



HOME CARE ADMINISTRATOR APPLICATION FOR DEEMED STATUS

General Information

The purpose of the application is to request consideration to defer the Preparedness Program requirement and take the OHCAPA.

Complete each section.

I. Contact Information

Name _____
Last First Middle Initial

Home Address _____
Number & Street City State Zip

Telephone: Home (_____) _____ Fax (_____) _____
Work (_____) _____

II. Qualification

Indicate **one** of the criteria listed which best describes your qualification for deeming.

- ___ 1. Baccalaureate or higher degree from an accredited institution and at least one (1) year full time experience in a management/supervisory level position in home care within the immediate past two (2) years;
- ___ 2. Associate or higher degree in a health field from an accredited institution and at least one (1) year of full time employment in home care within the immediate past two (2) years;
- ___ 3. Certificate of Achievement in Health Care Administration by completion of a minimum of thirty (30) college credit hours from an accredited institution in the state and at least one (1) year of full time employment in home care within the immediate past two (2) years;
- ___ 4. Registered nurse in the State and at least one (1) year of full time experience in home care -- within the immediate past two (2) years; or
- ___ 5. Evidence of achieving a passing score on the National Association for Home Care Executive Certification Program examination.

III. Documentation

- a. Attach the document to verify you meet the criterion selected in Section I. Identify as Attachment 1.
- b. Attach the documentation from your employer(s) who can verify your employment experience in the field specified in the qualifying criteria. The documentation must include the names and mailing addresses of employers, the corporate names, and the lengths of employment terms from month to month. Identify as Attachment 2.

IV. Legal Resident Affidavit

Attach an *Affidavit Of Lawful Presence By Person Making Application For A License, Permit Or Certificate*, [ODH Form 301](#).

V. Fee Payment

Include a check or money order in the amount of \$80.00 made payable to the Oklahoma State Department of Health. This payment is non-refundable. **Submit fee, application, and attachments to:**

Oklahoma State Department of Health
Protective Health Services
Home Care Administrator Registry
P. O. Box 268816
Oklahoma City, OK 73126-8816

Signature of Applicant

Date