State of California- Health and Human Services Agency

MAIL OR FAX APPLICATION TO:
California Department of Public Health (CDPH)
Licensing and Certification Division (L&C)
Healthcare Workforce Branch (HWB)
MS 3301, P.O. Box 997416
Sacramento, CA 95899-7416
PHONE: (916) 327-2445 FAX: (916) 552-8785

HOME HEALTH AIDE (HHA)
INITIAL APPLICATION

(See instructions on the reverse)

SECTION I (REQUIRED)

TYPE OF REQUEST

☒ Check here if you are enrolling in a **HHA** training program **(complete sections I, II, III, IV, and V)**
☐ Check here if you are requesting **RECONSIDERATION** for a previously revoked/denied certificate **(complete sections I, II, III and V)**

SECTION II (REQUIRED)

Last Name	First Name	MI	Sex
			☐ Male ☐ Female

Public Address (Required) – *Subject to Public Records Act Request release**	City	State	Zip Code

Confidential Address (Required)- (For CDPH Use only. If left blank all departmental mail will be sent to the address above)	*City*	*State*	*Zip Code*

Date of Birth	*Social Security Number (SSN) or Individual Taxpayer Identification Number (ITIN)*	Driver's License or State ID Number
_____ *(mm/dd/yy)*	___ ___ ___ - ___ ___ - ___ ___ ___ ___ **If you use an invalid SSN, your application process may be delayed*	*Number* _____ *State* _____

Phone Number *** _____

☐ By checking this box, you agree to receive text messages from the California Department of Public Health (CDPH) for reminders and notifications regarding your application and/or certification. You may receive up to 5 messages per month. Message and data rates may apply. By checking this box, you agree to the Terms and Conditions and Privacy Policy. Reply "STOP" to opt-out, and "HELP" for help.

Email Address***

SECTION III (REQUIRED)

1) Have you been **CONVICTED**, at any time, of any crime, other than a minor traffic violation? (You need not disclose any marijuana-related offenses specified in the marijuana reform legislation and codified at the Health and Safety Code, Sections 11361.5 and 11361.7).
   - ☐ Yes ☐ No
   - If yes, list conviction: _____
   - Court of conviction: _____ Date: _____

2) Has any health-related licensing, certification or disciplinary authority taken adverse action (revoked, annulled, cancelled, suspended, etc.) against you?
   - ☐ Yes ☐ No
   - Type of License/Certificate: _____
   - License/Certificate Number: _____
   - Type of Action: _____

SECTION IV (IF APPLICABLE)

Name of school or facility where you received/will receive the **HHA** training: All Healthcare Institute

Telephone Number: 562-469-9302

Mailing Address (Number and Street or P.O. Box Number)	City	State	Zip Code
12235 Beach Blvd., Suite 206	Stanton	CA	90680

California Training Program ID Number for **HHA** (Required) HHA: 1068

☒ 40 HOURS ☐ 120 HOURS

Beginning Date of Training _____ *(mm/dd/yy)*

End Date of Training _____ *(mm/dd/yy)*

SECTION V (REQUIRED)

I certify under penalty and perjury under the applicable state and federal laws that the information contained in this application and supporting documents, is true and correct. I further understand that any false, incomplete, or incorrect statements may result in denial of this application. I acknowledge that signing this document through electronic means shall have the same legal validity and enforceability as a manually executed signature or use of a paper-based record keeping system to the fullest extent permitted by applicable law.

_____ _____

Signature of Applicant Date

HOME HEALTH AIDE (HHA) INITIAL APPLICATION INFORMATION

A) HHA APPLICANTS (complete sections I, II, III, IV, and V)

1)The applicant must submit the following to HWB upon enrollment in the program and before patient contact:

a) This completed Initial Application (CDPH 283 D); ***and***

b) A copy of the completed Request for Live Scan Services (BCIA 8016) form. Applicants who are unable to obtain electronic prints may complete the fingerprint card (FD-258) and submit two copies to the department. Fingerprint cards (FD-258) must be accompanied by a $32.00 check or money order made payable to "The Department of Justice";

B) CRIMINAL RECORD CLEARANCE

1)All CNA applicants must undergo a criminal record review. For more information, please visit us at www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/CriminalRecordReview.aspx.

C) HHA RENEWAL INFORMATION

1)The initial HHA certificate is issued for two birthdays, not two calendar years, and will expire on your birthday. Each year of the certification will be from one birthday to the following birthday. Any additional time from the effective date until the first birthday will be counted towards the first year of the certification period. HHA certificates must be renewed every two (2) years. You may renew your certificate any time within four (4) years after the expiration date of your certificate. For more information, please visit us at https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/HHA.aspx.

D) NAME AND ADDRESS CHANGES

1)Certificate holders shall notify CDPH within sixty (60) days of any change of address.

a) If requesting a name change, submit legal verification of the change (marriage certificate, divorce decree, or court documents). Failure to report a name or address change on the CDPH 0929 form may result in the delay or loss of your certification.

E) RECONSIDERATION

1) If the applicant's HHA certificate was revoked or denied by the CDPH, after review of this application, the CDPH will reach out to the applicant for additional information/documentation as needed.

Aforementioned requirements are based on Health and Safety Code commencing with §1337 through 1338.5, 1725 through 1742 and Code of Federal Regulations Title 42, Chapter IV, commencing with §483.13 and California Code of Regulations, Title 22, commencing with §71801.

INFORMATION COLLECTION AND ACCESS-PRIVACY STATEMENT

*Pursuant to a court order, the California Department of Public Health will be required to release the address of record for certified nurse assistants, home health aides, certified hemodialysis technicians, and licensed nursing home administrators in response to a Public Records Act (PRA) request. (Government Code starting at section 6250.) Court Order: Service Employees International Union-United Healthcare Workers v. California Department of Public Health, Sacramento County Superior Court, February 21, 2018, No. 34-2017-80002636.**If you use an invalid SSN, your application process may be delayed ***Providing your telephone number and email address is for the California Department of Public Health's internal use only for contacting applicants. This information will not be released to the public nor will it be displayed online