

**DISTRICT OF COLUMBIA BOARD OF NURSING
HOME HEALTH AIDE REINSTATEMENT-REACTIVATION APPLICATION****PLEASE READ BEFORE COMPLETING THE APPLICATION AND RETAIN FOR YOUR RECORDS**

Your interest in reinstating your Home Health Aide certification in the District of Columbia is welcomed. We look forward to providing expedient and professional service. However, the quality of our service is dependent on the completeness of your application.

APPLICATION PROCESS

- Processing time for applications is 6-8 weeks. Please allow **21 business days** after applying before registering to check the status at <https://app.hpla.doh.dc.gov/mylicense/>. If you have questions about your application after viewing your checklist, email the Licensing Specialist for your license type from the BON's staff list at <https://dchealth.dc.gov/bon>.
- If we need additional information to complete your application, you will be contacted **via email** by a Licensing Specialist with instructions on how to submit the required documents. Please be sure to submit the required documents in the manner requested.
- Once your application is approved, you will be able to view your approved status at <https://doh.force.com/ver/s/> and can expect to receive the license by mail in 7-14 business days.

IMPORTANT CONTACT INFORMATION**DC Board of Nursing Location:**

District of Columbia Department of Health
899 North Capitol Street NE
Washington, D.C. 20002

Website:

dchealth.dc.gov/bon

Mailing Address:

D.C. Board of Nursing
P.O. Box 37802
Washington, D.C. 20013

BEFORE YOU SUBMIT YOUR APPLICATION MAKE SURE YOU HAVE PROVIDED OR REQUESTED ALL OF THE CHECKLIST ITEMS

APPLICATION CHECKLIST

HOME HEALTH AIDE REINSTATEMENT REQUIREMENTS (must reinstate within five (5) years after the certification expires).

- A completed, signed and dated application
- \$70.00 application fee (non-refundable)
- Social Security number or signed affidavit
- Email address
- Name change document- If the name on your application differs from the name on any of your supporting documents, proof of name change is required. Acceptable documents are marriage certificate, divorce decree, court order or spouse's death certificate.
- A copy of a government issued photo ID
- Criminal background check (**Required if your previous background check with the DC Board of Nursing is older than four years**). Criminal background check instructions are attached to the application and on our website at dchealth.dc.gov/bon) under **Criminal background check.**
- Home Health Aide Employment Attestation form- to be completed by your supervising nurse.
- Provides evidence (certificates of completion) of having completed twenty-four (24) hours of in-service training or continuing education hours within the past two (2) years prior to submission of the application.

HOME HEALTH AIDE REACTIVATION REQUIREMENTS

- A completed, signed and dated application
- \$34.00 application fee (non-refundable)
- Social Security number or signed affidavit
- Email address

- Name change document- If the name on your application differs from the name on any of your supporting documents, proof of name change is required. Acceptable documents are marriage certificate, divorce decree, court order or spouse's death certificate.
- A copy of a government issued photo ID
- Criminal background check (**Required if your previous background check with the DC Board of Nursing is older than two years**). Criminal background check instructions are attached to the application and on our website at dchealth.dc.gov/bon) under **Criminal background check.**
- Home Health Aide Attestation form- to be completed by your supervising nurse.
- Provides evidence (certificates of completion) of having completed twenty-four (24) hours of in-service training or continuing education hours within the past two (2) years prior to submission of the application.

PLEASE RETAIN FOR YOUR RECORDS

CRIMINAL BACKGROUND CHECK INSTRUCTIONS

1. Start by going to the **DC Health CBC Payment Portal**. Select this link <https://doh.force.com/payment/s/>
2. Once you make a payment:
 - You will receive an email receipt with a **Fieldprint Code** (please note your appropriate code). The Fieldprint Code will also appear on your payment confirmation page.
 - You will be redirected to the **Fieldprint scheduling website**.
3. At the **Fieldprint scheduling website**, under "New Users/Sign Up", enter an email address and select the "Sign Up" button. Follow the instructions for creating a Password and Security Question and then select "Sign Up and Continue".
4. Enter the contact and demographic information required by the FBI and schedule a fingerprint appointment at your preferred location.
5. At the end of the process, print the Confirmation Page. Take the **Confirmation Page** and **two forms of identification** with you to your fingerprint appointment.
6. If you have any questions or problems, you may contact our customer service team at **877-614-4364** or customerservice@fieldprint.com.

Legal Requirements

The criminal background check requirements for health care licensing and long-term care unlicensed personnel employment are based on the following laws and regulations:

Health Care Professional Licensing

["Licensed Health Professional Criminal Background Check Amendment Act of 2006", effective March 6, 2007, \(D.C. Law 16-222\), D.C. Official Code § 3-1205.22 et seq.](#)

Long Term Care Employment of Unlicensed Persons

[Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999, as amended by the Health-Care Facility Unlicensed Personnel Criminal Background Check Amendment Act of 2002, effective April 13, 2002, \(D.C. Laws 12-238 and 14-98\), D.C. Official Code § 44- 551 et seq.](#)

HOME HEALTH AIDE EMPLOYMENT ATTESTATION

PART 1: To be completed by the applicant

NAME (Last, First, Middle)	Date of Birth (MM/DD/YYYY)
Social Security Number	HHA LICENSE NUMBER
Name and Address of Employment	Employer's No. and Email address

PART 2: To be completed by the supervising nurse. I, this applicant's supervising nurse, confirm that this Home Health Aide has provided a minimum of eight (8) hours of patient care within the past two years. I hereby attest that the information I have provided on this form is true and complete to the best of my knowledge. I understand that making a false statement on this document, including all writings and attachments, may result in the Department of Health acting as it deems appropriate.

Supervising Nurse (Print name)	Supervising Nurse License state and No.
Supervising Nurse Signature	Date

BOARD OF NURSING HOME HEALTH AIDE REINSTATEMENT APPLICATION

All applicants must complete every section of this application and submit the original application, and all required supporting documents. If more space is needed to fully answer questions, attach additional sheets with typed responses. False or misleading statements will be cause for disciplinary action and could be cause for criminal prosecution pursuant to DC Code 22-2514. If you have any questions, call DCHEALTH Customer Service at 1-877-672-2174 Monday through Friday, 8:30 AM to 4:30 PM EST.

Please Note: Please refer to application instructions before completing this form.

SECTION 1. LICENSURE TYPE & FEES	
<p>HOME HEALTH AIDE</p> <p><input type="checkbox"/> Reinstatement expired HHA Certification \$70.00 (Non-refundable)</p> <p><input type="checkbox"/> Reinstatement paid inactive HHA Certification 34.00 (Non-refundable)</p> <p>DC LICENSE NUMBER _____</p> <p><input type="checkbox"/> CRIMINAL BACKGROUND CHECK: A criminal background check is required only if the previous background check with the DC Board of Nursing is older than two years.</p>	<p>LICENSURE EXPIRATION: All licenses expire October 30th of odd numbered years</p> <p><u>Make check or money order payable to:</u> DC Treasurer</p> <p><u>Mail your application to:</u> D.C. Board of Nursing P.O. Box 37802 Washington, D.C. 20013</p>

SECTION 2. APPLICANT INFORMATION			
<p>Note: LEGAL NAME: (Do not use any initials unless they are a part of your name)</p>			
<p>_____ FIRST NAME</p>	<p>_____ MI</p>	<p>_____ LAST NAME</p>	<p>_____ (SUFFIX: Jr., Sr. etc.)</p>
<p>____/____/____ Date of Birth</p>	<p>____ - ____ - ____ Social Security Number</p>	<p>GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE</p>	
<p>*All Applicants must provide a Social Security Number. If you are a foreign graduate and do not have a SSN or are waiting for one to be issued, you must complete the SSN affidavit form and submit it with your application. Your license will not be renewed without a valid SSN.</p>			

SECTION 3. OTHER NAMES USED: (Please print clearly)			
<p>If your name on this application is different from the name on your supporting documentation provide a copy of a legal document supporting the name change. Acceptable documents for individuals are marriage certificates, divorce decrees, court orders and spouse's death certificate.</p>			
<p>_____ FIRST NAME</p>	<p>_____ MI</p>	<p>_____ LAST NAME</p>	<p>_____ (SUFFIX: Jr., Sr. etc.)</p>
<p>_____ FIRST NAME</p>	<p>_____ MI</p>	<p>_____ LAST NAME</p>	<p>_____ (SUFFIX: Jr., Sr. etc.)</p>
<p>_____ Place of Birth: State/Providence/Territory</p>		<p>_____ Country if not USA</p>	

SECTION 4: RACE & ETHNICITY DESIGNATION:	LANGUAGE(S) SPOKEN:
<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian/South Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Other _____ <input type="checkbox"/> Native Hawaiian or other Pacific Islander	<i>Language(s) spoken other than English:</i> <input type="checkbox"/> Spanish <input type="checkbox"/> French <input type="checkbox"/> German <input type="checkbox"/> Arabic <input type="checkbox"/> Other _____

SECTION 5. PREFERRED MAILING ADDRESS

Note: A P.O. BOX MAY NOT BE USED FOR AN ADDRESS. PLEASE PROVIDE A STREET ADDRESS.

Indicate your preferred mailing address by placing an "X" in the appropriate box. This will be the address to which all future licensing documents will be mailed.

HOME ADDRESS BUSINESS ADDRESS

SECTION 6. HOME /BUSINESS ADDRESS

Home Address or DC Local/Mailing Address

ADDRESS: _____
(Street Number and Street Name) (City) (State/Province/Territory) (Zip Code)

APARTMENT # _____ PHONE NUMBER: (____) ____ - _____ FAX: (____) ____ - _____

You are statutorily required to notify the DC Board of Nursing in writing of an address change within 30 days. Failure to do may result in your not receiving your license, renewal notice or other official notices and can result in a disciplinary action or a fine.

EMAIL ADDRESS (REQUIRED): _____ CELL PHONE: _____

Business Address

ADDRESS: _____
(Street Number and Street Name) (City) (State/Province/Territory) (Zip Code)

APARTMENT # _____ PHONE NUMBER: (____) ____ - _____ FAX: (____) ____ - _____

EMAIL ADDRESS: _____ CELL PHONE: _____

SECTION 7. SCREENING QUESTIONS Applicants must answer all the following questions

Applicants Must Answer All of the Following Questions. If you answer “Yes” to questions A-D provide a detailed explanation on a separate sheet of paper. Submit copies of relevant court reports, personnel actions, or other relevant documents.

<p align="center">Clean Hands Before Receiving a License or Permit Act of 1996 Certification Form Requirement</p> <p>Please read the information below carefully before responding to this yes or no question, as any false information provided requires that the Department of Health proceed immediately to revoke your license for which you are now applying, and fine you one thousand dollars (\$1,000.00), pursuant to D.C. Official Code § 47-2864 (2001).</p> <p>PLEASE NOTE: Pursuant to D.C. Official Code §47-2862(a) (FY 2007 Budget Support Act of 2006) you cannot be issued a license if you have failed to file your District tax returns.</p> <p>IF YOU ANSWER “YES” TO THIS QUESTION, PLEASE SUBMIT PROOF OF THE ARRANGEMENTS YOU HAVE MADE TO PAY THE OUTSTANDING DEBT. IF YOU DO NOT HAVE AN APPROVED PAYMENT SCHEDULE TO PAY THE AMOUNT YOU OWE OR IF NO APPEAL IS PENDING, THE LAW REQUIRES THAT YOUR RENEWAL APPLICATION BE DENIED.</p> <p>As of this date, do you owe more than one hundred dollars (\$100.00) to the District of Columbia Government as a result of any of the following:</p> <ol style="list-style-type: none"> 1. Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 8, Chapter 8 (Litter Control Administrative Act of 1985). 2. Fines or interest assessed pursuant to D.C. Official Code Title 8, Chapter 9 (Illegal Dumping Enforcement Act of 1994). 3. Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 2, Chapter 18 (Civil Infractions Act of 1985). 4. Past due taxes; 5. Past due District of Columbia Water and Sewer Authority service fees; or 6. Fines or penalties assessed pursuant to D.C. Official Code Title 50, Chapter 23 (Traffic Adjudication)? <p>Information presented above is in compliance with the requirement to submit with your application for licensure under the <i>Clean Hands Before Receiving a License or Permit Act of 1996</i>, effective May 11, 1996 (D.C. Law 11-118, D.C. Code §47-2861 et seq.).</p>		<p>YES <input type="checkbox"/> NO <input type="checkbox"/></p>
A.	Has the use of drugs and/or alcohol resulted in an impairment of your ability to safely provide patient care?	YES <input type="checkbox"/> NO <input type="checkbox"/>
B.	Do you have a mental condition that currently impairs your ability to safely provide patient care?	YES <input type="checkbox"/> NO <input type="checkbox"/>
C.	Have you ever been arrested, or pled guilty instead of going to trial, or been found guilty after a trial, or pled nolo contendere, regardless of whether the arrest, conviction or plea of nolo contendere was sealed or expunged? If you answer “Yes” to this question, include all court documents pertaining to each arrest and/or conviction that occurred within the last seven (7) years, which detail the outcome or final decision.	YES <input type="checkbox"/> NO <input type="checkbox"/>
D.	Please answer with respect to DC or any other jurisdiction/state: (1) Have you withdrawn an application to practice your profession or voluntarily surrendered a license/certification after formal charges have been filed against you or while under investigation? (2) Have you been (or are you currently being) investigated by any authority or peer review board for any violation of state, federal, or local law?	YES <input type="checkbox"/> NO <input type="checkbox"/>

SECTION 8. LICENSEE AFFIDAVIT

I hereby attest that the information given in this application, including all writings and exhibits attached hereto, is true and complete to the best of my knowledge. I understand that the making of a false statement on this application, including all writings and exhibits attached hereto, is punishable by criminal penalties.

LICENSEE SIGNATURE

PRINT NAME

DATE

To report waste, fraud, or abuse by any DC Government office or official, call the DC Inspector General at 1-800-521-1639.

COMPLETE THIS FORM IF YOU DO NOT HAVE A SOCIAL SECURITY NUMBER

SOCIAL SECURITY AFFIDAVIT FORM

First Name:	MI	Last Name:
Address		
City:	State:	Zip code:
Email:	Date of Birth:	

In accordance with D.C. Official Code § 3-1205.05(b) a Social Security number is required to be placed on the application for licensure or certification. In accordance with § 466(a) (13) of the Social Security Act if you do not have a Social Security number at the time of application, you must submit a sworn affidavit, under penalty of perjury, stating that you do not have a Social Security number. If you were not born in the United States and depending on your immigration status you may not be eligible for a Social Security number. Please be advised that a Tax ID number (beginning with the number “9” and having a “7” as the fourth digit) will not suffice as a permanent substitute for a Social Security number.

ATTESTATION: By signing this Affidavit, I acknowledge my understanding agreement with the following:

1. As soon as I become eligible, I will apply for a Social Security Number. Immediately upon my receipt of a Social Security Number, I will provide to the Board, in writing at the address listed below, my valid Social Security Number and a copy of my Social Security card, or any other document issued by the Social Security Administration, as evidence of my Social Security Number.
2. I understand that if I fail to supply my valid Social Security Number to the Board before my District of Columbia license/certification expires, the Board shall not renew my license/certification until I provide my valid Social Security Number and, under such circumstances, I hereby WAIVE my right to renew my license until such time as I have provided my valid Social Security Number to the Board.
3. In accordance with D.C. Official Code § 3-1205.13(b) I will inform the Board within thirty (30) days of any change in my address.

Date

Applicant's Signature

Sworn to and subscribed before me this ____ day of _____ 20____.

Notary Public