CAHSAH
Shaping the Future of Home Care

The Homecare & Hospice Certification Examination

MANAGER | ADMINISTRATOR | EXECUTIVE

APPLICATION

Applicant must submit the fee payment form with the completed application. It is the responsibility of applicant to ensure all supporting documents are submitted with application. Applications received after the deadline for a specified event will not be processed.

Use only blue or black ink to complete the application or type the information if necessary. If your application is not legible, it will not be processed. If your application is not signed, it will not be processed.

Submit your application package to:

CAHSAH Certification Application
3780 Rosin Court, Suite 190
Sacramento, CA 95834

CHECKLIST

HAVE YOU:

q Read the "Candidate Handbook" cover to cover

q Read and agree to abide by the policies and procedures as outlined in the "Candidate Handbook"

q Filled out the application in its entirety (Application must be typed or legible.)

q Signed your application

q Made a photocopy of the completed application for your own records (documents submitted will not be returned)

q Enclosed the application fee

q Enclosed a copy of your college, university or school transcript or diploma

Once your application is approved, your eligibility status is valid for one year from the date of approval. You will receive an approval code - which is needed in order to sign up for the examination. For more information, please refer to the candidate handbook or contact CAHSAH at certification@cahsah.org. Thank you.

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The Homecare & Hospice Certification 2010

MANAGER • ADMINISTRATOR • EXECUTIVE

3780 Rosin Court, Suite 190, Sacramento, CA 95834 p: 916.641.5795; f: 916.641.5881; certification@cahsah.org; www.cahsah.org

APPLICANT INFORMATION

Please provide your legal name as it appears on your drivers license, passport or other official identification.

☐ Mr. ☐ Ms.

Name _____
LAST FIRST MIDDLE

Other Certifications/Designations _____

In the space provided below, please provide information for both your work and home address. Check the box next to the address that you would like to be listed as your primary mailing address. If neither box is checked, your primary address will default to your work address.

☐ WORK ADDRESS

Title _____ Organization _____

Mailing Address _____

City _____ State/Province _____ Zip/Postal Code _____

Phone _____ Fax _____

Email _____

☐ HOME ADDRESS

Mailing Address _____

City _____ State/Province _____ Zip/Postal Code _____

Phone _____ Fax _____

Email _____

1. I am applying for the:
   - ☐ Certified Home Care Manager Examination
   - ☐ Certified Home Care Administrator Examination
   - ☐ Certified Home Care Executive Examination
   - ☐ Certified Hospice Manager Examination
   - ☐ Certified Hospice Administrator Examination
   - ☐ Certified Hospice Executive Examination

2. I currently work in the following field (check one):
   ☐ Home Health ☐ Home Care Aide Organization ☐ Hospice ☐ Other _____

3. Total number of years in this profession:
   ☐ 0-2 years ☐ 3-5 years ☐ 6-10 years ☐ 10+ years

4. Current employer organization structure:
   - ☐ For profit
   - ☐ Non-profit
   - ☐ Government
   - ☐ Freestanding
   - ☐ Hospital-based

~ Optional demographic information ~

Age: ☐ Under 25 ☐ 25-29 ☐ 30-39 ☐ 40-49 ☐ 50-59 ☐ 60-69 ☐ Over 69

Race: ☐ African American/Black ☐ Asian/Asian American/Pacific Islander ☐ Caucasion
☐ Hispanic ☐ Multiracial ☐ Other

MANAGEMENT EXPERIENCE

Please provide your home care/hospice management experience beginning with your current or most recent position. Describe your responsibility for each position. Attach a separate sheet if more space is needed.

1. Current/Recent Job Title: _____

Description of Responsibilities: _____

_____

Name of Organization: _____

Address: _____ City_____ State/Province_____ Zip/Postal Code_____

Employment: From _____ To _____ *For this position, the percentage of time spent in:* Management _____ %

Number of people reporting to you? _____ Other _____ %

TOTAL 100%

2. Job Title: _____

Description of Responsibilities: _____

_____

Name of Organization: _____

Address: _____ City_____ State/Province_____ Zip/Postal Code_____

Employment: From _____ To _____ *For this position, the percentage of time spent in:* Management _____ %

Number of people reporting to you? _____ Other _____ %

TOTAL 100%

3. Job Title: _____

Description of Responsibilities: _____

_____

Name of Organization: _____

Address: _____ City_____ State/Province_____ Zip/Postal Code_____

Employment: From _____ To _____ *For this position, the percentage of time spent in:* Management _____ %

Number of people reporting to you? _____ Other _____ %

TOTAL 100%

To calculating actual years of management experience, multiply the percentage spent on management responsibilities from each job by the number of years. (i.e. 75% x 5 years = 3.75 years) *Subtotal*

1. _____% Management x _____ years = _____
2. _____% Management x _____ years = _____
3. _____% Management x _____ years = _____

TOTAL: _____

EDUCATION INFORMATION

My highest formal education level is:
☐ High School Diploma ☐ Associate Degree ☐ Bachelor's Degree
☐ Master's Degree ☐ Doctorial Degree ☐ Nurse Diploma
☐ Other _____

The discipline of my degree attained: ☐ Nursing ☐ Administration/Business ☐ Other_____

School Name _____

Address: _____ City_____ State/Province_____ Zip/Postal Code_____

REFERENCES

Please provide three references within the healthcare industry who can attest for your professional experience and qualifications as set forth in this application. Include the name of your current employer as the first reference, if applicable, list someone who has already received one of the CAHSAH home care or hospice certifications.

Name _____ Title _____

Organization _____

Mailing Address_____ City_____

State/Province_____ Zip/Postal Code_____ Email_____

Phone _____ Fax_____

Name _____ Title _____

Organization _____

Mailing Address_____ City_____

State/Province_____ Zip/Postal Code_____ Email_____

Phone _____ Fax_____

Name _____ Title _____

Organization _____

Mailing Address_____ City_____

State/Province_____ Zip/Postal Code_____ Email_____

Phone _____ Fax_____

☐ I have read and understand the contents of the "Candidate Handbook" and will act in accordance with these policies and procedures.

I certify that all the information contained in this application is accurate and truthful. I understand that all the information I have provided herein may be verified and I authorize such verification. I understand that falsification or misrepresentation of facts provided herin will be grounds for disqualification and/or revokation of the awarded certification designation. If certified, I agree to abide by the rules and regulations set forth by CAHSAH. I also agree, if certified, to be listed in the online directory.

I affirm that no state or government authority has taken any disciplinary action in relation to my working in a homecare or hospice agency. I further affirm that I have no felony convictions.

Name _____

Signature_____ Date_____

APPLICATION FEE PAYMENT FORM

Application Fee: ☐ $49 CAHSAH Member ☐ $99 Non-member

Method of Payment: ☐ Mastercard ☐ Visa ☐ American Express ☐ Check #_____(payable to CAHSAH)

If paying by credit card (please print):

Cardholder Name _____ Card # _____

Billing Address_____ Expiration Date_____ CVS # _____

City_____State____ Zip Code_____ Signature _____

CAHSAH USE ONLY

Scored by _____ Verified by _____

Date_____ Date_____

Qualified Not qualified Qualified Not qualified