Reset Form

NON-ASSOCIATED FACILITY HOME HEALTH AIDE REGISTRY APPLICATION

State Form 57885 (R / 7-26)
INDIANA DEPARTMENT OF HEALTH - DIVISION OF HOME & COMMUNITY BASED CARE

This application is only to be utilized for those training programs that are not associated with an agency or facility. If you are facility or agency based program, please submit applications through the Gateway system.

This form indicates that the supervisors of the licensed home health agency, hospice, third party or educational institution listed below have determined that this candidate has met the competency requirements listed in 42 CFR 484.80 and should be registered as a home health aide under Indiana Code 16-27-1.5.

*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 – RECORD OF COMPETENCY EVALUATION

Name of Agency, Third Party or Educational Institution Conducting Evaluation
Address *(number and street)*

City	State	County	ZIP Code

Facility Number *(if applicable)*	Facility E-mail Address

Registered Nurse's Name Conducting Evaluation	Professional License Number	Date Completed *(month, day, year)*

SECTION III – SIGNATURES 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 as required by this regulation.

_____ _____

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

SECTION III – SIGNATURES AND CERTIFICATION OF APPLICATION CONTINUED

Registered Nurse's Name Conducting Competency Evaluation:

I, _____, swear and affirm under the penalties of perjury that the foregoing is true and accurate, and that the home health aide applicant named in this application has satisfactorily completed a competency evaluation program as required by 42 CFR 484.80.

_____ _____

Registered Nurse's Signature, Professional License Number Date *(month, day, year)*