

Home Care Aide Certification Application Packet

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Important Social Security Number Information:

You are required by state and federal law to provide a social security number with your application. If you do not have a social security number at the time you send in this application, contact the Customer Service Center at 360-236-4700 for more information.

A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

In order to process your request:

Mail your application with initial documentation and your check or money order payable to:

Department of Health
Home Care Aide Credentialing
PO Box 1099
Olympia, WA 98507-1099

Send other documents not sent with initial application to:

Home Care Aide Credentialing
PO Box 47877
Olympia, WA 98504-7877

Contact us:

360-236-2700
Home Care Aide Credentialing
360-236-4700
Customer Service Center

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Certification Requirements

You must be certified as a home care aide if you are:

- An individual provider of home care services who is reimbursed by the state;
- A direct care employee of a home care agency;
- A provider of home care services to persons with developmental disabilities under [Title 71 RCW](#), paid by Department of Social and Health Services (DSHS);
- A direct care worker in a state licensed assisted living facility and adult family home;
- A respite care provider;
- A direct care worker providing home or community-based services to the elderly or persons with functional disabilities or developmental disabilities.

Apply for certification by completing the following requirements:

1. Fill out and submit the original application, signed and dated, and [fee](#);
2. Complete a DSHS fingerprint-based background check. If you do not have an OCA # when you submit your application to the department, please contact us when you receive your OCA #.

For DSHS background check process, go to their [website](#).

An employer must use the [Fingerprint Appointment form](#) to schedule a DSHS fingerprint appointment.

An applicant must use the [Background Authorization form](#).

If you are not required to get an OCA #, indicate this in section 3 of this application.

3. Provide your date of hire by having your employer complete the enclosed [Employment Verification form](#). Attach your certificate of completion to this form as proof of completion of training.
4. Complete a 75-hour basic training course approved by DSHS before taking the home care aide state certification examinations.
5. Complete four hours of AIDS education and training. You may have completed or will complete the AIDS training through the 75-hour basic training course or through your employer.
6. Pass the state home care aide written or oral, and skills certification examinations. See examination information.
7. If you worked as a healthcare provider in another state, submit a copy of the attached verification form to each state you hold or have held a credential. The state will complete its portion of the form and mail it directly to us.

Beginning July 28, 2013, the deadline to complete testing and certification as a Home Care Aide is extended from 150 to 200 days of hire. You may provide care if you complete the following:

- Fill out and submit the original application, signed and dated, and fee within 14 days of your date of hire;
- Complete the training required by [RCW 74.39A.074\(1\)\(d\)\(i\)\(A\) and \(B\)](#).

You must complete the training within 120 calendar days of the date of hire. If you have not completed the training within this time frame, you are no longer eligible to provide care. You must stop working until you receive a home care aide certification.

Provisional Certification Requirements

The Department of Health may issue a provisional certification to a home care aide who is limited in their ability to read, write or speak English. This will allow additional time to comply with the requirement to become certified within 200 calendar days after the date of hire. See [RCW 18.88B.021](#).

Effective 07/28/2013, if you are within the 150 day deadline of becoming certified, the Department of Health may issue a provisional certificate. The provisional certification may only be issued once and is valid for an additional 60 days for a total of 260 days from the hire date.

Examination Information

You must have a candidate ID number from the Department of Health for the Prometric exam application form. You will apply directly to Prometric, the testing company, to take the examination. You can find your credential number (candidate ID number) on our [website](#). Search by your name, use Home Care Aide as the credential type, use your last name and first name, and select "Search."

Prometric

Attn: Washington Home Care Aide Program

7941 Corporate Dr.

Nottingham, MD 21236

Phone: 800-324-4689

Website: <https://www.prometric.com/en-us/clients/wadoh/Pages/landing.aspx>

Submit to Prometric: examination application form and fee once you know the completion date of your training. Use your Prometric candidate ID number that starts with HM and ends with eight numbers. Prometric will send you the date, time, and place of the examination. Prometric will also send you and the Department of Health your examination results.

Additional Information

There are three categories where you are not required to have a home care aide certification. The categories are below. Follow the instructions if you choose to apply for home care aide certification:

A. You may choose to apply for home care aide certification if one of the following applies:

- You already hold an active healthcare credential as an advanced registered nurse practitioner, registered nurse, licensed practical nurse, nursing assistant certified.
- You are employed by a Medicare certified home health agency and have met the requirements of [42 CFR, Part 484.36](#);
- You have special education training and have an endorsement granted by the Office of Superintendent of Public Instruction;
- You are employed by a community residential service business, unless the employer is also licensed as an assisted living facility or adult family home provider.

Complete the following to apply for certification:

1. Fill out and submit the original application, signed and dated, and [fee](#);
2. Complete a DSHS fingerprint-based background check. If you do not have an OCA # when you submit your application to the department, please contact us when you receive your OCA #.

For DSHS background check process, go to their [website](#).

An employer must use the [Fingerprint Appointment form](#) to schedule a DSHS fingerprint appointment.

An applicant must use the [Background Authorization form](#).

If you are not required to get an OCA #, indicate this in section three of this application.

3. Provide your date of hire by having your employer complete the enclosed [Employment Verification form](#). Attach your certificate of completion to this form as proof of completion of training.
4. Complete four hours of AIDS education and training.
5. Pass the state home care aide written or oral, and skills certification examinations. See examination information.
6. If you worked as a healthcare provider in another state, submit a copy of the attached verification form to each state you hold or have held a credential. The state will complete its portion of the form and mail it directly to us.

B. You may choose to apply for home care aide certification if one of the following applies:

- You are an individual provider caring only for your biological, step, or adoptive child or parent.
- You are an individual provider hired before June 30, 2014, who provides 20 hours or less of care for one person in any calendar month.

Complete the following to apply for certification:

1. Fill out and submit the original application, signed and dated, and [fee](#);
2. Complete a DSHS fingerprint-based background check. If you do not have an OCA # when you submit your application to the department, please contact us when you receive your OCA #.

For DSHS background check process, go to their [website](#).

An employer must use the [Fingerprint Appointment form](#) to schedule a DSHS fingerprint appointment.

An applicant must use the [Background Authorization form](#).

If you are not required to get an OCA #, indicate this in section three of this application.

3. Provide your date of hire by having your employer complete the enclosed [Employment Verification form](#). Attach your certificate of completion to this form as proof of completion of training..
4. Complete a 75-hour basic training course approved by DSHS before taking the home care aide state certification examinations.
5. Complete four hours of AIDS education and training. You may have completed or will complete the AIDS training through the 75-hour basic training course or through your employer.
6. Pass the state home care aide written or oral, and skills certification examinations. See examination information.
7. If you worked as a healthcare provider in another state, submit a copy of the attached verification form to each state you hold or have held a credential. The state will complete its portion of the form and mail it directly to us.

C. You may choose apply for home care aide certification if the following applies:

- If you were employed during 2011, or between January 1, 2012 and January 6, 2012, and you completed all the training requirements in effect as of the date of hire.

Complete the following to apply for certification:

1. Fill out and submit the original application, signed and dated, and [fee](#);
2. Complete a DSHS fingerprint-based background check. If you do not have an OCA # when you submit your application to the department, please contact us when you receive your OCA #.

For DSHS background check process, go to their [website](#).

An employer must use the [Fingerprint Appointment form](#) to schedule a DSHS fingerprint appointment.

An applicant must use the [Background Authorization form](#).

If you are not required to get an OCA #, indicate this in section three of this application.

3. Submit the [Employment Verification form](#) from the employer that hired you or for whom you worked during 2011, and or between January 1, 2012 and January 6, 2012. The employment verification form must be submitted with your application for home care aide certification, you must add your date of hire to this form;
4. Submit proof of completion of the training requirements that were in place on your date of hire with that employer. The [Employment Verification form](#) must be submitted with your application for home care aide certification, you must add your date of hire to this form.
5. Complete four hours of AIDS education and training.
6. Pass the state home care aide written or oral, and skills certification examinations. See examination information.
7. If you worked as a healthcare provider in another state, submit a copy of the attached verification form to each state you hold or have held a credential. The state will complete its portion of the form and mail it directly to us.

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Application Instructions Checklist

You must type or print all information clearly in blue or black ink. It is your responsibility to submit the required forms to the Department of Health.

- ☐ **Application Fee.** This fee is **non-refundable**. You can check the online [fee page](#) for current fees.
- ☐ **Fingerprint-based Background OCA #:** You may have requested background checks from the Department of Social and Health Services in the past. If so, you may have received prior OCA #s. The Department of Health will only accept the most recent fingerprint-based background OCA #.
- ☐ **Check Yes or No:** Are you applying for a provisional certificate that is available for home care aides who are limited in their ability to read, write, or speak english.
- ☐ **1: Demographic Information:**
Social Security Number: You must list your social security number on your application. Please call the Customer Service Center at 360-236-4700 if you do not have one.

National Provider Identifier Number (NPI): The National Provider Identifier (NPI) is a standard unique identifier for health care professionals available from the Federal Centers for Medicare and Medicaid Services. The NPI is a 10 digit numeric identifier. If you have a NPI number, provide this on your application.

Legal Name: List your full name: first, middle, and last.

Definition of legal name: "Legal name" is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.

Birth date: Provide the month, day, and year of your birth.

Birth place: Provide the city, state, and country where you were born.

Address: List the address we should use to send you any information about your license. Be sure to include the city, state, zip code, county, and country. This will be your permanent address with the Department of Health until you notify us of a change. See [WAC 246-12-310](#).

Phone, Fax, and Cell Numbers: Enter your phone, fax, and cell numbers, if you have them.

Email: Enter your email address, if you have one.

Other Name(s): Indicate whether you are known or have been known by any other names. If you have a name change after obtaining a credential, you must notify the Department of Health in writing. You must include legal proof of this change. See [WAC 246-12-300](#).

☐ **2: Personal Data Questions:**

All applicants must answer the same personal data questions on the application. They are focused on your fitness to practice the essential skills of this profession.

If you answer “yes” to any questions in this section, you must provide a complete and accurate explanation. You must submit the appropriate documentation as noted in the personal data questions. If you do not provide this, your application is incomplete and it will not be considered.

- Question 5 refers to misdemeanors, gross misdemeanors and felonies. You do not have to answer “yes” if you have been cited for traffic infractions. You can get copies of your court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- Another jurisdiction means any other country, state, federal territory, or military authority in which convictions may have occurred.

☐ **3: Type of Services Provided:**

Check all that apply:

- Long-term care workers who must become certified home care aides.
- Individuals, who are not required to apply for a home care aide, but choose to apply.

☐ **4: Training and Education:**

List your training and education.

☐ **5: Work Experience:**

List your professional healthcare work experience.

☐ **6: Other License, Certification, or Registration:**

List all states where you hold or have held a credential.

☐ **7: AIDS Education and Training Attestation:**

Read the AIDS education and training attestation. AIDS training may include self-study, direct patient care, courses, or formal training. A minimum of four hours is required. You can find course content in [WAC 246-12-270](#).

☐ **8: Living Within or Outside of Washington State Attestation:**

You must attest to living within or outside of this state. Choose one.

☐ **9: Applicant’s Attestation:**

You must sign and date this for us to process the application.

Notice to Spouses and Registered Domestic Partners of Military Personnel Transferring to Washington

Under a new state law, a spouse or registered domestic partner of military personnel transferring to Washington may receive his or her health professional license more quickly. In order for us to do this, please complete the additional form found at [the military resources page](#) and include supporting documentation with your application.

Background
Check
Stamp Here

Date
Stamp
Here

Revenue 0299100001

Home Care Aide Certification Application

Fingerprint-based background OCA #: _____
(If you do not have a fingerprint-based background OCA #, be sure to complete section three of the application form.)

Provisional Certification

I am applying for a provisional certificate which is available for home care aides whose ability to read, write and speak English is limited: ☐ Yes ☐ No

1. Demographic Information

Social Security Number (SSN) (If you do not have a SSN, see instructions)	National Provider Identifier Number (NPI) (Enter 10 digit number)	<input type="checkbox"/> Male <input type="checkbox"/> Female
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Name: First Middle Last

Birth date (mm/dd/yyyy)	Place of birth		
	City	State	Country

Address

City	State	Zip Code	County
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Country

Phone (enter 10 digit #)	Fax (enter 10 digit #)	Cell (enter 10 digit #)
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Email address:

Mailing address if different from above address of record:

City	State	Zip Code	County
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Country

Note: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information on file with the department.

Have you ever been known under any other name(s)? ☐ Yes ☐ No
If yes, list name(s):

Will documents be received in another name? ☐ Yes ☐ No
If yes, list name(s):

2. Personal Data Questions

Yes No

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation..... ☐ ☐

“Medical Condition” includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disabilities, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

If you answered yes to question 1, explain:

1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.

1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

Note: If you answered “yes” to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.

The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

“Currently” means within the past two years.

“Chemical substances” include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism? ☐ ☐

4. Are you currently engaged in the illegal use of controlled substances? ☐ ☐

“Currently” means within the past two years.

Illegal use of controlled substances is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed healthcare practitioner.

Note: If you answer “yes” to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? .. ☐ ☐

Note: If you answered “yes” to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.

To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.

2. Personal Data Questions (Cont.)

Yes No

- a. Are you now subject to criminal prosecution or pending charges of a crime in any state or jurisdiction ☐ ☐

Note: If you answered "yes" to question 5a, you must explain the nature of the prosecution and/or charge(s). You must include the jurisdiction that is investigating and/or prosecuting the charges. This includes any city, county, state, federal or tribal jurisdiction. If charging documents have been filed with a court, you must provide certified copies of those documents. If you do not provide the documents, your application is incomplete and will not be considered.

- b. If you answered "yes" to question 5a, do you wish to have decision on your application delayed until the prosecution and any appeals are complete? ☐ ☐
6. Have you ever been found in any civil, administrative or criminal proceeding to have:
- a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes? ☐ ☐
- b. Diverted controlled substances or legend drugs? ☐ ☐
- c. Violated any drug law? ☐ ☐
- d. Prescribed controlled substances for yourself? ☐ ☐
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a healthcare profession? If "yes", please attach an explanation and provide copies of all judgments, decisions, and agreements? ☐ ☐
8. Have you ever had any license, certificate, registration or other privilege to practice a healthcare profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority? ☐ ☐
9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority? ☐ ☐
10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a healthcare profession? ☐ ☐
11. Have you ever been disqualified from working with vulnerable persons by the Department of Social and Health Services (DSHS)? ☐ ☐

3. Type of Services Provided

Long-term care workers who must become certified home care aides.

Check all that apply:

- ☐ Home care services
- ☐ Adult family home
- ☐ Assisted living facility
- ☐ Respite care
- ☐ Contracted individual provider
- ☐ Direct care employee of home care agency
- ☐ Any other direct care worker providing home or community based services to the elderly or persons with functional or developmental disabilities.

Individuals, who are not required to apply for a home care aide, but choose to apply.

Check all that apply:

- ☐ Currently unemployed, no OCA #
- ☐ Any other care worker who is not paid by the state or by a private agency, or facility licensed by the state.
- ☐ An individual provider caring only for his or her biological, step, or adoptive child or parent.
- ☐ A person hired as an individual provider who provides twenty hours or less of care for one person in any calendar month.
- ☐ Has a credential as a advanced registered nurse practitioner, registered nurse, licensed practical nurse, nursing assistant certified.
- ☐ A home health aide who is employed by a medicare certified home health agency and has met the training requirements of federal law.
- ☐ Has special education training and an endorsement granted by the Superintendent of Public Instruction.
- ☐ Worked as a long-term care worker at some time between January 1, 2011 and January 6, 2012 and completed the training required of you on your date of hire.
- ☐ Employed by community residential service business.

4. Training and Education

List your training and education. Attach additional completed pages if you need more space.

Full Name, City and State/Schools Attended	Degree Earned	Attendance	
		Entrance Date	Ending Date

5. Work Experience

List your professional healthcare work experience. Attach additional completed pages if you need more space.

Name and Location of Institution	From (mm/dd/yy)	To (mm/dd/yy)	Type of Experience or Speciality

6. Other License, Certification, or Registration

List all states where credentials are or were held. Attach additional completed pages if you need more space.

State	License/Certification/Registration Type	License/Certification/Registration		Method of Licensure		
		Year Issued	Number	Exam	Endorse	Grand Fathered

7. Aids Education and Training Attestation

I certify I have completed the minimum of four hours of education in the prevention, transmission and treatment of AIDS, which included the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations.

I understand I must maintain records documenting said education for two years and be prepared to submit those records to the department if requested. **I understand that should I provide any false information, my license may be denied, or if issued, suspended or revoked.**

Applicant's Initials	Date

8. Living Within Washington State Attestation

I certify I have lived within Washington State for the last two years.

Applicant's Initials	Date

9. Applicant's Attestation

I, _____, declare under penalty of perjury under the laws of the state of
(Print name of applicant clearly)
Washington that the following is true and correct:

- I am the person described and identified in this application.
- I have read [RCW 18.130.170](#) and [RCW 18.130.180](#) of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand that I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality healthcare. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated _____ at _____
(mm/dd/yyyy) (City, state)

by: _____
(Original signature of applicant)



Home Care Aide Credentialing
PO Box 47877
Olympia, WA 98504-7877
360-236-4700

Employment Verification Form

(to be completed by employer)

Note: this form is not required if you are unemployed.

Last Name of Individual Hired:	First Name:
Middle Name/Initial:	Date of Birth of Individual:
Date of Hire:	Last Date of Employment:
Job Title and Description:	

Training requirements completed on the date individual was hired:

Note: Individuals who worked between January 1, 2011 and January 6, 2012 must send proof of training requirements completed at the time of hire, which can be a certificate of completion.

Name of facility or agency, if applicable

Name of Employer (print)

Title (print)

Signature of Employer

Please send completed form to the above address.

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Home Care Aide Credentialing
PO Box 47877
Olympia, WA 98504-7877
360-236-4700

Out-of-State Credential Verification

To Applicant:

Please complete this side of form and send it to the state(s) and/or jurisdiction(s) where you are or have been licensed, certified, or registered as a healthcare provider. Instruct them to return the form directly to the address listed above. Make a copy of this form if you need to send it to more than one state or jurisdiction. Agencies normally charge a fee for verification. Please check in advance to help expedite this process.

Name	Last	First	Middle
Mailing Address			
City	State	Zip Code	
Any other names used			
Type of healthcare license, certification, or registration			
License, Certification, or Registration Number		Date Issued	

Have the licensing agency return this completed form to the address listed above.

If you have any questions, please call 360-236-4700.

(To be Completed by the Regulatory Agency)

Please complete this form regarding the applicant listed on the reverse. Submit the completed form and any other requested material directly to this office at the address on the reverse. We will not accept the form if submitted by the applicant. Thank you.

Name of license, certification, or registration holder:		
Authority providing verification: (state, name & title)		
Applicant was credentialed by: <input type="checkbox"/> Written Examination	Date:	Score:
Name of examination:		
<input type="checkbox"/> Other Examination	Date:	Score:
Name of examination:		
Is credential current: <input type="checkbox"/> Yes <input type="checkbox"/> No	Expiration Date:	
Is this individual considered to be in good standing in your state? <input type="checkbox"/> Yes <input type="checkbox"/> No If "no," please attach explanation.		
Has this credential ever been denied? Suspended? Revoked? Surrendered? Reinstated?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	
If "yes," please provide a copy of the final order or other documentation of action taken.		
If this credential holder has been disciplined, has he/she successfully completed all requirements and is currently in good standing? <input type="checkbox"/> Yes <input type="checkbox"/> No		

(SEAL)

Signature: _____

Title: _____

Date: _____



RCW/WAC and Online Website Links

RCW/WAC Links

[Uniform Disciplinary Act, RCW 18.130](#)

[Administrative Procedure Act, RCW 34.05](#)

[Administrative procedures and requirements, WAC 246-12](#)

[Home Care Aide Law, RCW 18.88B](#)

[Home Care Aide Rules, WAC 246-980](#)

On-line

[AIDS Training Resources, Reference Page](#)

[Department of Social and Health Services, Aging and Disability Services Administration,
http://www.adsa.dshs.wa.gov/professional/training](#)

[Home Care Aide Program, Web Page](#)

[Prometric,
http://www.prometric.com/default.htm](#)

List-Serv

To receive emails regarding important home care aide information, please join our interested parties at our [List-Serv](#).