

## **GENERAL INSTRUCTIONS:**

1. Complete all questions in Part I and the Operator’s Certification in Part II.
2. Submit all documentation requested in the application. Label each item submitted with the Part and the Question Number that it addresses.
3. If a question does not apply to your agency, answer N/A and attach an explanation of why it is not applicable. The explanation should be labeled with the Part and the Question Number.
4. Sign the certification contained in Part II.
5. Submit the application and all supporting documentation to:

NEW YORK STATE DEPARTMENT OF HEALTH

\_\_\_\_\_

\_\_\_\_\_ See Appendix C \_\_\_\_\_

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6. If you have questions about the application, please contact the appropriate NYSDOH regional office (See Appendix D).

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## PART I

**PROGRAM NAME:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

OPERATING CERTIFICATE NUMBER: \_\_\_\_\_ CERTIFIED HOME CARE AGENCY (CHHA)

LICENSE NUMBER: \_\_\_\_\_ LICENSED HOME CARE SERVICE AGENCY (LHCSA)

LICENSE NUMBER: \_\_\_\_\_ LIMITED LICENSED LHCSA

OPERATING CERTIFICATE NUMBER: \_\_\_\_\_ HOSPICE

OTHER TYPE OF ORGANIZATION OR OTHER THAN ABOVE (specify): \_\_\_\_\_

PERSON TO BE CONTACTED FOR QUESTIONS RELATED TO THE INFORMATION CONTAINED IN THE APPLICATION:

\_\_\_\_\_ PHONE NUMBER: (\_\_\_\_) \_\_\_\_\_

E-mail: \_\_\_\_\_

1. List the NAME of the person(s) assigned to supervise and teach the home health aide training program. Also list the name(s) of additional program trainers on a separate sheet. Attach a copy of the resume and license for each named individual to document that the required qualifications are met.
  - 1a. PROGRAM DIRECTOR: \_\_\_\_\_
  - 1b. PROGRAM INSTRUCTOR (S) AND CLINICAL SUPERVISOR (S): \_\_\_\_\_  
Please use and attach additional sheets if needed.
2. Indicate the maximum number of trainees each instructor/supervisor will be responsible for at any one time during the training program. Maximum trainee: supervisor ratio allowable is 20:1 for classroom training (consistent with training space) and 10:1 for supervised practical training.

3. What is the total number of program hours allocated to:
  - a. Knowledge content [didactic] \_\_\_\_\_
  - b. Supervised practical training [SPT] in classroom \_\_\_\_\_
  - c. Supervised practical training with clients/patients \_\_\_\_\_. At least 50% of the supervised practical training time must be performed with clients/patients in patient care settings, not the classroom lab.
  
4. What is the total length of the program from the first to the last training day? \_\_\_\_\_ Days
  
5. How many days from the last day of training until the Certificate of Completion is issued? \_\_\_\_\_  
(NOTE: The training program must be completed within the first 60 days from the first day of training and the training program Certificate of Completion must be issued to the student within 30 days of training program completion. The training period cannot exceed 90 days.)
  
6.
  - a. Complete the enclosed Appendix A indicating the training program day and time for each required topic.
  - b. Prepare a home health aide training program schedule, by training program day, indicating the training program schedule for each day, including training topic and time, testing time, break time and meal time. The training program schedule may be completed on the format provided [Appendix B] or on your own format, provided the required information is present.
  - c. Provide a copy of the Competency Evaluation form used to substantiate the individual's clinical skills competencies. The competency evaluation form must list all of the skills to be evaluated, the method of evaluation, the satisfactory or unsatisfactory outcome of the evaluation, and the identity [full name and license number] of the registered nurse who performed the evaluation of the trainee's performance of each task.
  
7. Attach copies of your Agency's policy and procedures pertaining to or addressing the following:
  - a. Home health aide training program, including training program admission criteria, training program attendance requirements, training program remediation, competency evaluation only (testing out), personal care aide upgrading, and certified nursing home nurse aide transitioning.

- b. Home health aide trainee supervised practical training (SPT). If SPT will NOT be performed utilizing clients of your home care agency, please provide copies of signed contracts or letters of intent from other home care agencies or health care settings. Appropriate location(s) for the home health aide trainees to perform the required supervised practical training with residents or clients must be secured. **Nursing homes may not be used as SPT locations.**
  - c. Maintenance and confidentiality of all home health aide training records including examinations, standardized curricula unit and module tests/quizzes, standardized assessment materials, and competency evaluation forms.
  - d. Maintenance of training program records for all persons trained. The training record for each person who has successfully completed home health aide training and/or competency evaluation, including copies of the training certificate of completion and the competency evaluation form must be retained for a period of at least six [6] years.
  - e. Provide a blank copy of the Certificate of Training Program Completion to be issued by your program.
  - f. Home Health Aide trainee probation period and performance evaluations (NOTE: The training program must be completed within the first 60 days from the first day of training and the training program Certificate of Completion must be issued to the student within 30 days of training program completion. The training period cannot exceed 90 days).
8. Attach documentation that the area and space provided for conducting the training program are adequate for the maximum number of trainees to be accepted for a program. Include the following:
- a. Location of the classroom and clinical training space;
  - b. Diagram of the training space showing the dimensions [length and width], doors and windows of the training room. Also, indicate the location of tables/desks and chairs, running water, kitchen facilities, audiovisual equipment, storage space, electrical outlets and lighting that support a teaching environment;
  - c. Listing of all training program equipment and supplies available at the training location to adequately demonstrate and practice clinical skill tasks;
  - d. Copy of the lease or signed written agreement for the use of the training space; and
  - e. Copy of the "Certificate of Occupancy" for the training space.

**IMPORTANT NOTE:**

Any home health aide training program, regardless of sponsor, who requires the trainee to pay any amount of tuition money in excess of \$100.00 fee in connection with receiving and/or completing home health aide training or a home health aide certificate of completion, **MUST** obtain New York State Education Department [NYSED] licensure as a proprietary school. The Department of Health will not approve any home health aide training program that charges any type or form of tuition in excess of \$100.00 in exchange for home health aide training. Directions to obtain NYSED proprietary school licensure may be found on the NYSED WEB site: <http://www.highered.nysed.gov/bpss/steps.htm>.

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**BELOW FOR DEPARTMENT USE ONLY:**

DATE OF RECEIPT OF APPLICATION: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

DATE OF DOH RESPONSE: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Approval \_\_\_\_\_

Request for additional information/clarification \_\_\_\_\_ Date additional information received \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

DATE OF TRAINING PROGRAM APPROVAL: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

REVIEW BY: \_\_\_\_\_

## **PART II**

### **OPERATOR'S CERTIFICATION**

**AGENCY NAME:** \_\_\_\_\_

**AGENCY ADDRESS:** \_\_\_\_\_

\_\_\_\_\_

**OPERATING CERTIFICATE/LICENSE#:** \_\_\_\_\_

**DIRECTIONS:** The agency's Operator or Director/Administrator must read and sign the following certification statement. Enter only one signature. Please be sure the date, signature and title of the responsible individual are legible.

#### **CERTIFICATION STATEMENT**

Misrepresentation or falsification of any information contained in this application may be punishable by fine and/or imprisonment under New York State law and Federal law.

The training program must be completed within 60 calendar days and the certificate of completion must be issued to the trainee within 30 calendar days of the completion of training.

No fees or costs of any form will be charged to or collected from any individual participating in home health aide training or receiving a home health aide certificate of completion from this agency.

I hereby certify that I have read the above statements and that the information furnished in this Home Health Aide Training Program Application is true and correct to the best of my knowledge.

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**SIGNATURE**

**Print or type Name:** \_\_\_\_\_

**Print or type Title:** \_\_\_\_\_

## APPENDIX A

### HOME HEALTH AIDE TRAINING PROGRAM SCHEDULE

#### HOME CARE CURRICULUM AND HEALTH RELATED TASKS CURRICULUM

NAME OF AGENCY: \_\_\_\_\_

CONTACT PERSON NAME: \_\_\_\_\_

CONTACT PERSON PHONE: \_\_\_\_\_ DATE OF SUBMISSION: \_\_\_\_/\_\_\_\_/\_\_\_\_

### HOME CARE CURRICULUM

Module	Unit	Sub-unit	Lesson	Required Topics	Minimum Training Time Required (in minutes)			Scheduled Times					
					Total Course	SubTotal Didactic	SubTotal Lab	Training Day (1st, 2nd, etc.)	Training Time ("00:00am/pm")		Day and Time of Quiz or Evaluation (day "# - 00:00am/pm")		
									From	To	From	To	
<b>I</b>	<b>Introduction to Home Care</b>				<b>90</b>	90							
	<b>A</b>			Home Care, the Home Care Worker, and the Client									
	<b>B</b>			What is a Home Care Worker									
	<b>C</b>			Providing Home Care									
<b>II</b>	<b>Working Effectively with Home Care Clients</b>				<b>180</b>								
	<b>A</b>			Theories of Basic Human Needs			45						
	<b>B</b>			Diversity			30						
	<b>C</b>			Communication and Interpersonal Skills			45						
	<b>D</b>			Caregiver Observation, Recording and Reporting			30						
	<b>E</b>			Confidentiality			30						
<b>III</b>	<b>Working with the Elderly</b>				<b>120</b>	120							
	<b>A</b>			What is Aging									
	<b>B</b>			Aging and the Body/Body Systems									
	<b>C</b>			Aging and the Mind									
<b>IV</b>	<b>Working with Children</b>				<b>60</b>	60							
	<b>A</b>			Family Situations in Which Children may need home care workers									
	<b>B</b>			How Children Develop and how you can work with them									
	<b>C</b>			Problems that affect the family and how children react									
	<b>D</b>			How you can help strengthen families through work with parents or caregivers									
<b>V</b>	<b>Working with People who are Mentally Ill</b>				<b>60</b>	60							
	<b>A</b>			What is mental health?									
	<b>B</b>			What is mental illness?									
	<b>C</b>			Mental Health, Mental Illness and the Home Care Worker									
<b>VI</b>	<b>Working with People with Developmental Disabilities</b>				<b>60</b>	60							
	<b>A</b>			Understanding Developmental Disabilities									
	<b>B</b>			Developmental Disabilities and Home Care									
<b>VII</b>	<b>Working with People with Physical Disabilities</b>				<b>60</b>	60							
	<b>A</b>			What is a physical disability?									
	<b>B</b>			How the home care worker can help the physically disabled.									

## HOME CARE CURRICULUM

Module	Unit	Sub-unit	Lesson	Required Topics	Minimum Training Time Required (in minutes)			Scheduled Times				
					Total Course	SubTotal Didactic	SubTotal Lab	Training Day (1st, 2nd, etc.)	Training Time ("00:00am/pm")		Day and Time of Quiz or Evaluation (day "# - 00:00am/pm")	
									From	To	From	To
<b>VIII</b>	<b>Food, Nutrition and Meal Preparation</b>				<b>240</b>	240						
	<b>A</b>			The Basics of Nutrition								
	<b>B</b>			Meal Planning								
	<b>C</b>			Food preparation and serving								
	<b>D</b>			Food Shopping, storage and handling								
	<b>E</b>			Modified Diets								
<b>IX</b>	<b>Family Spending and Budgeting</b>				<b>30</b>	30						
	<b>A</b>			Role of the home care worker in family spending and budgeting								
	<b>B</b>			Ways to make the most effective use of the family's finances								
<b>X</b>	<b>Care of the Home and Personal Belongings</b>				<b>90</b>	90						
	<b>A</b>			The importance of housekeeping in home care								
	<b>B</b>			Performing housekeeping tasks in the client's home								
	<b>C</b>			Ways to save energy and time								
	<b>D</b>			How to get the job done								
<b>XI</b>	<b>Safety and Injury Prevention</b>				<b>90</b>	90						
	<b>A</b>			Injuries								
	<b>B</b>			Injury Prevention								
	<b>C</b>			What to Do When Injuries and Emergencies Happen								
<b>XII</b>	<b>Personal Care</b>											
	<b>A</b>			<b>Defining Personal Care</b>	<b>90</b>	90						
	<b>B</b>			<b>Personal Care Skills (15 hours):</b>								
	<b>A)</b>			Handwashing	<b>20</b>	10	10					
	<b>B)</b>			Infection control	<b>40</b>	40						
	<b>C)</b>			Freedom from Pain	<b>40</b>	40						
	<b>1</b>			Pain Management								
	<b>2</b>			Recognizing and Reporting Pain								
	<b>D)</b>			Urinary System								
	<b>1</b>			Assisting with Bedpan/Urinal/Fracture Pan	<b>35</b>	20	15					
	<b>2</b>			Bedside Commode /Toilet	<b>35</b>	20	15					
	<b>3</b>			Incontinence	<b>50</b>	30	20					
	<b>E)</b>			Digestive System								
	<b>1</b>			Nutrition and a Balanced Diet (20)								
	<b>2</b>			Assisting with Eating and Hydration	<b>65</b>	35	30					
				a) Proper feeding Techniques								
				1) Positioning								
				2) Assistance for Independent Eaters								
				3) Partial Assistance with Eating								
	<b>3</b>			Measuring and Recording Weight	<b>15</b>	10	5					
	<b>F)</b>			Integumentary System								
	<b>1</b>			Skin Care and Alterations in Skin								
				a) Healthy Skin	<b>40</b>	20	20					
				b) Alterations in Skin	<b>60</b>	60						
	<b>G)</b>			Musculoskeletal System								
	<b>1</b>			Transfers, positioning and turning								
				a) Body Mechanics	<b>35</b>	15	20					
				b) Turning and positioning in bed and chair	<b>35</b>	15	20					
				c) Transfer with one assist	<b>35</b>	15	20					

## HOME CARE CURRICULUM

Module	Unit	Sub-unit	Lesson	Required Topics	Minimum Training Time Required (in minutes)			Scheduled Times					
					Total Course	SubTotal Didactic	SubTotal Lab	Training Day (1st, 2nd, etc.)	Training Time ("00:00am/pm")		Day and Time of Quiz or Evaluation (day "# - 00:00am/pm")		
									From	To	From	To	
			2	Ambulation	30	20	10						
				a) One assistant									
				b) Assistive devices (canes, walkers, etc.)									
				c) Safety Principles									
			3	Range of Motion	30	20	10						
		H)		Bathing	90	30	60						
			1	Processes									
				a) Partial/Sponge bath									
				b) AM/PM care									
				c) Shower									
				d) Tub									
		I)		Grooming									
			1	Haircare	20	10	10						
				a) Shampooing									
				b) Bushing/Combing									
			2	Mouthcare	60	30	30						
				a) Conscious resident/client patient									
				1) partial assistance									
				2) total assistance									
				b) Dentures									
				c) Edentulous									
			3	Shaving	40	20	20						
			4	Hand and Nail Care	20	10	10						
			5	Footcare	40	20	20						
		J)		Dressing									
			1	Assisting with Client	30	10	20						
				a) Dependent									
				b) Needing assistance									
			2	Adaptive Equipment	15	10	5						
				a) Glasses									
				b) Prosthesis									
		K)		The Clients' Environment									
			1	Componants and care of the environment - drawers, closets and immediate environment (40)									
			2	Unoccupied bed	30	10	20						
			3	Occupied bed	20	10	10						
		C		Personal Care Skills for the Well Baby	120	120							
		D		Special Equipment Used by Home Care Clients	60	60							
		E		Assisting with Self-Administration of Medications	120	120							
				<b>Total minutes</b>	<b>2400</b>	<b>2000</b>	<b>400</b>						
				<b>Total hours</b>	<b>40</b>								

## HEALTH RELATED TASKS CURRICULUM

Unit	Required Procedures	Required Topics Required and Optional Procedures	Required Procedures	Optional Procedures	Total Minimum Time Required (in hours)	SubTotal Didactic	SubTotal Supervised Skills Demonstration	Training Day (1st, 2nd, etc.)	Scheduled Times				
									Training Time ("00:00 am/pm")		Day and Time of Quiz or Evaluation (day "# - 00:00 am/pm")		
									From	To	From	To	
<b>A</b>	<b>Orientation to Health Related Tasks</b>				<b>1.0</b>								
	A-1	Proper Handwashing	x										
<b>B</b>	<b>Performing Simple Measurements and Tests</b>				<b>6.5</b>								
	B-1	Cleaning a glass thermometer	x										
	B-2	Measuring an oral temperature with a glass thermometer	x										
	B-3	Measuring an oral temperature with an electronic thermometer		x									
	B-4	Measuring an axillary with a glass thermometer		x									
	B-5	Measuring an axillary temperature with an electronic thermometer		x									
	B-6	Measuring a rectal temperature with a glass thermometer		x									
	B-7	Measuring a rectal temperature with an electronic thermometer		x									
	B-8	Measuring pulse and respirations	x										
	B-9	Measuring blood pressure	x										
	B-10	Collecting a specimen (routine urine, stool and sputum)		x									
<b>C</b>	<b>Assisting with the Preparation of Complex Modified Diets</b>				<b>4.5</b>								
<b>D</b>	<b>Assisting with a Prescribed Exercise Program</b>				<b>3.5</b>								
	D-1	Transfer to the sitting position	x										
	D-2	Helping the client to sit at the side of the bed	x										
	D-3	Helping the client to stand	x										
	D-4	Assisting with passive ROM exercises	x										
	D-5	Assisting with postural drainage	x										
<b>E</b>	<b>Assisting with the Use of Prescribed Medical Equipment, Supplies and Devices</b>				<b>8.0</b>								
	E-1	Assisting with the use of an ace bandage		x									
	E-2	Assisting with the use of condom catheters		x									
	E-3	Assisting with cleaning the skin and catheter tubing		x									
	E-4	Assisting with the emptying of the urinary drainage bag		x									
	E-5	Assisting with the use of a commercially prepared enema		x									

## HEALTH RELATED TASKS CURRICULUM

Unit	Required Procedures	Required Topics Required and Optional Procedures	Required Procedures	Optional Procedures	Total Minimum Time Required (in hours)	Scheduled Times							
						SubTotal Didactic	SubTotal Supervised Skills Demonstration	Training Day (1st, 2nd, etc.)	Training Time ("00:00 am/pm")		Day and Time of Quiz or Evaluation (day "# - 00:00 am/pm")		
									From	To	From	To	
<b>E</b>	<b>Assisting with the Use of Prescribed Medical Equipment, Supplies and Devices</b> (continued)												
	E-6	Assisting with the use of a soap solution enema	x										
	E-7	Assisting with the use of a douche	x										
	E-8	Assisting with the use of a commercially prepared douche	x										
	E-9	Assisting with the use of the oxygen concentrator	x										
	E-10	Assisting with the use of the oxygen tank and liquid oxygen reservoir	x										
	E-11	Assisting with the use of the medication nebulizer and air compressor	x										
	E-12	Assisting with the use of the CPAP machine	x										
<b>F</b>	<b>Assisting with Special Skin Care</b>				<b>2.0</b>								
	F-1	Positioning on the back	x										
	F-2	Positioning on the side	x										
<b>G</b>	<b>Assisting with a Dressing Change</b>				<b>1.5</b>								
	G-1	Assisting with changing a clean dressing	x										
<b>H</b>	<b>Assisting with Ostomy Care</b>				<b>8.0</b>								
	H-1	Assisting with changing an ileostomy or colostomy pouch	x										
	H-2	Assisting with emptying an open-end ileostomy or colostomy pouch	x										
	H-3	Assisting with cleaning a reusable pouch	x										
	H-4	Assisting with a colostomy irrigation	x										
	H-5	Assisting with routine tracheostomy care	x										
<b>TOTAL REQUIRED HOURS</b>					<b>35</b>								
<b>Additional Agency Specific Topics</b>													
<b>TOTAL HOURS</b>													

Please use this space for any comments regarding the training program (additional pages may be attached):

**Appendix B**

**HOME HEALTH AIDE TRAINING PROGRAM APPLICATION  
DAILY TRAINING PROGRAM SCHEDULE**

NAME OF AGENCY: \_\_\_\_\_

Please complete the Daily Training Program Schedule for your proposed Home Health Aide Training Program. Reference the content of the home health training program modules/units and administration of written and [required and optional] skills performance evaluations. Additional topics may be included in the training, but must be in addition to the minimum 75-hour requirement and may not be substituted for required topics. Identify on the schedule the time allocated for each training topic, breaks and meals, quizzes or tests, supervised practical training (SPT), and skills performance evaluations. Also indicate the day that the certificates of completion are distributed to the trainees. **DIRECTIONS:** Under "Time of Day" indicate the beginning and ending time of the training topic. Under "Topic" identify the training topic. Examples would be: 10:00am – 11:00am, Module II-A Understanding Basic Human Needs; 12:00pm – 12:30pm, Lunch; 3:00pm – 3:30pm, Quiz-Module X-ABCD. You may utilize this format or your own format as long as the required information is present. Use additional sheets as required.

DAY 1 Time of Day    Topic	DAY 2 Time of Day    Topic	DAY 3 Time of Day    Topic	DAY 4 Time of Day    Topic	DAY 5 Time of Day    Topic
DAY 6 Time of Day    Topic	DAY 7 Time of Day    Topic	DAY 8 Time of Day    Topic	DAY 9 Time of Day    Topic	DAY 10 Time of Day    Topic
DAY 11 Time of Day    Topic	DAY 12 Time of Day    Topic	DAY 13 Time of Day    Topic	DAY 14 Time of Day    Topic	DAY 15 Time of Day    Topic

## **Appendix C Application Addresses**

Addresses to which applications are sent to open a home health aide training program. Complete the following application and sent it to the address noted for the applicable county:

Bronx, Kings, New York, Richmond and Queens Counties:

**New York State Department of Health  
Metropolitan Area Regional Office  
Home Health Aide Training Program  
90 Church Street; 13<sup>th</sup> floor  
New York, New York 10001  
(212) 417-5888**

Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, and Westchester Counties:

**New York State Department of Health  
Metropolitan Area Regional Office  
Home Health Aide Training Program  
145 Huguenot Street, 6<sup>th</sup> Floor  
New Rochelle, New York 10801  
(914) 654-7124**

Nassau and Suffolk Counties:

**New York State Department of Health  
Home Health Care Unit  
Home Health Aide Training Program  
320 Carlton Avenue, Suite 5000  
Central Islip, New York 11722  
(631) 851-3607**

Albany, Canton, Columbia, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Oswego, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington Counties:

**New York State Department of Health  
Capital District Regional Office  
Home Health Aide Training Program  
Frear Building  
One Fulton Street  
Troy, New York 12180  
(518) 408-5413**

Broome, Cayuga, Cortland, Chenango, Herkimer, Jefferson, Lewis, Madison, Oneida, St. Lawrence, Tioga and Tompkins Counties:

**New York State Department of Health  
Central New York Regional Office  
Home Health Aide Training Program  
217 South Salina Street  
Syracuse, New York 13202  
(315) 477-8472**

Alleghany, Cattaraugus, Chemung, Chataugua, Erie, Genesee, Livingston, Monroe, Niagara, Ontario, Orleans, Schuyler, Steuben, Seneca, Wayne, Wyoming and Yates Counties:

**New York State Department of Health  
Western Regional Office  
Home Health Aide Training Program  
584 Delaware Avenue  
Buffalo, New York 14202  
(716) 847-4320**

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## **Appendix D Home Care Program Directors**

Bronx, Kings, New York, Richmond and Queens Counties; Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, and Westchester Counties and Nassau and Suffolk Counties:

**Home Care Program Director  
New York State Department of Health  
Metropolitan Area Regional Office  
Home Health Aide Training Program  
90 Church Street; 13<sup>th</sup> floor  
New York, New York 10001  
(212) 417-5888**

Albany, Canton, Columbia, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Oswego, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington Counties:

**Home Care Program Director  
New York State Department of Health  
Capital District Regional Office  
Home Care Unit  
Frear Building  
One Fulton Street  
Troy, New York 12180  
(518) 408-5413**

Broome, Cayuga, Cortland, Chenango, Herkimer, Jefferson, Lewis, Madison, Oneida, St. Lawrence, Tioga and Tompkins Counties:

**Home Care Program Director  
New York State Department of Health  
Central New York Regional Office  
Home Care Unit  
217 South Salina Street  
Syracuse, New York 13202  
(315) 477-8421**

Alleghany, Cattaraugus, Chemung, Chataugua, Erie, Genesee, Livingston, Monroe, Niagara, Ontario, Orleans, Schuyler, Steuben, Seneca, Wayne, Wyoming and Yates Counties:

**Home Care Program Director  
Western Regional Office  
Home Care Unit  
584 Delaware Avenue  
Buffalo, New York 14202  
(585) 238-8185**