

Home Health Aide Qualification by Experience Documentation



Phone 800.875.4404

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www.ncctinc.com

To be completed by the applicant: (Please return this form to NCCT with your application.)

Name of applicant _____

Today's Date (MM/DD/YYYY) _____ NCCT User ID # _____

The remainder of this form is to be completed by the applicant's direct supervisor .

The person named above is applying for certification in the field of Home Health Aide. References are an important part of the application process. Please answer these questions about the candidate, and return this form to the candidate for inclusion with their own application. If, for any reason, you do not wish to return this form to the candidate, you may send it to us directly at: NCCT, 11020 King Street, Suite 400, Overland Park, Kansas 66210. Please notify candidate if you choose to do so. Thank you.

Note: This page may be photocopied if more than one employer or supervisor will be verifying cases and providing documentation.

Have you known this candidate for more than one year? Yes No How long?
Is/Was this candidate employed by you or your organization? Yes No
If you answered "Yes" to the above question, has the candidate had at least 6 months of full time Home Health Aide experience with at least two (2) clients or at least one (1) year of full time Home Health Aide experience with one (1) client? Yes No
Client date of care: _____ (month/year) to _____ (month/year) Client date of care: _____ (month/year) to _____ (month/year) Client date of care: _____ (month/year) to _____ (month/year)
Can you attest to this candidate's proficiencies and qualifications in the Home Health Aide field? Yes No
Do you believe this candidate to be of good moral character?

The Certified Home Health Aide (CHHA) examination will assess whether the candidate possesses the essential knowledge and skills required to competently perform tasks as a Certified Home Health Aide.

Verification Statement: Minimum Critical Skill Competency Requirements

By signing this form, I am verifying the applicant named above is competent (dependable, consistent, and successful) in performing their duties as a Home Health Aide.

Today's Date: MM/DD/YYYY _____

Supervisor/Verifier Contact Information:

Supervisor/Verifier Signature _____

Supervisor/Verifier Printed Name _____

Company Name _____

Supervisor's Title _____

Address _____ City, State _____ Zip _____

Phone _____ Email _____

Note: School may not verify skills or employment. Employment and skills are to be verified by employer.