|  |
| --- |
| FORM A: HHATP Application Cover Sheet |
| Submit an individual application for each program (multiple sites, secondary and adult). |
| A. Program Information |
| School District or BOCES:       | Program Number: (Ex. 24XXXX)       |
| [ ]  New Program Request[ ]  Change(s) Request: [ ]  Site/Facility [ ]  RN Director Coordinator [ ]  RN Instructor [ ]  Curriculum[ ]  Deactivate program (no longer delivered/not meeting regulatory requirements)[ ]  Site Visit/Continuing Program Approval  |
| Level: [ ]  Secondary [ ]  AdultPCA requested: [ ] CNA to HHA Transition requested (Form F attached): [ ]  | School/Site Name:      Address:      County:       |
| RN Director Coordinator: | RN Instructor: |
| Name:       | Name:       |
| Work Address:       | Work Address:       |
| Phone:       | Phone:       |
| E-mail address:       | E-mail address:       |
| B. Course Detail |
| RN to student ratio:Lab(10:1 max):     Clinical(8:1/3:1/1:1):      | *Minimum required hours*:*Secondary and Adult* - 75 total hours: 59 class and 16 supervised practical training (long-term care facilities are not permitted hours)Class hours:      Clinical hours:      Total hours:      PCA requested (if so, indicate hours):     CNA to HHA Transition requested (if so, indicate hours):      | Number of course offerings per year:      | Number of students per class(20:1 max):      |
| C. Supervised Clinical Experience Site |
| *List all home care agencies used and attach a copy of clinical affiliation agreement for each. Use additional sheets if needed*. |
| Name | Address | Phone | Expiration Date |
|       |       |       |       |
|       |       |       |       |
| Attestation Signatures |
| *I certify that the above information is correct and attest to program compliance with regulatory requirements:* |
| RN Director Coordinator Signature: | Date:       |
| School Administrator Signature: | Date:       |
| **For State Use Only** |
| Approval: | Yes [ ]  | No [ ]  | NYSED Staff Person: | Date: |