

**HOME CARE AIDE TRAINING PROGRAM FOR REGISTRY LISTING  
COMMUNITY COLLEGE APPROVAL APPLICATION**

Community College Name:	
Mailing Address:	Area Code/Phone Number:
	Area Code/Fax Number:
Site Address:	Program Coordinator's E-mail Address:

**Note: Please complete all appropriate blanks. Incomplete forms will be returned.**

<b>If a Home Care Aide program number has been assigned by DHSR, please list here:</b> _____
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<b>REQUIRED MINIMUM HOURS:</b>	<b>Total Hours = 100</b>
<b>Specify Curriculum Type:</b> <input type="checkbox"/> Continuing Education	<input type="checkbox"/> Curriculum

**STATEMENT OF UNDERSTANDING**

- I understand that approval to offer this program is based on our agency using the state-approved Home Care Aide Specialty curriculum. I understand that I must teach, at a minimum, 100 hours of content, to include all modules as written in the curriculum. I understand that students must be listed on the Nurse Aide I Registry prior to attending the course. I further understand our agency may be required to make modifications to this program as requested by North Carolina Division of Health Service Regulation (DHSR). Modifications made by the state to the state-approved curriculum and provided to our agency will be incorporated into the currently approved program under which our agency operates.
- I understand that a college must require a minimum numerical grade of 75 as the final theory grade and a lab/activity grade as pass/fail.
- I understand that changes in faculty must be approved by the DHSR prior to implementation.
- I understand that the instructor should be a registered nurse with an unencumbered license with a minimum of one year (2000 hours) of home care/home health experience.
- I understand DHSR may withdraw approval of this training program if it determines that the program does not meet state requirements.
- I certify that class rosters with records of successful completion of the course will be made available to DHSR upon request.
- **I understand that the Instructor/PC is required to fax the original completion certificates of all completers to DHSR in order for them to be listed on the Home Care Aide Registry.**

\_\_\_\_\_  
Signature of Program Coordinator

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Administrator

\_\_\_\_\_  
Date

**FACULTY**  
**(Faculty Approval Request forms can be found at [www.ncnar.org](http://www.ncnar.org))**

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NAT Program Coordinator: \_\_\_\_\_ RN License Number \_\_\_\_\_

Previously approved as NAI program coordinator **OR**  Faculty approval form is attached.

Will program coordinator serve as instructor?  Yes  No

Instructor: \_\_\_\_\_ RN License Number \_\_\_\_\_

Previously approved as NAI instructor with at least one year home care/home health experience  
**OR**  Faculty approval form is attached.

Instructor: \_\_\_\_\_ RN License Number \_\_\_\_\_

Previously approved as NAI instructor with at least one year home care/home health experience  
**OR**  Faculty approval form is attached.

Instructor: \_\_\_\_\_ RN License Number \_\_\_\_\_

Previously approved as NAI instructor with at least one year home care/home health experience  
**OR**  Faculty approval form is attached.

**COMPLETING THE APPLICATION PROCESS:**  
**(actual signatures are required)**

Please print/sign/pdf e-mail application to [brenda.sanders@dhhs.nc.gov](mailto:brenda.sanders@dhhs.nc.gov) or print/sign and fax the application to the attention of Brenda Sanders at 919-733-9764.

Please contact Ms. Sanders at (919) 855-3986 if you need further information.

**FOR OFFICE USE ONLY - DO NOT WRITE IN THIS BOX**

<b>Program # Assigned</b> _____	<b>Continuing Education</b> _____ <b>Curriculum</b> _____
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