

## 40 HOUR HOME HEALTH AIDE (HHA) TRAINING PROGRAM APPLICATION

Name of Provider		Telephone Number (include extension #)	
Address (Number and Street or P.O. Box Number)		City	State
			Zip Code
Provider Email Address		Provider Training Number	Date
		HHP - _____	
<b>Provider:</b> <input type="checkbox"/> School <input type="checkbox"/> Hospice Agency <input type="checkbox"/> Health Facility <input type="checkbox"/> Home Health Agency			
Program Director Name		Registered Nurse (RN) License Number	
Program Director Signature		Program Director Email Address	
<b>Clinical Sites:</b> <input type="checkbox"/> Skilled Nursing Facility <input type="checkbox"/> Hospice Agency <input type="checkbox"/> Home Health Agency <input type="checkbox"/> Acute Care Hospital			
A) Name of the Clinical Site		Telephone Number	
Address (Number and Street or P.O. Box Number)		City	State
			Zip Code
B) Name of the Clinical Site		Telephone Number	
Address (Number and Street or P.O. Box Number)		City	State
			Zip Code

### Submit the following documents for the 40 Hour Program:

- Letter attesting that the school will use all components of classroom and clinical training (including assignments and tests) in accordance with the 40 Hour Model Curriculum for Home Health Aides, as developed by the California Community College Chancellor's Office. Free download at [www.CA-hwi.org](http://www.CA-hwi.org) (see product ordering – CNA, Acute Care Nursing Assistant and HHA Curriculum).
- Copy of student record used to validate classroom and clinical curriculum, including evaluation. The student record will include the topic of instruction, the date and hours of instruction, date of skill demonstration and evaluation, and the name of the instructor performing the skill evaluation.
- Resume for RN instructor(s) verifying at least two (2) years of RN nursing experience, with one (1) year full time employment with a Home Health Agency. Resume must include: month/year to month/year of nursing experience, name/address/phone number of employer, including supervisor and phone number. Resumes that lack verifiable information will not be approved.
- Clinical site agreement with Skilled Nursing Facilities, Home Health/Hospice Agency or Acute Care Hospital (2 year duration) where students will receive supervised clinical training. The HHA Training Program has full responsibility of classroom/clinical training.
- CDPH 276 D – Disclosure of Ownership Form (for proprietary schools only).

**California Department of Public Health Use Only**

Provider Identification #: \_\_\_\_\_ Date: \_\_\_\_\_

Approved By: \_\_\_\_\_  
 (CDPH, ATCS, Training Program Review Unit Representative)