General Instructions of Application Forms for CNA and HHA

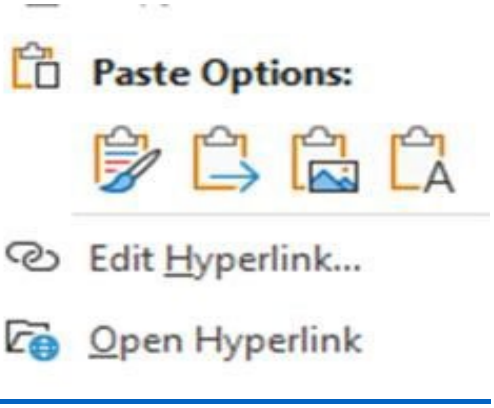
The Instruction provided here are images of the forms that are hard to fill out

Note: The review unit will not process the forms sent to the California Department if the documents have smudges or are not legible. Please make sure to type all information except for your signature (Your signature must match that found on your ID, Driver's license, or passport). See the instructions on signing a digital document if you do not know already.

PLEASE NOTE THAT You must download the documents using the links in these instructions or visit the Allied Health Website.

Allied-Health/Nursing-Assistant-Home-Health-Aide-Program/Enrollment-Forms (Link Access, Click here for external site access).

If you never opened a link, use your mouse to do a right-click on the link above, and you will see a drop menu (see image below). From the drop menu, choose open hyperlink, and you will access the website to find the forms.



After you download the forms, **save the blank forms and re-open these before you fill these out. (Downloading the forms and saving them prevents the loss of your information).** If you only open the forms and start filling these out you will note that you are putting your information out into the internet not on the saved forms and the print out will come out blank (doing this is not safe). The healthcare facilities where the clinical practice will take place require that all students have their COVID-19 Vaccinations-Required vaccinations and booster.

Additional Information: Malpractice Insurance: You do not need to purchase the insurance. The insurance *will be purchased through the Arthur Rupe Foundation once you are accepted into the Program*

PHYSICAL EXAM: *MUST BE DONE TWO MONTHS or less* ***before the start of the Program****. See the examples for each semester.*

Spring Semester ***physicals should be done around the 3rd week of December***

Summer Semester ***Physicals should be done around the 2nd or 3rd week of April***

Fall Semester ***Physical should be done around the 2nd week of July***

If you are having issues securing a physical appointment with a physician, use our recommended vendors who do physicals at a low cost.

Book for the programs: You will receive a Book Loan Free of Charge once accepted and enrolled in the Program.
LIVESCAN Fingerprints: DONE Through LA Mission College, Do not go and get these Done independently.

Scrubs: Purchase after formally enrolled in the Programs

CPR card: either take the Allied Health 021 class at LA Mission College or see the vendors recommended on the Allied Health Website. The card must be from the **American Heart Association with no Exceptions.** See the LINKS BELLOW

LINK *The CPR Hero Training Center*

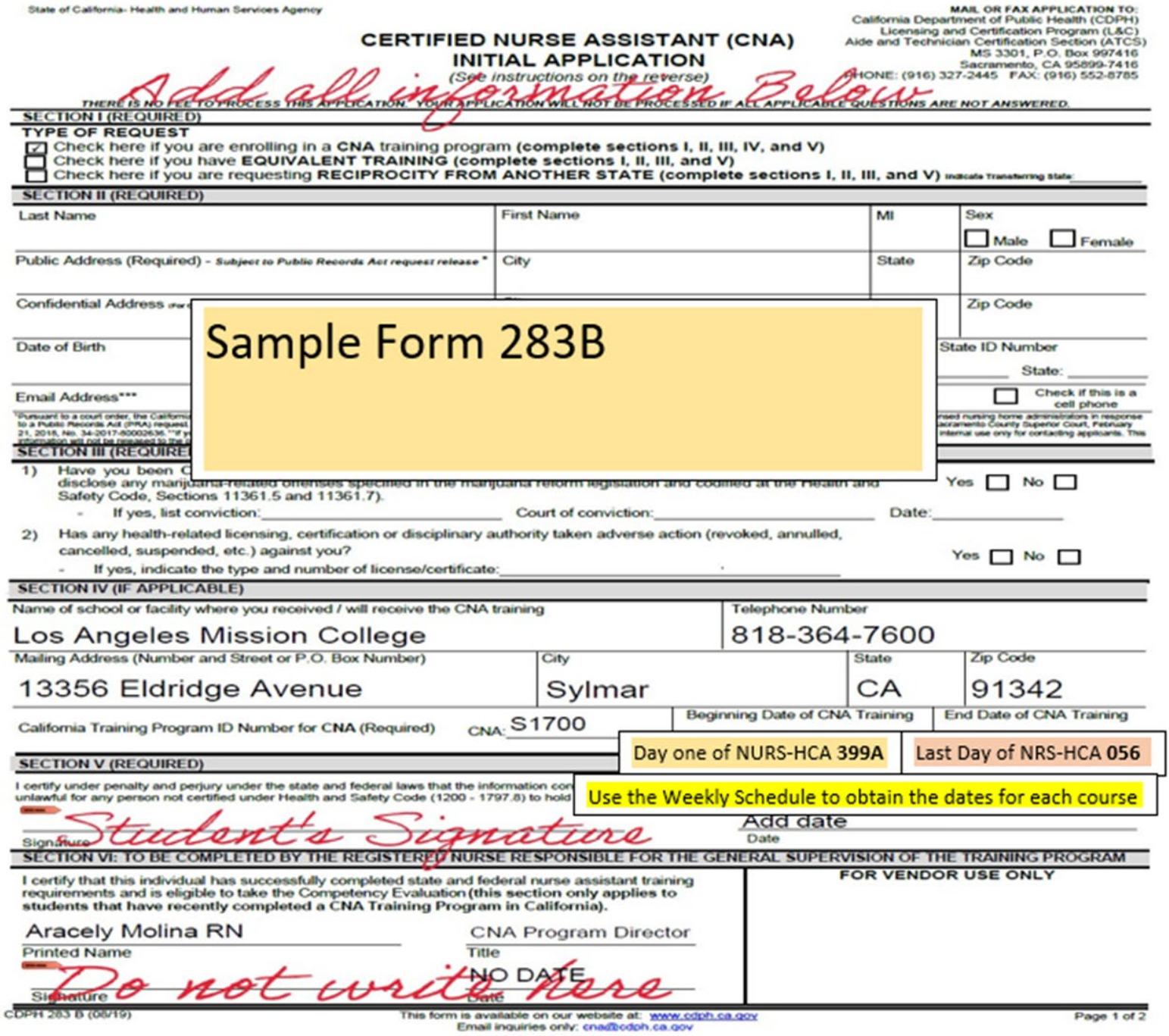
LINK *CPR 3G Training Center*

Image of E-Wallet Card you will forward to me

283 B CNA form LINK. (Click Here To Access the actual form).
CNA form 283B. The Program Number is S**1700.** Section VI Enter the *director's* names and titles. Make sure you add the correct Program Director for each form.

For example, for the 283B form, the CNA director is→ Aracely Molina *RN*
Title:
CNA Program Director. See the image provided with detailed instructions below.

PAY attention to the START and END DATES in the instructions below.



State of California- Health and Human Services Agency

MAIL OR FAX APPLICATION TO:
California Department of Public Health (CDPH)
Licensing and Certification Program (L&C)
Aide and Technician Certification Section (ATCS)
MS 3301, P.O. Box 997416
Sacramento, CA 95899-7416
PHONE: (916) 327-2445 FAX: (916) 552-8785

CERTIFIED NURSE ASSISTANT (CNA)
INITIAL APPLICATION
(See instructions on the reverse)

Add all information Below

THERE IS NO FEE TO PROCESS THIS APPLICATION. YOUR APPLICATION WILL NOT BE PROCESSED IF ALL APPLICABLE QUESTIONS ARE NOT ANSWERED.

SECTION I (REQUIRED)

TYPE OF REQUEST

- ☑ Check here if you are enrolling in a **CNA** training program **(complete sections I, II, III, IV, and V)**
- ☐ Check here if you have **EQUIVALENT TRAINING (complete sections I, II, III, and V)**
- ☐ Check here if you are requesting **RECIPROCITY FROM ANOTHER STATE (complete sections I, II, III, and V)** Indicate Transferring State:

SECTION II (REQUIRED)

Last Name | First Name | MI | Sex ☐ Male ☐ Female

Public Address (Required) - *Subject to Public Records Act request release* * | City | State | Zip Code

Confidential Address | Zip Code

Date of Birth | State ID Number | State:

Email Address*** | ☐ Check if this is a cell phone

Sample Form 283B

SECTION III (REQUIRE

1) Have you been C… disclose any marijuana-related offenses specified in the marijuana reform legislation and codified at the Health and Safety Code, Sections 11361.5 and 11361.7). Yes ☐ No ☐
   - If yes, list conviction: _____ Court of conviction: _____ Date: _____
2) Has any health-related licensing, certification or disciplinary authority taken adverse action (revoked, annulled, cancelled, suspended, etc.) against you? Yes ☐ No ☐
   - If yes, indicate the type and number of license/certificate: _____

SECTION IV (IF APPLICABLE)

Name of school or facility where you received / will receive the CNA training: Los Angeles Mission College
Telephone Number: 818-364-7600

Mailing Address (Number and Street or P.O. Box Number): 13356 Eldridge Avenue
City: Sylmar
State: CA
Zip Code: 91342

California Training Program ID Number for **CNA** (Required) CNA: S1700
Beginning Date of CNA Training: Day one of NURS-HCA **399A**
End Date of CNA Training: Last Day of NRS-HCA **056**

Use the Weekly Schedule to obtain the dates for each course

SECTION V (REQUIRED)

I certify under penalty and perjury under the state and federal laws that the information cor… unlawful for any person not certified under Health and Safety Code (1200 - 1797.8) to hold…

Student's Signature
Signature
Add date
Date

SECTION VI: TO BE COMPLETED BY THE REGISTERED NURSE RESPONSIBLE FOR THE GENERAL SUPERVISION OF THE TRAINING PROGRAM

I certify that this individual has successfully completed state and federal nurse assistant training requirements and is eligible to take the Competency Evaluation **(this section only applies to students that have recently completed a CNA Training Program in California).**

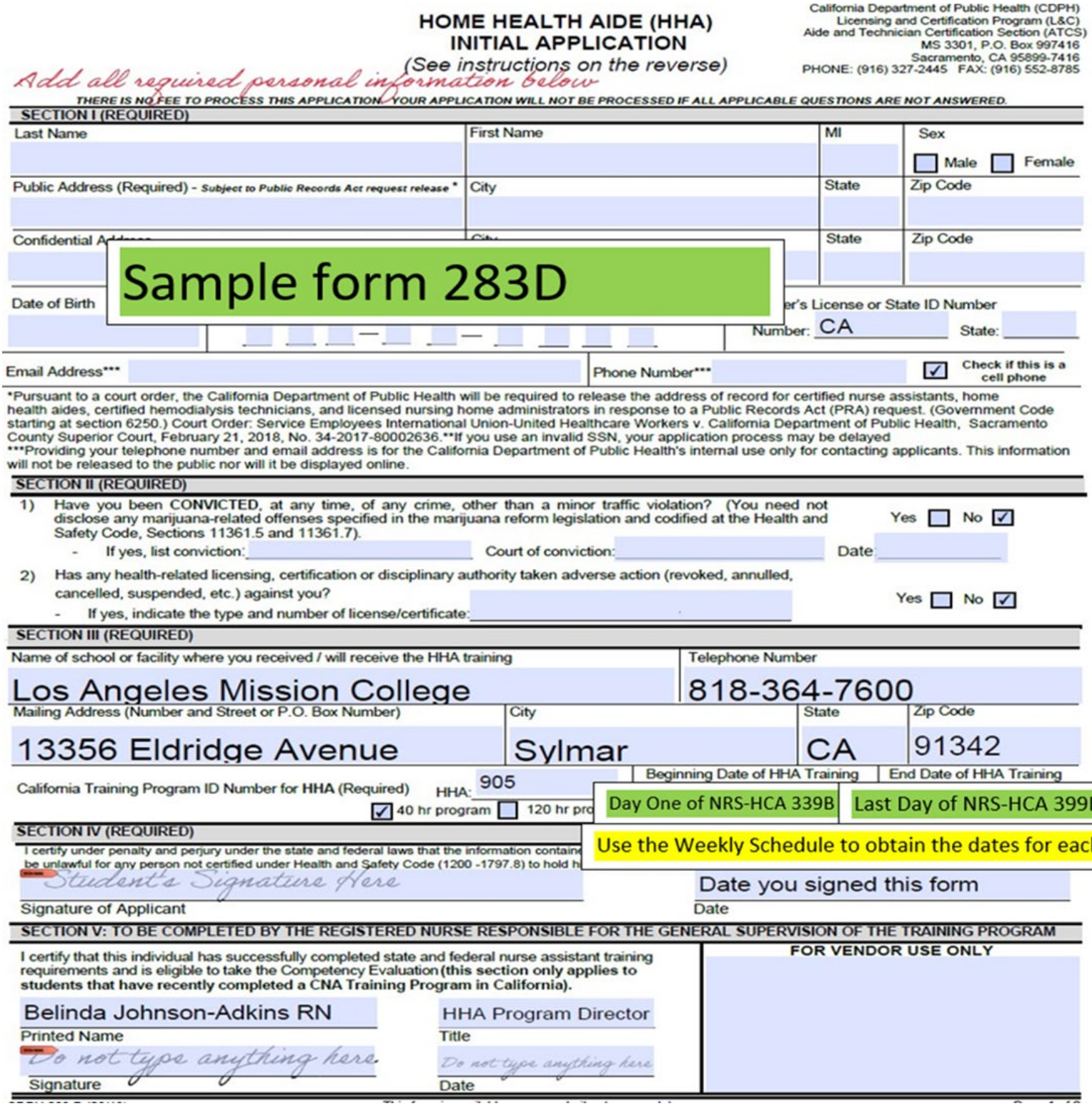
Aracely Molina RN
Printed Name
CNA Program Director
Title

Do not write here
Signature
NO DATE
Date

FOR VENDOR USE ONLY

[283D HHA form LINK. (Click here to Access the actual form)]

40-hour Program /Program number 905



HOME HEALTH AIDE (HHA)
INITIAL APPLICATION
(See instructions on the reverse)

California Department of Public Health (CDPH)
Licensing and Certification Program (L&C)
Aide and Technician Certification Section (ATCS)
MS 3301, P.O. Box 997416
Sacramento, CA 95899-7416
PHONE: (916) 327-2445 FAX: (916) 552-8785

Add all required personal information below

THERE IS NO FEE TO PROCESS THIS APPLICATION. YOUR APPLICATION WILL NOT BE PROCESSED IF ALL APPLICABLE QUESTIONS ARE NOT ANSWERED.

SECTION I (REQUIRED)

Last Name | First Name | MI | Sex ☐ Male ☐ Female

Public Address (Required) - *Subject to Public Records Act request release* * | City | State | Zip Code

Confidential Address | City | State | Zip Code

Sample form 283D

Date of Birth | er's License or State ID Number Number: CA State:

Email Address*** | Phone Number*** ☑ Check if this is a cell phone

*Pursuant to a court order, the California Department of Public Health will be required to release the address of record for certified nurse assistants, home health aides, certified hemodialysis technicians, and licensed nursing home administrators in response to a Public Records Act (PRA) request. (Government Code starting at section 6250.) Court Order: Service Employees International Union-United Healthcare Workers v. California Department of Public Health, Sacramento County Superior Court, February 21, 2018, No. 34-2017-80002636.**If you use an invalid SSN, your application process may be delayed
***Providing your telephone number and email address is for the California Department of Public Health's internal use only for contacting applicants. This information will not be released to the public nor will it be displayed online.

SECTION II (REQUIRED)

1) Have you been CONVICTED, at any time, of any crime, other than a minor traffic violation? (You need not disclose any marijuana-related offenses specified in the marijuana reform legislation and codified at the Health and Safety Code, Sections 11361.5 and 11361.7). Yes ☐ No ☑
   - If yes, list conviction: Court of conviction: Date:

2) Has any health-related licensing, certification or disciplinary authority taken adverse action (revoked, annulled, cancelled, suspended, etc.) against you? Yes ☐ No ☑
   - If yes, indicate the type and number of license/certificate:

SECTION III (REQUIRED)

Name of school or facility where you received / will receive the HHA training: Los Angeles Mission College | Telephone Number: 818-364-7600

Mailing Address (Number and Street or P.O. Box Number): 13356 Eldridge Avenue | City: Sylmar | State: CA | Zip Code: 91342

California Training Program ID Number for HHA (Required) HHA: 905 | Beginning Date of HHA Training: Day One of NRS-HCA 339B | End Date of HHA Training: Last Day of NRS-HCA 399B

☑ 40 hr program ☐ 120 hr pro

Use the Weekly Schedule to obtain the dates for each

SECTION IV (REQUIRED)

I certify under penalty and perjury under the state and federal laws that the information contain
be unlawful for any person not certified under Health and Safety Code (1200 -1797.8) to hold h

Student's Signature Here — Signature of Applicant

Date you signed this form — Date

SECTION V: TO BE COMPLETED BY THE REGISTERED NURSE RESPONSIBLE FOR THE GENERAL SUPERVISION OF THE TRAINING PROGRAM

I certify that this individual has successfully completed state and federal nurse assistant training requirements and is eligible to take the Competency Evaluation **(this section only applies to students that have recently completed a CNA Training Program in California).**

Belinda Johnson-Adkins RN — Printed Name | HHA Program Director — Title

Do not type anything here — Signature | Do not type anything here — Date

FOR VENDOR USE ONLY

LA Mission College Program Admission Application fill in all your demographic information and submit it with your packet.

LA MISSION NATP and HHA Admission Application Packet LINK. (Click Here to Access).

Use the Check off list to keep track of all the documents you need to submit and submit this form with your application. See portion of the form below to know what it looks like.

NURSE ASSISTANT & HOME HEALTH AIDE TRAINING PROGRAMS
STUDENT APPLICATION CHECK LIST

Student Name: _____ **Semester:** _____

Students must have all of the following items present in their student file to be eligible to participate in the program.
Students must provide a specific number of copies of documentation as indicated.
Students must keep their own copy for their records.

☐ Must be officially enrolled at Los Angeles Mission College – www.lamission.edu - [Apply Online]

☐ Passed all Health Occupation courses with a grade of "C" or better (STRONGLY RECOMMENDED)

☐ *(2 copies)* **Cardiopulmonary Resuscitation (CPR) – American Heart Association *(AHA)* Basic Life Support *(BLS)* for Health Care Providers** certification valid through the duration of the program. ***(Available at LAMC as Allied Health 021).***

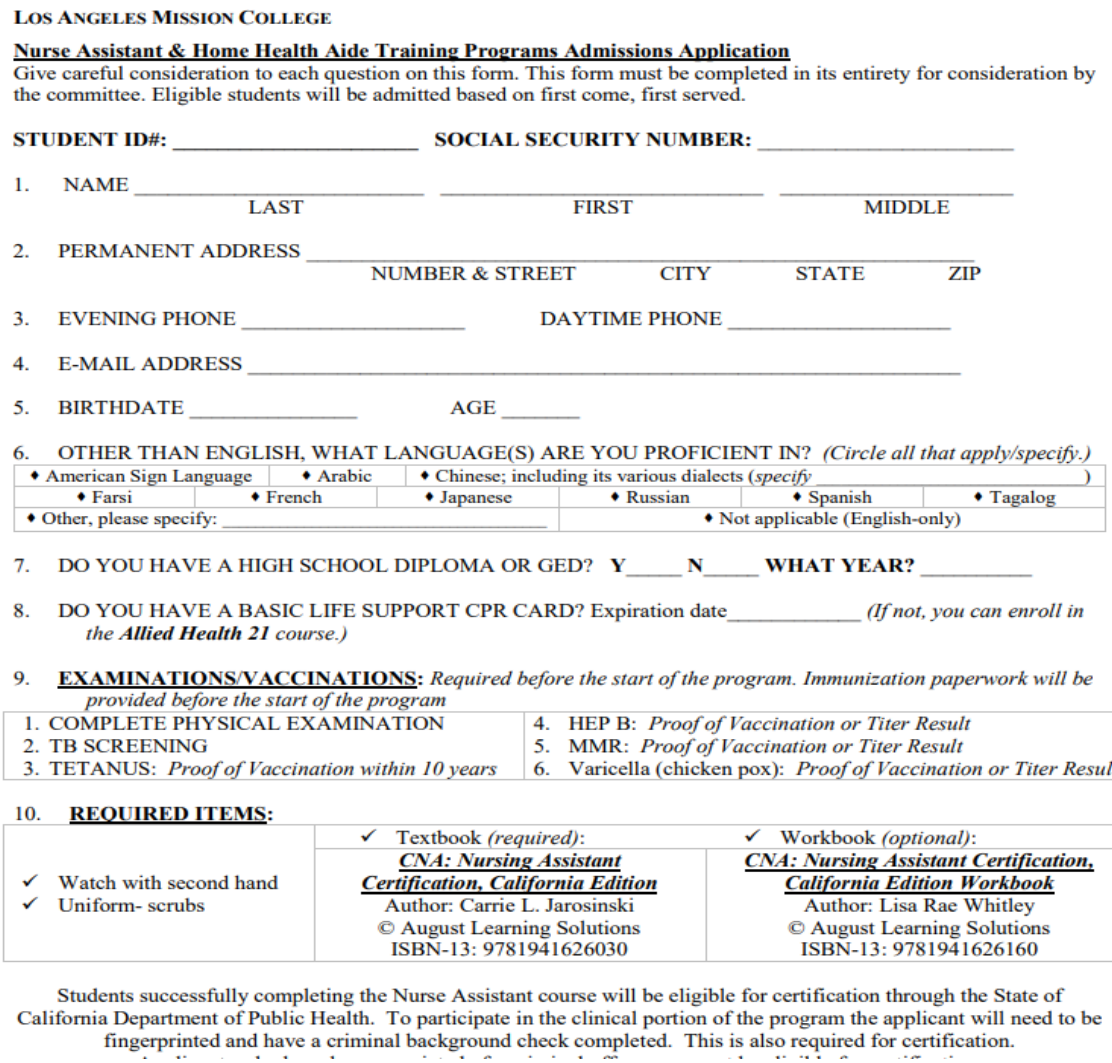
☐ **Health Record** *(pages 6-7)* must be completed *prior to the start of the program* and signed by a Physician, Nurse Practitioner, or Physician Assistant, specifying that you can participate in the classroom and clinical internship portions of the program without any limitations. Health Record must include the following *(provide 2 copies of each documentation listed)*:

☐ **Free of Communicable Diseases** | ☐ **Approved & Recommended for Nursing Program**

- ☐ **Physical Examination** - *must be completed within 60 days prior to the start of the program*
- ☐ **Proof of Absence of Tuberculosis** - *negative skin test (within 60 days prior to the start of program) -OR- negative Quantiferon Gold TB test (within 60 days prior to the start of program) -OR- negative chest x-ray (within 2 years prior to the start of program)*
- ☐ **Immunization Record or Titer Test Result of:**
  - ☐ ***Hepatitis B*** ☐ ***MMR:*** ☐ ***Measles,*** ☐ ***Mumps,*** ☐ ***Rubella***
  - ☐ ***Polio*** ☐ ***Tetanus*** *(within 10 years)* ☐ ***Varicella*** *(Chicken pox)*
  - ☐ **COVID-19 vaccinations and booster are required by healthcare facilities where clinical training takes place. Include record.**

Submit Page 4 of the packet.

See the image below to know what it looks like.



LOS ANGELES MISSION COLLEGE

Nurse Assistant & Home Health Aide Training Programs Admissions Application

Give careful consideration to each question on this form. This form must be completed in its entirety for consideration by the committee. Eligible students will be admitted based on first come, first served.

STUDENT ID#: _____ **SOCIAL SECURITY NUMBER:** _____

1. NAME _____ _____ _____
   LAST FIRST MIDDLE
2. PERMANENT ADDRESS _____
   NUMBER & STREET CITY STATE ZIP
3. EVENING PHONE _____ DAYTIME PHONE _____
4. E-MAIL ADDRESS _____
5. BIRTHDATE _____ AGE _____
6. OTHER THAN ENGLISH, WHAT LANGUAGE(S) ARE YOU PROFICIENT IN? *(Circle all that apply/specify.)*

♦ American Sign Language	♦ Arabic	♦ Chinese; including its various dialects (*specify* _____)			
♦ Farsi	♦ French	♦ Japanese	♦ Russian	♦ Spanish	♦ Tagalog
♦ Other, please specify: _____			♦ Not applicable (English-only)		

7. DO YOU HAVE A HIGH SCHOOL DIPLOMA OR GED? **Y**_____ **N**_____ **WHAT YEAR?** _____
8. DO YOU HAVE A BASIC LIFE SUPPORT CPR CARD? Expiration date_____ *(If not, you can enroll in the **Allied Health 21** course.)*
9. **EXAMINATIONS/VACCINATIONS:** *Required before the start of the program. Immunization paperwork will be provided before the start of the program*

1. COMPLETE PHYSICAL EXAMINATION	4. HEP B: *Proof of Vaccination or Titer Result*
2. TB SCREENING	5. MMR: *Proof of Vaccination or Titer Result*
3. TETANUS: *Proof of Vaccination within 10 years*	6. Varicella (chicken pox): *Proof of Vaccination or Titer Result*

10. **REQUIRED ITEMS:**

	✓ Textbook *(required)*:	✓ Workbook *(optional)*:
✓ Watch with second hand ✓ Uniform- scrubs	***CNA: Nursing Assistant Certification, California Edition*** Author: Carrie L. Jarosinski © August Learning Solutions ISBN-13: 9781941626030	***CNA: Nursing Assistant Certification, California Edition Workbook*** Author: Lisa Rae Whitley © August Learning Solutions ISBN-13: 9781941626160

Students successfully completing the Nurse Assistant course will be eligible for certification through the State of California Department of Public Health. To participate in the clinical portion of the program the applicant will need to be fingerprinted and have a criminal background check completed. This is also required for certification.

LA MISSION NATP and HHA Admission Application Packet LINK. (Click Here to Access).

The image below is half of the application page to show you the page you need to fill out and submit. ***Do not use this form to fill out your information.***

LOS ANGELES MISSION COLLEGE

Nurse Assistant & Home Health Aide Training Programs Admissions Application

Give careful consideration to each question on this form. This form must be completed in its entirety for consideration by the committee. Eligible students will be admitted based on first come, first served.

STUDENT ID#: _____ **SOCIAL SECURITY NUMBER:** _____

1. NAME _____ _____ _____
   LAST FIRST MIDDLE

2. PERMANENT ADDRESS _____
   NUMBER & STREET CITY STATE ZIP

3. EVENING PHONE _____ DAYTIME PHONE _____

4. E-MAIL ADDRESS _____

5. BIRTHDATE _____ AGE _____

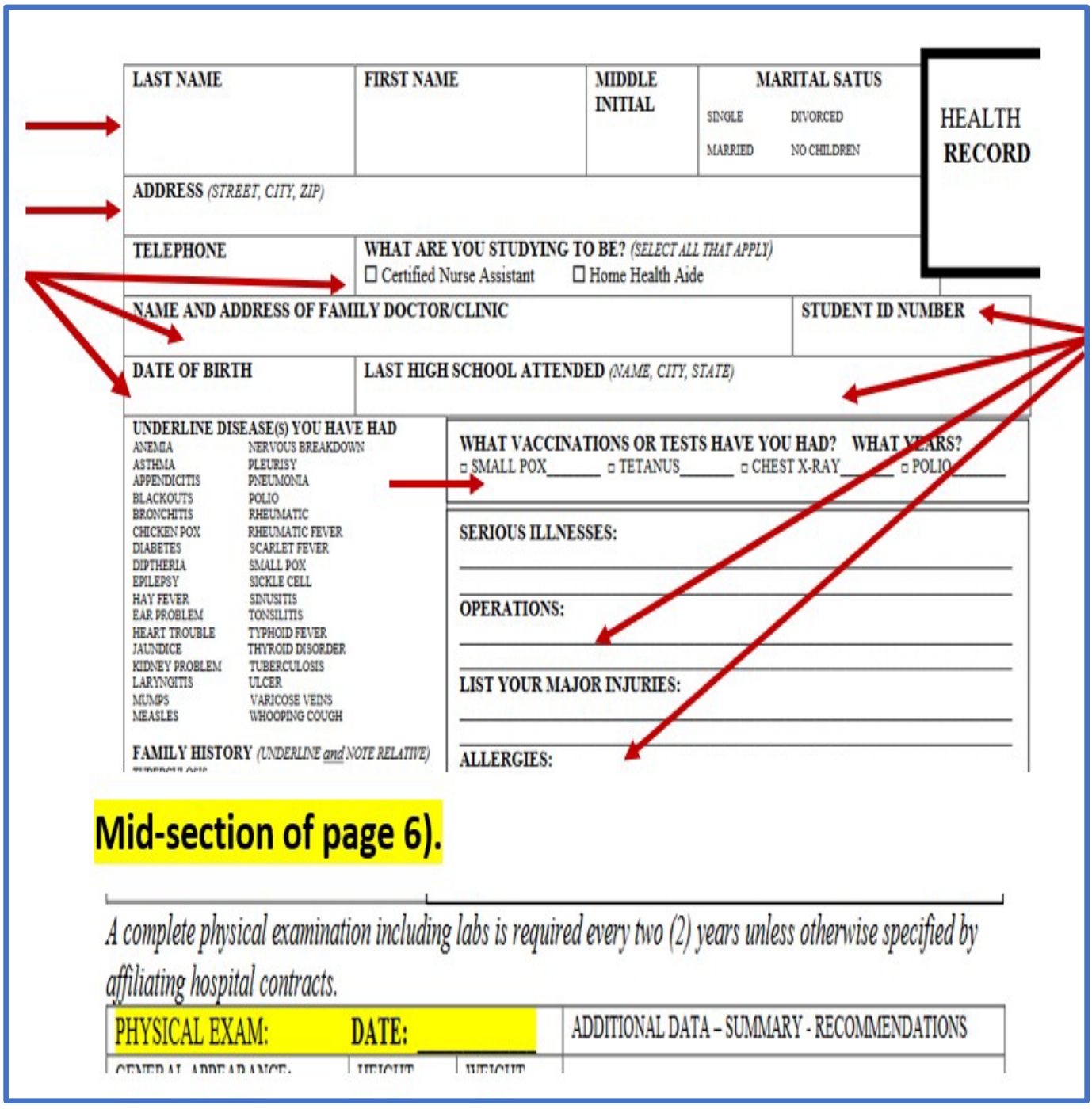
6. OTHER THAN ENGLISH, WHAT LANGUAGE(S) ARE YOU PROFICIENT IN? *(Circle all that apply/specify.)*

♦ American Sign Language	♦ Arabic	♦ Chinese; including its various dialects (*specify* _____)			
♦ Farsi	♦ French	♦ Japanese	♦ Russian	♦ Spanish	♦ Tagalog
♦ Other, please specify: _____			♦ Not applicable (English-only)		

7. DO YOU HAVE A HIGH SCHOOL DIPLOMA OR GED? **Y**____ **N**____ **WHAT YEAR?** _____

Physical assessment forms. See the sections you need to complete before going for a physical

- Below is an image of the top Portion of Page 6 in your packet. The actual pages 6 and 7 (not shown here) are on the NATP, and HHA Packet downloaded throught he link above. *On the day of your physical, make sure your doctor orders the urine drug test, any missing vaccinations, or titers. Your pocket must include the urine panel test results. Any TB testing forms must be filled out with details of which arm it was done in and results signed off and dated.*



LAST NAME	FIRST NAME	MIDDLE INITIAL	MARITAL SATUS SINGLE DIVORCED MARRIED NO CHILDREN
ADDRESS *(STREET, CITY, ZIP)*			
TELEPHONE	WHAT ARE YOU STUDYING TO BE? *(SELECT ALL THAT APPLY)* ☐ Certified Nurse Assistant ☐ Home Health Aide		
NAME AND ADDRESS OF FAMILY DOCTOR/CLINIC			STUDENT ID NUMBER
DATE OF BIRTH	LAST HIGH SCHOOL ATTENDED *(NAME, CITY, STATE)*		

HEALTH RECORD

UNDERLINE DISEASE(S) YOU HAVE HAD

ANEMIA	NERVOUS BREAKDOWN
ASTHMA	PLEURISY
APPENDICITIS	PNEUMONIA
BLACKOUTS	POLIO
BRONCHITIS	RHEUMATIC
CHICKEN POX	RHEUMATIC FEVER
DIABETES	SCARLET FEVER
DIPTHERIA	SMALL POX
EPILEPSY	SICKLE CELL
HAY FEVER	SINUSITIS
EAR PROBLEM	TONSILITIS
HEART TROUBLE	TYPHOID FEVER
JAUNDICE	THYROID DISORDER
KIDNEY PROBLEM	TUBERCULOSIS
LARYNGITIS	ULCER
MUMPS	VARICOSE VEINS
MEASLES	WHOOPING COUGH

FAMILY HISTORY *(UNDERLINE and NOTE RELATIVE)*

WHAT VACCINATIONS OR TESTS HAVE YOU HAD? WHAT YEARS?
□ SMALL POX_____ □ TETANUS_____ □ CHEST X-RAY_____ □ POLIO_____

SERIOUS ILLNESSES:

OPERATIONS:

LIST YOUR MAJOR INJURIES:

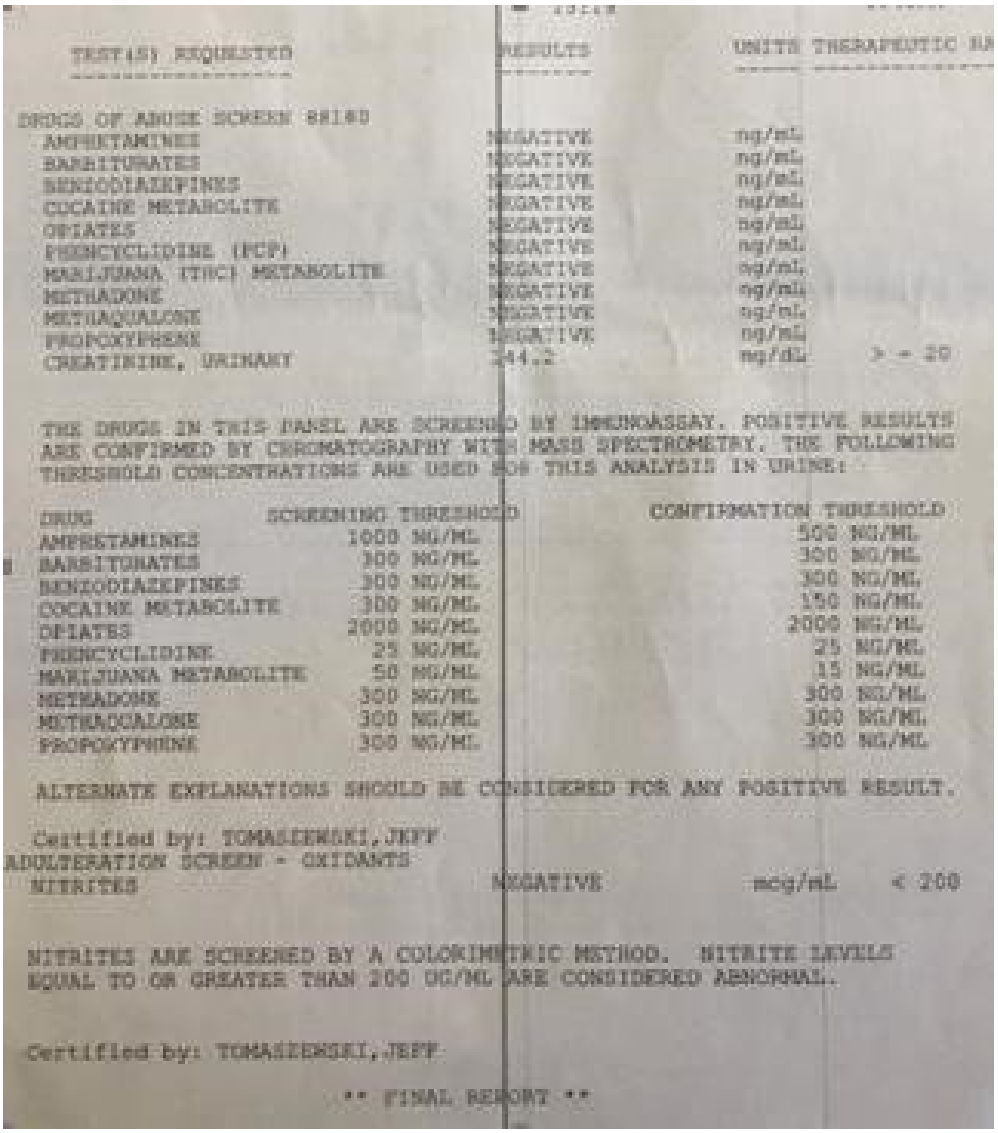
ALLERGIES:

Mid-section of page 6).

A complete physical examination including labs is required every two (2) years unless otherwise specified by affiliating hospital contracts.

PHYSICAL EXAM: DATE: _____	ADDITIONAL DATA – SUMMARY - RECOMMENDATIONS
GENERAL APPEARANCE:	HEIGHT WEIGHT

Example of a Urine Drug Test Panel Results



TEST(S) REQUESTED | RESULTS | UNITS | THERAPEUTIC RA

DRUGS OF ABUSE SCREEN 8818D

AMPHETAMINES	NEGATIVE	ng/mL	
BARBITURATES	NEGATIVE	ng/mL	
BENZODIAZEPINES	NEGATIVE	ng/mL	
COCAINE METABOLITE	NEGATIVE	ng/mL	
OPIATES	NEGATIVE	ng/mL	
PHENCYCLIDINE (PCP)	NEGATIVE	ng/mL	
MARIJUANA (THC) METABOLITE	NEGATIVE	ng/mL	
METHADONE	NEGATIVE	ng/mL	
METHAQUALONE	NEGATIVE	ng/mL	
PROPOXYPHENE	NEGATIVE	ng/mL	
CREATININE, URINARY	244.2	mg/dL	> = 20

THE DRUGS IN THIS PANEL ARE SCREENED BY IMMUNOASSAY. POSITIVE RESULTS ARE CONFIRMED BY CHROMATOGRAPHY WITH MASS SPECTROMETRY. THE FOLLOWING THRESHOLD CONCENTRATIONS ARE USED FOR THIS ANALYSIS IN URINE:

DRUG	SCREENING THRESHOLD	CONFIRMATION THRESHOLD
AMPHETAMINES	1000 NG/ML	500 NG/ML
BARBITURATES	300 NG/ML	300 NG/ML
BENZODIAZEPINES	300 NG/ML	300 NG/ML
COCAINE METABOLITE	300 NG/ML	150 NG/ML
OPIATES	2000 NG/ML	2000 NG/ML
PHENCYCLIDINE	25 NG/ML	25 NG/ML
MARIJUANA METABOLITE	50 NG/ML	15 NG/ML
METHADONE	300 NG/ML	300 NG/ML
METHAQUALONE	300 NG/ML	300 NG/ML
PROPOXYPHENE	300 NG/ML	300 NG/ML

ALTERNATE EXPLANATIONS SHOULD BE CONSIDERED FOR ANY POSITIVE RESULT.

Certified by: TOMASZEWSKI,JEFF

ADULTERATION SCREEN - OXIDANTS

NITRITES	NEGATIVE	mcg/mL	< 200

NITRITES ARE SCREENED BY A COLORIMETRIC METHOD. NITRITE LEVELS EQUAL TO OR GREATER THAN 200 UG/ML ARE CONSIDERED ABNORMAL.

Certified by: TOMASZEWSKI,JEFF

** FINAL REPORT **

Instruction of information to enter in the LIVESCAN form (for fingerprints).

Make sure to download the form and enter all the NUMBERS and AGENCY NAMES as indicated below.

Live Scan application form – prefilled (Click on this Link to access) **Do not use the image below to enter your information**

STATE OF CALIFORNIA
BCIA 8016
(orig. 4/01; rev. 6/09)

DEPARTMENT OF JUSTICE

SAMPLE FOR CERTIFICATION OF NURSE ASSISTANTS OR HOME HEALTH AIDES

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

A1226
ORI (Code assigned by DOJ)

Certification
Authorized Applicant Type

Certified Nurse Assistant (CNA) or Home Health Aide (HHA)
Type of License/Certification/Permit OR Working Title (Maximum 30 characters - if assigned by DOJ, use exact title assigned)

Contributing Agency Information:

California Department of Public Health (CDPH)
Agency Authorized to Receive Criminal Record Information

03314
Mail Code (five-digit code assigned by DOJ)

MS 3301, P.O. Box 997416
Street Address or P.O. Box

(Leave blank)
Contact Name (mandatory for all school submissions)

Sacramento | CA | 95899-7416
City | State | Zip Code

(Leave blank)
Contact Telephone Number

Applicant Information:

Your last name
Last Name

Your first name & middle initial
First Name | Middle Initial | Suffix

Other Name (AKA or Alias): Other last names known as
Last

Other first names known as
First Name | Suffix

(Check one)

Date of Birth
Date of Birth

Sex: ☐ Male ☐ Female

California Driver's License Number
Driver's License Number

Height | Weight | Color | Color
Height | Weight | Eye Color | Hair Color

Billing Number: Not Applicable
(Agency Billing Number)

Place of Birth
Place of Birth (State or Country)

*Social Security Number (Required by CDPH
Social Security Number

Misc. Number: Your telephone number
(Other Identification Number)

Home Address: Your mailing address
Street Address or P.O. Box

City | State | Zip Code

Your Number: *Social Security Number (Required by CDPH)
OCA Number (Agency Identification Number)

Level of Service: ☒ DOJ ☐ FBI

If re-submission, list ATI number:
(Must provide proof of Rejection)

Original ATI Number

Employer (Additional response for agencies specified by statute):

(Leave blank)
Employer Name

Mail Code (five-digit code assigned by DOJ)

Street Address or P.O. Box

City | State | Zip Code

Telephone Number (optional)

Live Scan Transaction Completed By:

Name of Operator

Date

Transmitting Agency | LSID | ATI Number | Amount Collected/Billed

BCIA 8016 (Rev 07/11) SAMPLE

ORIGINAL - Live Scan Operator SECOND COPY - Applicant THIRD COPY (if needed) - Requesting Agency

NOTE TO APPLICANT: *Please input your Social Security Number (SSN) where required. The submission of your SSN will allow results to be transmitted from DOJ to CDPH accurately and timely. Failure to submit your SSN could cause delay in your certification.

Sign and date all 3 areas of Page 23 of the Student Handbook after reading it.

One *(1)* original + one *(1)* copy of the last page (Evidence of Understanding) from:

- **Student Handbook LINK**