HOME HEALTH AIDE REGISTRY APPLICATION

State Form 49560 (R6 / 6-12)
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, hospice, third party or educational institution 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.

Please type or print legibly.

SECTION I – AIDE IDENTIFICATION

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

SECTION II – RECORD OF COMPETENCY EVALUATION

Name of Agency, Third Party or Educational Institution Conducting Evaluation		
Address *(number and street)*		
City	County	ZIP Code
Facility Number *(if applicable)*		
Registered Nurse's Name Conducting Evaluation	Professional License Number	Date Completed *(month, day, year)*

SECTION III – Employer of Home Health Aide Identification

Name of Employer		
Address *(number and street)*		
City	County	ZIP Code
Employer's Telephone Number	Administrator's Name	

SECTION IV – 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 484.36 and have completed a competency evaluation program as required by this regulation.

_____ _____

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

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 484.36.

_____ _____

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

Employing Administrator of Home Health Aide:

_____ _____

Administrator's Signature Date *(month, day, year)*