <i>number and street</i> )			
City	State	County	ZIP Code
Aide Telephone Number		Aide E-mail Address	
Aide Social Security Number*		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
<b>SECTION II – VERIFICATION OF CERTIFICATION</b>			
List all state(s) are you certified as a Home Health Aide:			
List your Home Health Aide certification number(s) from other state(s):			
<b>SECTION III – STATE(S) VERIFICATION OF CURRENT STANDING</b>			
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).			
<b>SECTION IV – NATIONAL CRIMINAL BACKGROUND CHECK</b>			
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.			

<b>SECTION V– SIGNATURE AND CERTIFICATION OF APPLICATION</b>	
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 ( <i>month, day, year</i> )