**GENERAL INSTRUCTIONS**

1. **Complete all questions in Part I and Part II.**
2. **Sign the Operator’s Certification contained in Part II.**
3. **Submit a completed and signed PCATP Nurse Instructor application for each Director/Coordinator and Nurse Instructor listed in application.**
4. **Submit all documentation requested in the application. Label each item submitted with the Part and the Question Number that it addresses.**
5. **Submit all requested Policies and Procedures. Please refer to the Guidance Documents located on the DOH website to assist you in writing your Policies and Procedures:**

**https://www.health.ny.gov/facilities/home\_care/lhcsa/**

1. **Submit the application and all supporting documentation in PDF format to:**

**NYS DEPARTMENT OF HEALTH**

**Division of Home and Community Based Services**

**pcatp@health.ny.gov**

**If you have any questions about the application, contact the Division of Home and Community Based Services at 518-408-1638 or email to:** **pcatp@health.ny.gov**

**PART I**

**LEGAL ENTITY NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AGENCY/DBA NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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**AGENCY TYPE (CHECK ONE):**

**[ ]  LICENSED HOME CARE SERVICES AGENCY (LHCSA)**

**[ ]  CERTIFIED HOME HEALTH AGENCY (CHHA)**

**[ ]  HOSPICE**

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

**PERSON TO BE CONTACTED FOR QUESTIONS RELATED TO THE INFORMATION CONTAINED IN THE**

**APPLICATION (NAME & TITLE):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PHONE NUMBER:** ( )\_\_\_\_\_\_\_\_\_\_\_\_\_ **E-MAIL:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HCS USER ID:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IMPORTANT NOTICE**

**The Department of Health will not approve any Personal Care Aide Training Program that charges any type or form of tuition and/or fee in exchange for personal care aide training.**

**Any personal care aide training program, regardless of sponsor, that requires the trainee to pay any amount of tuition or other fees in connection with receiving and/or completing personal care aide training or a personal care aide certificate of completion, MUST obtain New York State Education Department (SED) approval to operate the training program and will not be approved by the New York State Department of Health.**

**PART II**

**OPERATOR’S CERTIFICATION**

**LEGAL ENTITY NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AGENCY/DBA NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

**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 90 calendar days of the first day of the training program or date of hire.

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

The training program cannot withhold certificates from those who completed training and cannot require the individual be employed by the agency, for any length of time, in order to receive their certificate.

I hereby certify that I have read the above statements and that the information furnished in this personal care aide training program application is true and correct to the best of my knowledge.

**PRINT OR TYPE NAME AND TITLE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**All applicants must review the “New York State Department of Health Guide to the Operation of a Personal Care Aide Training Program” and “Alternative Competency Demonstration for the Personal Care Aide Guide” for additional information to assist with completing this application.**

**PLEASE SUBMIT RESPONSES TO THE FOLLOWING:**

1. Total number of days and total number of hours of the training program, excluding breaks and examinations.
2. Language(s) that the course will be taught in. If the training program proposes to conduct training in additional languages, applications must include the following:
	1. Identification of each language you are seeking approval to train in;
	2. Policies and procedures for training in additional languages;
	3. PCATP Nurse Instructor Application(s) with required documentation of fluency in the identified language(s);
	4. A list of all materials that have been translated and documentation/attestation of translation by a certified language translation service;
	5. Documentation of permission from the textbook publisher for the requirements and limitations of translating test questions (if applicable); and
	6. An attestation stating understanding from the training program that class can only be conducted in one language at a time and not through an interpreter.
3. Identify the name of the textbook, publisher and edition that you will obtain your test bank of questions from. The textbook must be one that is approved by the Department.
4. List the name of the senior official who is responsible for the oversight of your training program. The senior official is a person authorized to execute a legally binding instrument on behalf of the operator of the home care agency or owner of the training entity. (The senior official is required to sign a written sworn statement, made under penalty of perjury, certifying that each person entered into the Home Care Registry by the training program has in fact successfully completed the training, identifying each person by name, address, date of birth, and date on which such training was successfully completed, and describing the nature of the education or training covered in the program. Training programs are required to keep the executed certification forms on file and provide them when requested at the time of survey.)
5. List the name(s) of the Director/Coordinator(s) assigned to supervise and coordinate the personal care aide training program. Provide Nurse Instructor application for each individual listed as a Director/Coordinator. Please provide a copy of their NYS License/Registration.
6. List the name(s) of Nurse Instructors. Provide Nurse Instructor application for each individual listed as a Nurse Instructor. Please provide a copy of their NYS License/Registration.
7. List the name(s) of any additional basic training course instructors. Please provide a copy of their resume and a copy of their NYS License/Registration.
8. The goals and objectives of the training program, including measurable performance criteria specific to the curriculum material and clinical content required by the Department.
9. Identification of the curriculum from which training, lesson plans, and learning objectives are derived (See Appendix 1 and Appendix 2).
10. Documentation that the area and space provided for conducting training are adequate for the maximum number of trainees to be accepted in the program.

**PLEASE SUBMIT POLICIES AND PROCEDURES FOR THE FOLLOWING:**

1. Minimum criteria for accepting an individual for basic training as defined in 18 NYCRR 505.14(d)(4). The minimum criteria must include:
	1. maturity, emotional and mental stability, and experience in personal care or homemaking;
	2. ability to read and write, understand and carry out directions and instructions, record messages, and keep simple records;
	3. sympathetic attitude towards patients who have medical problems;
	4. documented good health as required for all home care workers by 10 NYCRR 766.11.
2. No fees of any kind will be charged to the trainee for the cost of personal care aide training, including the costs for textbooks, materials, and supplies.
3. Instruction in training in additional language(s), if applicable.
4. Trainees Rights. Method and form(s) for documentation of the trainee’s receipt of the Trainee Rights (Appendix 3).
5. Quality Management process and annual evaluation of the training program.
6. Attendance. This should include information on scheduling make-up sessions and dismissal from the program for attendance issues.
7. Submission of the PCATP Annual Program Evaluation to the agency’s governing authority or operator.
8. Training program pass/fail standard. The policy must address:
	1. The minimum pass score of 80% for each module;
	2. A testing remediation process; and
	3. The skills evaluation.
9. Alternative Competency Demonstration (ACD) testing program for any eligible individuals (based on established criteria) for exemption from the 40-hour basic training program. Refer to Alternative Competency Demonstration for the Personal Care Aide Guide.
10. Maintenance and confidentiality of training program records, including examinations, standardized curricula, unit and module tests and quizzes, ACD materials. Must address the following:
	1. Maintenance and confidentiality of tests and examinations;
	2. Test security;
	3. Use of test bank of questions from approved text book;
	4. Evaluation of the trainee;
	5. Identification of the source of procedure skills checklists; and
	6. A copy of the program’s trainee competency evaluation forms.

1. Maintenance and confidentiality of training program records for all persons trained. The training records for each person who has successfully completed personal care aide training and/or ACD, including documentation of their receipt of Trainee Rights, attendance and sign-in/sign-out sheets, completed written exams, and a copy of their certificate, must be retained for a period of **at least six years**.
2. Notification to the Department within 10 business days of changes to the training program, including, but not limited to, curriculum, class schedules, faculty/Nurse Instructors.
3. Attach a copy of the program’s policies and procedures addressing compliance with the Home Care Registry (HCR) requirements found in 10 NYCRR Part 403 and mandated by Chapter 594 of the Laws of 2008.

**PLEASE SUBMIT THE FOLLOWING:**

1. Appendix A. The Home Care Curriculum (HCC) is required, and all programs must base their training, including lesson plans on the content of the HCC. A minimum of 40 hours of basic training is required. Complete the Training Program Schedule (Appendix A), indicating the following: training program day and time for each required topic; the time allocated to each module; unit within each module; didactic and lab sessions. ***Please note that the number of minutes allocated to each module and unit cannot be less than what is specified in the Home Care Curriculum.***
2. Appendix B. Prepare a Daily Training Schedule (Appendix B) which indicates the training program schedule for each day, including training topic and time, testing time, break and mealtimes. The training program daily schedule may be completed on the format provided or in a format of choice, provided the required information is included.