

CHCE Application

Home Care University does not discriminate on the basis of race, color, religion, national origin, sex, age, disability, or marital status. If the application form is incomplete or if any required documentation is missing, your application will not be approved.

Print or type this application

1. Name

Mr. Ms. Mrs. Dr.

Last First Middle Name

2. Home Address

Number Street

City State Zip Country

3. Telephone

() ()

Office Home

()

Fax Number E-mail

4. Have you previously applied to Home Care University for certification as a home care/hospice executive?

Yes No

5. Mother's Maiden Name _____

6. Birth date _____

7. Social Security Number _____

8. Education (Check highest educational level attained)

- A. Diploma nurse D. Master's degree
B. Associate degree E. Doctoral degree
C. Bachelor's degree

Please attach a copy of your degree/diploma

9. Discipline of highest degree held

Nursing Administration/Business Other, specify _____

10. Home care experience in provider organization.

Indicate your total years of experience in home care and/or hospice and the number of full-time consecutive months in executive and/or management positions.

Total home care and/or hospice experience _____ years

Executive Experience in Home Care or Hospice Organization

_____ Consecutive months full time in last 3 years

OR

Management Experience in Home Care or Hospice Organization

_____ Consecutive months full time in last 4 years

For individuals in leadership positions in home care/hospice related organizations, please complete item 10A.

10A. Home care/hospice experience in provider organization(s)

_____ Total years experience in home care/hospice provider organization(s)

Executive Senior Management Experience in Home Care/Hospice Provider Organization(s)

_____ Consecutive months full time within last 12 years

Leadership/Executive in Home Care/Hospice Related Organization(s)

If Master's degree, consecutive months full time within last 4 years _____

If Bachelor's degree, consecutive months full time within last 5 years _____

If Associates degree or professional health related licensure, consecutive months full time within last 6 years _____

**Note: Full time is defined as 1800 work hours and is considered equal to 1 year.*

Please attach exact dates and places of employment and job responsibilities.

Current position/Title

Identify the category that best describes your current position.

- | | |
|--|---|
| <input type="checkbox"/> Chief Executive Officer | <input type="checkbox"/> Director Clinical Services |
| <input type="checkbox"/> Chief Operating Officer | <input type="checkbox"/> Director Quality Improvement |
| <input type="checkbox"/> Chief Financial Officer | <input type="checkbox"/> Association Executive |
| <input type="checkbox"/> Vice President | <input type="checkbox"/> Surveyor |
| <input type="checkbox"/> Regional Director | <input type="checkbox"/> Consultant |
| <input type="checkbox"/> Branch Manager | <input type="checkbox"/> Other _____ |

11. Your present employment setting

Name of Organization

Address Street

City State Zip

Country

()

Phone NAHC ID Number

12. Your organization's structure

A. OWNERSHIP

- Voluntary Combination Private
 Publicly held company Government

B. CONTROL

- Sole corporation Chain affiliate
 Hospital-based Nursing facility-based
 Rehab-based HMO based
 Wholly owned or subsidiary corporation (other than chain)
 Other

C. PROFIT STATUS

- Proprietary Not-for-profit Public/
Government

D. TYPE OF PROGRAMS

- Home Health Care Hospice
 Home Care Aide Organization Home Infusion Therapy
 Other, Specify

E. AGENCY CERTIFICATION/LICENSURE/ACCREDITATION

- Medicare Certified State Licensed
 Medicaid Certified CHAP
 Other, specify JCAHO

13. If not currently employed, date of last employment _____

14. Do you require accommodations to take the exam because of religious reasons?

Yes No

If yes, provide a written request and documentation as noted on pages 5-6 of this handbook.

15. Do you require accommodations to take the exam because of a functional limitation?

Yes No

If yes, provide a written request and documentation as noted on page 5 of this handbook.

16. Have you ever been known by any given or surname other than those shown on this application?

Yes No

If yes, _____

Questions 17-20

If yes, for any or all of the following, attach a written explanation stating the facts in full including dates, locations, nature of original and subsequent changes, and status or disposition of the matter.

17. Have you ever been placed on probation by a professional credentialing body?

Yes No

18. Have you even been dismissed by an employer because of dishonesty in connection with your employment or occupation?

Yes No

19. Have you ever received or been offered a grant of immunity, testified, or been called as a witness in a grand jury proceeding?

Yes No

20. Have you ever been suspended, disqualified, or disciplined, or have any charges ever been made or filed or proceedings instituted against you as a member of any business, trade, or profession?

Yes No

21. References

Please provide letters of reference from two persons who can attest to your character and performance in home care/hospice executive and/or management positions. Give the names, telephone numbers, occupations, nature and length of acquaintance of these persons. None may be related to you by blood, adoption, or marriage, and all must have known you for at least three years.

Name/Phone

Occupation

Nature/Length of Acquaintance

Name/Phone

Occupation

Nature/Length of Acquaintance

16

NAHC and HCU have my permission to use my name to promote the CHCE program.

Please print your name as you want it to appear on your certificate.

Certification Compliance Requirements

Violation of any of the following requirements may result in actions taken up to and including denial or revocation of the CHCE designation.

- Knowingly and intentionally falsifying the application or other documents.
- Violation of the code of ethics governing the profession on which one's eligibility for certification as a CHCE was based.
- Cheating on the certification exam.
- Failure to maintain eligibility requirements once certified.
- Failure to pay required fees.

Statement of Understanding

I hereby apply for certification as a Certified Home/Hospice Care Executive (CHCE), a voluntary professional credential sponsored by Home Care University, an affiliate of the National Association for Home Care & Hospice. I understand that initial certification depends on my satisfying all the criteria for knowledge and experience established by Home Care University and an ongoing certification is given by my satisfying the criteria as set by Home Care University. This includes the submission of all required documents and references. I also understand that any false inaccurate, or misleading statements included here will constitute grounds for the suspension or revocation of the CHCE designation awarded on the basis of the information contained herein. Furthermore, I agree that data resulting from my participation may be used in a confidential manner for research and statistical purposes. As an inducement to Home Care University and its committees to investigate and reach a determination regarding my character, reputation, and fitness for certification, I hereby release, discharge, and exonerate Home Care University and its committees, members, agents, and representatives, and any person or entity furnishing documents, records, or other information from any and all liability of every kind and nature arising out of the furnishing, inspection or use of such documents, records, or information.

_____ Signature for Statement of Understanding	_____ Date	Application Fee:	<input type="checkbox"/> \$30 NAHC Member	<input type="checkbox"/> \$50 Nonmember
_____ Signature if paying by credit card	_____ Date	Amount of Payment	\$ _____	
_____ Name as it appears on card (please print)		Method of Payment:	<input type="checkbox"/> Check	<input type="checkbox"/> MasterCard
			<input type="checkbox"/> Visa	<input type="checkbox"/> Amex