HOME HEALTH AIDE TRAINING PROGRAM (HHATP)
SCHEDULE OF CLASSES WITH LOCATION OF CLASS

HHATP NAME		LICENSE NUMBER	OP CERT NUMBER	
DATE OF CLASS:				
TIME OF CLASS:				
LOCATION:	ADDRESS	CITY	STATE	ZIP CODE
PHONE NUMBER:				
RN INSTRUCTOR NAME:				
DATE OF CLASS:				
TIME OF CLASS:				
LOCATION:	ADDRESS	CITY	STATE	ZIP CODE
PHONE NUMBER:				
RN INSTRUCTOR NAME:				
DATE OF CLASS:				
TIME OF CLASS:				
LOCATION:	ADDRESS	CITY	STATE	ZIP CODE
PHONE NUMBER:				
RN INSTRUCTOR NAME:				
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RN INSTRUCTOR NAME:				
DATE OF CLASS:				
TIME OF CLASS:				
LOCATION:	ADDRESS	CITY	STATE	ZIP CODE
PHONE NUMBER:				
RN INSTRUCTOR NAME:				

Directions for Completing HHATP Schedule of Classes Form

Home health aide-training programs must provide the Department with a schedule of anticipated classes biannually using this form. Approved programs are expected to submit an anticipated schedule of training every six months each October 1st and April 1st.

Please complete each box that corresponds with the requested information. This includes the training program name, and the license number or operating certificate for each agency sponsoring the training program.

The schedule must include the dates, times and location of each class, phone number and the name of the Nurse Instructor of the program. This information should be sent to the Department's home care program manager or designee in the region where the program is located. Subsequent changes to the submitted schedule should be reported as soon as they occur.