|  |
| --- |
| PERSONAL CARE AIDE (PCA)/HOME HEALTH AIDE (HHA)/ NURSE ASSISTANT (NA)APPLICATION |

**Please print or type all information. Applying for: (Circle below all that apply)**

**Home Health Aide (HHA) Personal Care Associate (PCA) Nurse Assistant (NA)**

**Albany Campus Schoharie Campus Day Evening Starting Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name:**

#### Last First MI

**Address:**

**Street City State Zip**

**Date of Birth: Age: Social Security # Sex: [ ] Female [ ] Male**

**Telephone: ( ) Cell: ( ) E-Mail:**

**PERSONAL STATUS: (Check one) [ ] Veteran [ ] U.S. Citizen or [ ] Alien Registration #**

**(copy of card required)**

**ETHNIC GROUPING: (Check one)**

**[ ]Native American [ ]Asian Pacific [ ]African/American Black [ ]Hispanic [ ]White [ ]Unknown**

**FAMILY STATUS: (Check one) [ ]Single [ ]Married [ ]Widowed [ ]Separated [ ]Divorced**

**Write in each box, the number of your own children by age group who are living with you.**

**[ ] 0-2 [ ] 3-5 [ ] 6-12 [ ] 13-16 [ ] 17+**

**EDUCATION/TRAINING: Circle the highest grade of school completed:**

**K 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17+**

**Graduated HighSchool date \_\_\_\_\_\_\_\_ GED date \_\_\_\_\_\_\_**

**How did you learn about this program?**

**[ ] Referral Source: Telephone:**

**Are you presently employed? [ ] No Are you receiving unemployment? [ ] Yes [ ] No**

**[ ] Yes Employer:**

**Job Title:**

**Do you receive any of the following Public Assistance? (Check all that apply):**

**[ ] Aid for Dependent Children (AFDC) [ ] Rental Assistance from the Department of Social Services**

**[ ] Supplemental Security Income (SSI) [ ] Women, Infants and Children (WIC)**

**[ ] Home Relief (HR) [ ] Medicaid [ ] Food Stamps**

**Do you have a disability or medical condition that may affect or limit your ability to work or attend school?**

**[ ] Yes [ ] No Please describe:**

**NOTE: Any previous criminal felony or misdemeanor conviction may prevent you from obtaining Certification.**

**PLEASE NOTE:** All information on this form is **CONFIDENTIAL**. Only the data will be used for statistical purposes.

**SIGNATURE: DATE:**

|  |
| --- |
| PERSONAL CARE AIDE (PCA)/HOME HEALTH AIDE (HHA)/ NURSE ASSISTANT (NA)APPLICATION |

Please write a statement explaining what you hope to gain by coming to BOCES at this time:

**Release of Information:**

I understand that the information on this application will be kept private and confidential. I allow Albany-Schoharie-Schenectady-Saratoga BOCES to submit this application to appropriate funding agencies to ascertain my eligibility for financial assistance to attend BOCES Adult Education Programs. I allow BOCES to use this release of information to seek and provide information to relevant agencies within and outside BOCES and to employers regarding my attendance and participation as based on funding assistance requirements. I understand that information regarding current status of physical, medical and psychological conditions will be sought and secured by a separate release outlining the need and use of information requested.

Signature: Date:

Staff Signature: Date:

|  |
| --- |
| CONSENT FORM |

[ ] I give consent (agree)

[ ] I do not give consent (do not agree)

to allow the release of information (data from this application, test data, notes, correspondence and other documents) in written or verbal to personnel from the referring agency and/or other relevant funding agencies and appropriate organizations.

Signature: Date:

Witness Signature/Title: Date:

# PERSONAL CARE AIDE (PCA) /

# HOME HEALTH AIDE (HHA)/NURSE ASSISTANT (NA)

# EMPLOYMENT HISTORY

**Please list all employment in the last five years (list most recent experience first).**

**1. Employer: From: To:**

**Address: Title:**

**Job Responsibilities:**

**2. Employer: From: To:**

**Address: Title:**

**Job Responsibilities:**

**Reason for Leaving:**

**3. Employer: From: To:**

**Address: Title:**

**Job Responsibilities:**

**Reason for Leaving:**

**SIGNATURE: DATE:**

If you need the assistance of an interpreter, need material translated into any language other than English, please call Ottavio Lo Piccolo at (518) 862-4703 and leave a voice message. Thank you.

Si usted necesita asistencia de un interprete, o necesita traducion en espanol, y otros idiomas, por favor llame a Ottavio Lo Piccolo a este tel. (518) 862-4703, y deje un mensaje de voz. Gracias

The Capital Region BOCES does not discriminate on the basis of race, color, national origin, sex, disability, or age in its programs, activities, employment, and admissions; and provides equal access to the Boy Scouts and other designated youth groups. The following person has been designated to handle inquiries regarding the non-discrimination policies: Carol Ratigan, compliance officer/coordinator, at [carol.ratigan@neric.org](mailto:carol.ratigan@neric.org), (518) 862-4910 or 900 Watervliet-Shaker Road, Albany, NY 12205. Inquiries concerning the application of the Capital Region BOCES non-discrimination policies may also be referred to the U.S. Department of Education, Office for Civil Rights (OCR), 32 Old Slip, 26th Floor, New York, NY 10005, telephone (646) 428-3800 (voice) or (800) 877-8339 (TTY).