

## Instructions Page for Verifiers

Thank you for assisting this applicant in completing the form required prior to approval for the CHHA certification exam. This form provides essential verification of critical skill competency in the Home Health Aide field, including client care history and dates of service

### Instructions for Completing This Form:

#### 1. Documentation Requirements

- Complete all fields clearly and legibly
- One (1) verifier per form
- Verification must be based on direct oversight of the applicant's Home Health Aide services.
- Forms that appear altered or falsified will not be accepted and may result in denial of eligibility.

#### 2. Who Should Complete Which Parts

- **Applicant:** Section A (Applicant Information)
- **Verifier:** Sections C-D
  - Must provide a work email address (facility domain) and a direct business phone number.  
*\*Personal email accounts or personal phone numbers will not be accepted*
  - If verification is provided by a client or client's authorized representative (e.g., a family member who employed and directly supervised the aide), valid contact information must still be supplied.
  - The verifier must have had direct supervisory responsibility for the applicant's services and be able to confirm the applicant's experience and dates of service.

#### 3. Experience Pathway Guidance

- **Experience requirement:** At least six (6) months of full-time Home Health Aide experience with two (2) or more clients, OR at least one (1) year of full-time experience with a single client within the past five (5) years.  
*\*Experience must be obtained within the United States or its territories*
- **Full-time definition:** 40 hours/week (as defined by NCCT)
- **Who verifies**
  - Facility/Agency employment: Supervisor (e.g., RN LPN/LVN, Nursing Supervisor, or Agency Director)
  - Private home care: The client or the client's authorized representative (e.g., family member) who directly employed and oversaw the aide's services.
- **What is verified**
  1. Dates of service or employment
  2. Length and type of client care provided (to meet the 6-month/2 client or 1-year/1 client requirement)
  3. Applicant's job title (if employed through a facility/agency)
  4. Attestation of qualifications and moral character

#### 4. Additional Notes

- Each verifier may only verify work they directly supervised (facility/agency, client, or client's authorized representative).
- Illegible/incomplete forms may delay processing.
- NCCT staff may contact verifier directly to confirm employment or training verification.
- Approval to test is subject to employment/training verification.



# Home Health Aide Certification Qualification by Experience Documentation

2025 - TE-0207CSQEHH

### Section A: To Be Completed by the Applicant

Please enter your full legal name as it appears on a government-issued ID (e.g., driver's license, passport).

Legal Name of Applicant \_\_\_\_\_ NCCT User ID # \_\_\_\_\_

### Section B: To Be Completed by Verifier

Important: Before completing this section, **please read the Instruction Page (Page 1)**. Verifier must be the applicant's direct supervisor or employer. Each verifier may only verify work they directly supervised, whether through an employing facility/ organization or as the client (or client's authorized representative) who received the aid's services.

### Section C: Critical Skill Performance Competency

Verifier must attest to the applicant's Home Health Aide experience, client care, and demonstrated competency in required skills.

Have you known this candidate for more than one year?	Yes	No	How long?
Is/Was this candidate employed by you or your agency?	Yes	No	
If you answered "Yes" to the above question, has the candidate had at least 6 months of full time Home Health Aide experience with at least two (2) or at least one (1) year of full time Home Health Aide experience with one (1) client?			
	Yes	No	
Client date of care: _____ (month/year) to _____ (month/year)			
Client date of care: _____ (month/year) to _____ (month/year)			
Client date of care: _____ (month/year) to _____ (month/year)			
Applicant's Job Title (if employed through an agency/facility):			
Can you attest to this candidate's proficiencies and qualifications in the Home Health Aide field?			
	Yes	No	
Do you believe this candidate to be of good moral character?			

The Certified Home Health Aide (CHHA) examination will assess whether the candidate possesses the essential knowledge and skills required to competently perform tasks as a Certified Home Health Aide.

### Section D: Verification Statement

By signing this form, I am verifying the applicant named above is competent (dependent, consistent, and successful) in performing their duties as a Home Health Aide.

I acknowledge that falsifying, omitting, or misrepresenting information on this form may result in denial of the applicant's eligibility, cancellation of examination results, or revocation of certification. I understand that my role as verifier requires that I either directly employed or directly supervised the applicant's work as a Home Health Aide, whether through a facility, organization, or as the client (or client's authorized representative). I also understand and agree that NCCT staff may contact me directly to verify the accuracy of this attestation.

Today's Date: MM/DD/YYYY \_\_\_\_\_

Supervisor/Verifier Signature \_\_\_\_\_

Supervisor/Verifier Printed Name \_\_\_\_\_

Supervisor/Verifier Job Title \_\_\_\_\_

Institution/Company Name \_\_\_\_\_

Institution/Company Address \_\_\_\_\_ City, State \_\_\_\_\_ Zip \_\_\_\_\_

Business Phone \_\_\_\_\_ Business Email \_\_\_\_\_