



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, please read, complete, and return this [form](#) with your application.

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
P.O. Box 1099
Olympia, WA 98507-1099

Send other documents not sent with initial application to:

Home Care Aide Credentialing
P.O. 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 disabilities.

Apply for certification by completing the following requirements:

1. Complete and submit the original application, signed and dated, and [fees](#).
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](#).

To schedule a DSHS fingerprint appointment work with your employer to complete the [Fingerprint Appointment form](#) and [Background Check Authorization form](#).

3. Provide your date of hire by having your employer complete the enclosed [Employment Verification form](#).
4. Complete a 75-hour basic training course approved by DSHS before taking the home care aide state certification examination.
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. Indicate how you are applying in section three of this application.
7. Pass the state home care aide knowledge and skills certification examinations.
8. If you worked as a healthcare provider in another state or jurisdiction, submit a copy of the attached verification form to each state you hold or have held a healthcare license, certification, or registration. The state will complete its portion of the form and mail it directly to us.

You may provide care if you complete the following:

- Fill out and submit the original application and fees, signed and dated. Your application must be submitted 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. The deadline to become certified as a home care aide is 200 days from date of hire. If you do not meet these time frames, 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](#).

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

An email address is required for examination. All testing information will be sent to this email address. Please check your email daily.

First time test takers:

Complete this application including [section nine](#). Once we have received notification that your training has been completed, the examination fee has been paid and all documents have been received by the Department of Health, then we will notify Prometric, the examination company that you are authorized to test and will email an examination authorization letter to you.

Prometric will email you an admission to test letter with the date, time, and place of the examination. Once you have taken your examination, Prometric will send the Department of Health your examination results.

Examination retakes are scheduled directly by Prometric. See the [Prometric website](#) for more information.

Reasonable testing accommodations:

If you are applying for reasonable testing accommodations recognized under the Americans with Disabilities Act (ADA), print the [testing accommodations request packet](#) and submit directly to [Prometric](#) at: Prometric, Attn: Washington Home Care Aide Program, 7941 Corporate Dr., Nottingham, MD 21236.

Note: Reasonable testing accommodations are provided to allow candidates with documented disabilities recognized under the Americans with Disabilities Act (ADA) an opportunity to demonstrate their skills and knowledge.

Thirty days advance notice is required for all special testing. You will be notified the outcome of the review before testing is scheduled. There is no additional charge for these accommodations. If English is your second language, a language barrier is not considered a disability.

Interpreter Request:

Please see the Department of Health [website](#) for information on testing with a one on one interpreter in a language that is not listed on [page six](#) of this application.

To apply to test with a one on one interpreter, print and complete the [testing accommodations request packet](#) and submit directly to [Prometric](#) at: Prometric, Attn: Washington Home Care Aide Program, 7941 Corporate Dr., Nottingham, MD 21236.

Additional Information

There are four 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.
- Within the last year you are or have been 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 an endorsement that is active and in good standing 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. Complete and submit the original application, signed and dated, and [fees](#);
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](#).

To schedule a DSHS fingerprint appointment work with your employer to complete the [Fingerprint Appointment form](#) and [Background Check Authorization form](#).

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. Indicate how you are applying in section three of this application.
6. Pass the state home care aide knowledge and skills certification examination.
7. If you worked as a healthcare provider in another state or jurisdiction, submit a copy of the attached verification form to each state you hold or have held a healthcare license, certification, or registration. 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. Complete and submit the original application, signed and dated, and [fees](#);
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](#).

To schedule a DSHS fingerprint appointment work with your employer to complete the [Fingerprint Appointment form](#) and [Background Check Authorization form](#).

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. Indicate how you are applying in section three of this application.
7. Pass the state home care aide knowledge and skills certification examination.
8. If you worked as a healthcare provider in another state or jurisdiction, submit a copy of the attached verification form to each state you hold or have held a healthcare license, certification, or registration. The state will complete its portion of the form and mail it directly to us.

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

- If you were employed at some time between January 1, 2011 and January 6, 2012 in Washington State, and you completed all the training requirements in effect as of the date of hire.

Complete the following to apply for certification:

1. Complete and submit the original application, signed and dated, and [fees](#);
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](#).

To schedule a DSHS fingerprint appointment work with your employer to complete the [Fingerprint Appointment form](#) and [Background Check Authorization form](#).

3. Submit the [Employment Verification form](#) from the employer you worked for between January 1, 2011 and January 6, 2012 in Washington State. 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. Indicate how you are applying in section three of this application.
7. Pass the state home care aide knowledge and skills certification examinations.
8. If you worked as a healthcare provider in another state or jurisdiction, submit a copy of the attached verification form to each state you hold or have held a healthcare license, certification, or registration. The state will complete its portion of the form and mail it directly to us.

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

- If you are a training instructor and are not providing long-term care services.
- If you are unemployed and have not completed a finger-print background check through a long-term care agency.
- If you are not paid by the state, private agency or facility licensed by the state.

Complete the following to apply for certification:

1. Complete and submit the original application, signed and dated, and [fees](#);
2. Complete a 75-hour basic training course approved by DSHS before taking the home care aide state certification examinations.
3. Pass the state home care aide knowledge and skills certification examination.
4. If you worked as a healthcare provider in another state or jurisdiction, submit a copy of the attached verification form to each state you hold or have held a healthcare license, certification, or registration. The state will complete its portion of the form and mail it directly to us.
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. Indicate how you are applying in section three of this application.

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Application Instructions Checklist

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

- Application and Examination Fees.** Application fees are **non-refundable**. You can check the online [fee page](#) for current fees.
- Fingerprint-based Background OCA #:** The Department of Health will only accept the most recent fingerprint-based background OCA #.
- Provisional Certificate:** Select if you 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.
- Examination and payment selection:**
 - Select state pay, if your fees are being paid for by the [SEIU Training Partnership](#).
 - Select self pay if you or your employer are paying your fees. Send your payment with the completed attached form.
- Select if the following applies:**
Spouse or Registered Domestic Partner of Military Personnel
- 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 Address for Test Date (Required): Enter your email address for examination. Correspondence sent by the examination company will be sent to this email address. An email address is required for your examination.

Personal Email Address: Enter your personal email address. Correspondence sent by the department will be sent to this address.

Employer Email: Enter your employer's email address. Your employer will be added to all correspondence sent to you by the department.

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:
List your training.

5: Other License, Certification, or Registration:
List all states where you hold or have held a credential. Submit the [Out-of-State Credential Verification Form](#) to all states that you list.

6: 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. AIDS education and training is included in the 75 hour basic training course. You can find course content in [WAC 246-12-270](#).

7: Examination:

You must complete this section to be scheduled for the required examination.

8: Applicant's Attestation:

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

For Spouses and Registered Domestic Partners of Military Personnel Being Transferred or Stationed in Washington:

Under state law, if you are the spouse or state-registered domestic partner of a servicemember of any branch of the U.S. Military, to include Guard or Reserve, and are applying for a health care professional credential in this state, you may be eligible to have the processing of your application expedited to receive your credential more quickly.

Documents to submit with your application should include the following:

- A copy of your spouse's or registered domestic partner's military transfer orders to Washington State.
- One of the following:
 - A copy of your marriage certificate to show proof of marriage; or
 - A copy of a state's declaration or registration showing you are in a state registered domestic partnership with a member of the U.S. military.

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Washington State Department of
Health
Home Care Aide Credentialing
P.O. Box 1099
Olympia, WA 98507-1099

Date
Stamp
Here

Revenue 0299100001

Home Care Aide Certification Application

Fingerprint-based background OCA #: _____
If you are unemployed with no fingerprint-based background OCA #, check the box in section three of the application.

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

Select if the following applies: State pay Self Pay

Select if the following applies: Spouse or Registered Domestic Partner of Military Personnel

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 for Test Date (Required)

Personal Email	Employer Email
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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

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:

- Unemployed and have not completed a finger-print based background check through a long-term care agency.
- 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 or nursing assistant certified, that is active and in good standing.
- Within the year prior to being hired as a long-term care worker was employed by a medicare certified home health agency and has met the training requirements of federal law.
- Has an active special education endorsement granted by the Office of Superintendent of Public Instruction.
- Worked as a long-term care worker at some time between January 1, 2011 and January 6, 2012 in Washington State and completed the training required of you on your date of hire.
- Employed by community residential service business.
- A person that is a training instructor but not providing long-term care services.

4. Training

List the training program you will or have completed. Provide a copy of the certificate of completion to the Department of Health.

Note: If you are in the process or have completed the required training through the SEIU Training Partnership, you do not need to submit a copy of your certificate of completion to the Department of Health. The department will receive your training information electronically.

Name of 75 hour home care aide training program	Date of Completion

Training Exemption:

If you are exempt from the 75 hour home care aide training, list the training that was required on your date of hire.

Name of training completed	Date of Completion

5. 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

6. 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.** If AIDS education was included in your professional education or training, an additional course is not required.

Applicant's Initials	Today's Date

7. Examination (This section should only be completed if you are a first time test taker.)

You must complete this section to be scheduled for the required examination.

Note: You will be required to provide government issued identification for admission to test. If the name you use in this application does not exactly match the name on your identification, you will not be allowed to test.

Test Site Information—Check One:

Regional Test Site—I am applying to test at a Regional Test Site.

My preferred exam site code is: _____
See the online list at www.prometric.com/wadoh.

In-Facility Site—My employer or training program is scheduling my testing and I will take the exams at their facility.

The site code is _____. Your employer or training program can provide this to you.

Examination Selection:

Reasonable testing accommodations:

Are you applying for testing accommodations? Yes No—**This question cannot be left blank.**

If you are applying for reasonable testing accommodations recognized under the Americans with Disabilities Act (ADA), print the [testing accommodations request packet](#) and submit directly to **Prometric** at:

Prometric, Attn: Washington Home Care Aide Program, 7941 Corporate Dr., Nottingham, MD 21236.

Note: 30 day advance notice is required for all special testing arrangements.

If you would like to take an exam in a language other than English, please indicate which language:

Knowledge Exam: Korean Russian Simplified Chinese Spanish
 Vietnamese Khmer Ukrainian Arabic
 Samoan Somali Tagalog Laotian

Skills Evaluation: Korean Russian Simplified Chinese Spanish
 Vietnamese Khmer Ukrainian Arabic
 Samoan Somali Tagalog Laotian

Individual Interpreter:

Are you applying for a one on one interpreter for a language that is not listed above? Yes No

To apply to test with a one on one interpreter, print and complete the [testing accommodations request packet](#) and submit directly to **Prometric** at:

Prometric, Attn: Washington Home Care Aide Program, 7941 Corporate Dr., Nottingham, MD 21236.

Applicant's Affidavit and Release Statement:

- I understand I am responsible for making sure all of the information I have provided is completely true and correct.
- I understand if information given is not true, my status as a certified home care aide may be jeopardized.
- I understand I must pass both parts of the Washington Home Care Aide Certification Examination and meet all other Washington State requirements, to receive my certification.
- I understand that I may be asked to play the part of the client for another candidate on exam day. I do not have any physical, medical or other condition that would be affected in any way by my participation in the exam.
- I agree that I am responsible for my own personal safety both while taking the exam and acting as a client. I hereby release Prometric, the Washington State Department of Health, and their agents and assigns from any responsibility or liability for any claim or damage that may result from my participation in the examination.

Applicant's Initials	Date

8. 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 have read all laws and rules related to my profession.

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 _____ by: _____
(mm/dd/yyyy) (Original signature of applicant)

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Washington State Department of
Health
 Home Care Aide Credentialing
 P.O. Box 47877
 Olympia, WA 98504-7877
 360-236-4700

Long Term Care Employment Verification Form (to be completed by the client or 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 (mm/dd/yyyy):	Last Date of Employment:
Job Title and Description:	
Training required on the date individual was hired:	

Note: If you have worked at some time between January 1, 2011 and January 6, 2012 in Washington State, your employer during this time frame must complete the job title and description section of this form and 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 or Client (print)	Title (print)
------------------------------------	---------------

Address of employer

City	State	Zip Code
------	-------	----------

Signature of Employer or Client

Please send completed form to the above address.

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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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Suspended?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Revoked?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Surrendered?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Reinstated?	<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](#)

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

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