INSTRUCTIONS:

1. Complete all questions/areas in the application.
2. Label attachments with the question number that they address.
3. Submit application and supporting documentation, including any proposed changes that have NOT been approved by the Department, to pcatp@health.ny.gov

**OPERATOR'S CERTIFICATION**

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

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

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AGENCY TYPE (CHECK ONE):**

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

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

**[ ]  HOSPICE**

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

**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 and may result in immediate program disapproval.

The training program must abide by all Personal Care Aide Training Program and Home Care Registry policies and guidelines set forth by the Department.

I hereby certify that I have read the above statements and that the information furnished in this Personal Care Aide Training Program Re-Approval Application is true and correct to the best of my knowledge.

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

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

**PERSON TO BE CONTACTED FOR QUESTIONS**

**NAME & TITLE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

1. Has the curriculum changed since last approval? ☐ Yes ☐ No

If yes, attach changes or indicate DOH curriculum Approval Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have any of your policies and procedures been updated since last approval? ☐ Yes ☐ No

If yes, attach those updated policies and procedures.

1. How does the student/aide receive his/her certificate?

☐ Aide/student picks up

☐ Certificate is mailed

☐ Other, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Attach most current Annual Program Evaluation.

**FOR DEPARTMENT USE ONLY:**

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

REVIEWED BY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REQUEST FOR ADDITIONAL INFORMATION/CLARIFICATION REQUIRED: ☐ Yes ☐ No

DATE OF REQUEST: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

DATE ADDITIONAL INFORMATION RECEIVED: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

APPROVAL: ☐ Yes ☐ No

IF NO, REASON FOR DISAPPROVAL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IF YES, DATE OF TRAINING PROGRAM APPROVAL: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

DATE TO HCR: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_