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| 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  Adult  PCA 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: | | | |