

Home Care Aide Certification Application Packet

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Important Social Security Number Information:

If you have a Social Security Number, the law requires you to disclose it on your application for a professional or occupational license. [42 U.S.C. § 666\(a\)\(13\)](#); [RCW 26.23.150](#). It will be used under the state's child support enforcement program to locate individuals for purposes of establishing paternity and establishing, modifying, and enforcing support obligations. You are not required to have or obtain a Social Security Number to apply for or obtain a license from the Department of Health. If you do not have a Social Security Number, you are still eligible to apply for and obtain a credential if you meet the requirements. Please see the [Declaration of No Social Security Number Form](#). Please call the Customer Service Center at 360-236-4700 if you have questions.

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

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email doh.information@doh.wa.gov.

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Requirements for Home Care Aide Certification

1. Submit the completed home care aide application to the Department of Health, including the [Employment Verification form](#) unless unemployed or information is provided on this initial application.
2. Complete Department of Social and Health Services (DSHS) long-term care fingerprint-based background check.
3. Complete a 75-hour basic training course approved by DSHS.
4. Pass the home care aide knowledge and skills certification examinations.

You may provide care without certification after you complete the following:

- Submit completed application 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 all training within 120 calendar days of the date of hire. The deadline to become certified as a home care aide is 365 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.

The Department of Health and the Department of Social and Health Services have rules in place to allow additional time to complete training and become certified. Please see the alternative training timeline on our [Home Care Aide](#) webpage.

Application Instructions Checklist

You must hand write in English all information clearly in ink. It is your responsibility to submit the required forms to the department.

- Application Fee.** Complete and submit the original, handwritten application with the application [fee](#). Application fees are **non-refundable** per [WAC 246-980-990](#).
- Provisional Certificate:** The department may issue a provisional certification to long-term care workers who are limited in their ability to read, write, or speak English. See [WAC 246-980-065](#). The provisional certification may only be issued once and is valid for an additional 60 days, for a total of 425 days. A date of hire is required in order to be issued a provisional certification.
- 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 application to avoid delays in processing.

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

1. Demographic Information:

Social Security Number: If you have a valid Social Security Number, you are required to list your social security number on your application. You are not required to have or obtain a Social Security Number to apply for or obtain a license from the Department of Health. Please see the [Declaration of No Social Security Number Form](#) if you do not have one.

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

Please Note: You will be required to provide a valid 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.

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 you were born.

Address: List the address we should use to send you any information about your credential. 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 and cell numbers, if you have them.

Email Address for Exam Notifications (Required): Enter your valid email address for examination. The examination company will email instructions on how to schedule the exam to this email address. If your email address changes, please notify us immediately.

Employer Email (Optional): Enter your employer’s email address. Your employer will receive emails sent to you by the department and the exam company.

Other Name(s): List any other legal names you are or have been known by. If you have a name change at any point, you must notify the department and 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.

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: Employment Information:

- Indicate if you are currently employed.
- Fingerprint-based Background Inquiry ID/OCA #: Work with your employer to complete a DSHS long-term care fingerprint-based background check. The department will only accept the final long-term care fingerprint-based background inquiry ID# or OCA#. If you do not have an inquiry ID# or OCA# submit the application without it and contact us when you receive it.
- Please provide your date of hire with your employer, if applicable. You may also call the home care aide unit directly to provide your date of hire.
- Provide your employer’s name, email address, and phone number.

4: Other License, Certification, or Registration:

List all states, including Washington, in which professional credentials are or were held. Attach additional page if you need additional space. You must also print a verification form and provide it to each state in which you have listed, requesting that they complete and submit the form directly to DOH.

5: Training and Testing Information:

Complete this section to assist with scheduling your exams.

- Provide your estimated training completion date if you are registered for a training program. Once your training is completed, please submit your certificate of completion to the Department of Health.
- Please provide a regional or in-facility test site code that best fits your needs in order to schedule your exam with Prometric
- Provide the program site code if you are testing within your training program.
- Check “Yes” if you will need Americans with Disabilities Act (ADA) accommodations or a language interpreter.

Once your application and fee are processed, you will receive a confirmation email with instructions on how to schedule your exams.

During the exam scheduling process, you will be asked again if you need to request interpreter services or Americans with Disabilities Act (ADA) accommodation arrangements. There is no additional charge for accommodations.

Once you have taken your examination, Prometric will send the department your examination results.

If you have taken your exams within an approved training program, your instructor will send us your exam results directly.

6: Applicant’s Attestation:

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

Additional Documents Required with the Application:

Employment Verification Form:

Applicants that are exempt from training require an additional [Long Term Care Employment Verification Form \(wa.gov\)](#) or letter from the employer they worked for between January 1, 2011, and January 6, 2012, and a copy of their fundamentals training certificate of completion from DSHS.

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 an active servicemember of any branch of the U.S. Military, to include Guard or Reserve, and are applying for a healthcare 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.

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. Employment Information:

Are you currently employed as a long-term care worker?:

- Yes No

If you are not currently employed, but completed your long-term care fingerprint-based background check, please complete OCA/Inquiry ID field in section 3B.

- Please check this box if you are currently a Highschool student in an HCA Program

3A. Long-term care workers type of service. Please check all that apply:

- Adult family home provider Contracted individual provider Respite Care
 Home Care Services Caregivers for a VHA Medical Foster Home
 Assisted living facility provider Direct care employee of home care agency
 Any other direct care worker providing home community-based services to the elderly or persons with functional or developmental disabilities

3B. Please enter your inquiry ID/OCA number, and employer information below if you are employed.

Please note: Please be sure to add your **long-term care final fingerprint OCA/Inquiry ID number**. Name and date of birth background check numbers are not valid.

Inquiry ID# or OCA#: _____

Please provide your Date of Hire: (mm/dd/yyyy) _____

Please provide your employer's information:

Employer Name: _____

Employer Email: _____

Employer Phone Number: _____

4. Other License, Certification, or Registration

List all states, including Washington, where licenses/certifications/registrations are or were held.

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

5. Training and Testing Information:

You must be registered for training in order to schedule your exam.

What is your estimated completion date for training? _____

Test Site Information Required:

If you are testing with Prometric, please fill out the information below:

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

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 with Prometric and I will take the exams at their facility.

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

If you are testing with your approved instructor at their program site, please fill out the information below:

Program test site code is _____. (Your training instructor can provide you this code.)

Testing Accommodations and Interpreter Services Required:

Please answer the following questions whether you are testing with Prometric or within your training program. If you are testing within your training program, please let your training instructor know of any accommodations you will need.

Are you applying for testing accommodations? Yes No

Do you need an interpreter to assist with the knowledge and skills exam? Yes No

5. Testing Accommodations and Interpreter Services (Continued)

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

- Knowledge Exam:** Arabic Amharic Khmer Korean
 Laotian Russian Samoan Simplified Chinese
 Somali Spanish Tagalog Ukrainian
 Vietnamese
- Skills Evaluation:** Arabic Amharic Khmer Korean
 Laotian Russian Samoan Simplified Chinese
 Somali Spanish Tagalog Ukrainian
 Vietnamese

6. 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)



Home Care Aide Credentialing
 P.O. Box 47877
 Olympia, WA 98504-7877
 360-236-4700

Long Term Care Employment Verification Form

Please email to: hmccapplication@doh.wa.gov

Note: This form is not required if you are unemployed or information was provided on your initial application.

Name of Long-Term-Care Worker (last, first, middle):		
Date of birth:	First Date of hire (mm/dd/yyyy): (For initial applications only)	New Date of hire (mm/dd/yyyy): (For applicants returning to the profession)
Pending Home Care Aide credential number (HMCC.HM.XXXXXXXXXX) Credential number can be found here .		
If you have not successfully passed the Prometric exams, please provide your estimated training completion date (mm/dd/yyyy) _____		

Employer Name (please print)

Employer Address

Employer Email Address

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email doh.information@doh.wa.gov.

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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](#)

Online

[Training Information - Department of Social and Health Services](#)

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

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

Get important information about your credential type by [subscribing to email alerts](#).