INSTRUCTIONS FOR COMPLETING THE IOWA DIRECT CARE WORKER REGISTRY APPLICATION

The Iowa Direct Care Worker Registry Application **only** needs to be completed in the following instances:

1. When a Direct Care Worker on the Registry has changed their name (legally or through marriage or divorce).
2. When a Direct Care Worker on the Registry has moved from the previous address listed on the Registry.
3. When a Direct Care Worker is transferring into Iowa from another State (see the Direct Care Worker Registry Directory for phone numbers).
4. When an applicant is not found on the Registry. This individual must enroll in and complete the 75-hour (minimum) course plus competency test (written & skills) within 4 months of hire date. The Registry does receive the address from the testing sites upon completion of the skills portion of the test.

Section 1:

This portion of the application is to be completed by the Direct Care Worker. It is imperative that all areas are completed and signed by the Direct Care Worker.

If the DCW is transferring from another State, please use the "State Certified (if other than IA)" field to indicate state(s) where the DCW is presently active. It is the facility's responsibility to contact the Registry from the previous State to verify status. Many States will provide a license number and/or an expiration date. Please include a copy of the DCW's present Registry certification card, if available, as well as a legible copy of their Social Security card.

For instate DCWs, please complete the "Employment History" section of the form. This will allow us to verify that we have all employer information in order to maintain a DCW's active status. This employment must be verifyable, as all employers will be contacted for confirmation. Please list employment in date order, starting with the most recent.

Section 2:

This portion of the application is to be completed by the provider. It is imperative that all areas are completed and signed by the DON, or other authorized individual.

Also, please provide the hire date at your entity in section 2 in the "Hire Date" field. If the individual no longer is employed at your entity, please provide the separation date in the "Separation Date (if applicable)" field.

All information can either be mailed or faxed to our office. The mailing address, and fax number are located at the top of the application form.

If you have questions, please contact Greg DeMoss at 515-281-4077.

Due to the threat of identity theft, and HIPAA Privacy regulations, we no longer automatically mail cards!!!

Cards can now be securely printed from our website: www.dia-hfd.state.ia.us, by users who are logged in with an account id and password. Generally, an account id is the last 4-digits of the CNA's Social Security Number, an underscore, and the first initial of their first and last name, capitalized (6789_FL). The temporary password is the first 5-digits of the CNA's Social Security Number, an underscore, and the first initial of their first and last name, capitalized (12345_FL). There are situations when this format may differ. If you are unable to access a record with the formats given, please contact Greg DeMoss @ 515-281-4077.

If you do not have access to the internet, or to a printer, and would like a card to be mailed, please indicate this on the application form, and one will be sent to you.

DIRECT CARE WORKER REGISTRY APPLICATION
Division of Health Facilities
Department of Inspections & Appeals
Lucas State Office Building – 3rd Floor
Des Moines, IA 50319-0083
Fax: 515-281-6259

All Direct Care Workers who wish to work in a Medicare or Medicaid certified Nursing Facility in the State of Iowa MUST complete and sign Section 1 of this form. Please ask your employer (if you have one) to complete Section 2. If there is no employer, you may leave section 2 blank.

SECTION 1: Fill in all blanks that apply to you.

SOCIAL SECURITY NUMBER | **DATE OF BIRTH** | **STATE CERTIFIED (IF OTHER THAN IA) / LICENSE NUMBER / EXPIRATION DATE**

LAST NAME | **FIRST NAME** | **MIDDLE NAME**

HOME MAILING ADDRESS | **CITY**

STATE | **ZIP CODE** | **MAIDEN NAME**

( ) **CONTACT TELEPHONE** | **E-MAIL ADDRESS** | **YES NO NOW ENROLLED IN MINIMUM 75-HR COURSE**

C.N.A. Employment History:

Most Recent Prior Employer	City	Hire Date (mm/dd/yyyy)	Separation Date (if applicable)
Next Prior Employer	City	Hire Date (mm/dd/yyyy)	Separation Date (if applicable)
Next Prior Employer	City	Hire Date (mm/dd/yyyy)	Separation Date (if applicable)
Next Prior Employer	City	Hire Date (mm/dd/yyyy)	Separation Date (if applicable)
Next Prior Employer	City	Hire Date (mm/dd/yyyy)	Separation Date (if applicable)
Next Prior Employer	City	Hire Date (mm/dd/yyyy)	Separation Date (if applicable)
Next Prior Employer	City	Hire Date (mm/dd/yyyy)	Separation Date (if applicable)

I SWEAR AND AFFIRM THAT THE ABOVE INFORMATION IS ACCURATE TO THE BEST OF MY KNOWLEDGE

Signed _____ **Date** _____
(Signature of Direct Care Worker)

SECTION 2: AFFIDAVIT OF LICENSEE-Hiring Entity: please complete all requested fields, and sign below.

New/Present Employer (if Different than Below)	City	Hire Date	Separation Date (if applicable)

Provider Name _____ located in _____, Iowa will maintain in the personnel file of this applicant, written documentation of the above, as well as any proof of certification information:

Signed _____ Title _____ Date _____
(Agent of the Licensee)

FAX OR MAIL THIS COMPLETED APPLICATION TO THE FAX NUMBER OR ADDRESS AT THE TOP OF THIS FORM

Revised 12/22/2005