COMMUNITY HEALTH WORKER TRAINING APPLICATION

Provider number	Provider expiration date	CPR date
Last name	First name	Date of birth
Mailing address		
City	State	ZIP code
Phone numbers ( ) — ( ) —	Email	

List four community resources in your neighborhood or community and the service they provide:

1. _____
2. _____
3. _____
4. _____

This training is only available to eligible Homecare Workers at **no cost.**

Please note that the commission does **not** provide stipends(payments) for certification training.

I understand that by signing this document I agree to the term and conditions of the training when qualified. I also acknowledge that I will not be receiving any stipend from the Homecare Commission for taking this training. I commit to taking the 96 hour of class time for certification and 20 additional courses hours upon the renewed of my certificate in 3 years. Sign here _____

(Participation in the training does not guarantee employment)

Food allergies

Lunch will be provided. Do you have any food allergies or diet requirements that we need to know about? Please list in the box below.

Rights and responsibilities

Check the boxes if you understand and agree with each statement below.

- ☐ There is no cost for OHCC's CHW certification training. Stipend (payment for attending) and travel allowance are **not** available.
- ☐ A telephone or in-person interview before enrollment may be required before the application is accepted. Enrollment by application is a competitive process.
- ☐ **Class attendance is required.** Certification is based on class participation.

Census data *(optional)*

Please mark the county you currently live in:

☐ Baker	☐ Harney	☐ Morrow
☐ Benton	☐ Hood River	☐ Multnomah
☐ Clackamas	☐ Jackson	☐ Polk
☐ Clatsop	☐ Jefferson	☐ Sherman
☐ Columbia	☐ Josephine	☐ Tillamook
☐ Coos	☐ Klamath	☐ Umatilla
☐ Crook	☐ Lake	☐ Union
☐ Curry	☐ Lane	☐ Wallowa
☐ Deschutes	☐ Lincoln	☐ Wasco
☐ Douglas	☐ Linn	☐ Washington
☐ Gilliam	☐ Malheur	☐ Wheeler
☐ Grant	☐ Marion	

1. Please explain below why you will make a great candidate for this training?

2. Describe two reasons for which you will like to become a Community Health Worker?

Language:

Speak	Read	Write

Race and ethnicity:

- ☐ African
- ☐ African American
- ☐ Alaska native
- ☐ American Indian
- ☐ Asian Indian
- ☐ Canadian Inuit, Metis or First Nation
- ☐ Caribbean
- ☐ Chinese
- ☐ Eastern European
- ☐ Filipino/a
- ☐ Guamanian or Chamorro
- ☐ Hispanic or Latino Central American
- ☐ Hispanic or Latino Mexican
- ☐ Hispanic or Latino South American
- ☐ Hmong
- ☐ Indigenous Mexican, Central or South American
- ☐ Japanese
- ☐ Other Black
- ☐ Middle Eastern
- ☐ Native Hawaiian
- ☐ Northern Africa
- ☐ Samoan
- ☐ Slavic
- ☐ South Asian
- ☐ Vietnamese
- ☐ Western European
- ☐ Other White
- ☐ Other Asian
- ☐ Other Hispanic or Latino
- ☐ Other Pacific Islander
- ☐ Other (write in) _____
- ☐ Unknown
- ☐ Decline to answer

Highest education level:

- ☐ GED/High school
- ☐ Some college -vocational
- ☐ Bachelor's degree
- ☐ Bachelor's degree +
- ☐ Master's degree
- ☐ Doctorate

Other health certificates or licenses *(list both expired and current)*:

Expired?	Current?	Certificate or license type
☐	☐	
☐	☐	
☐	☐	

Return your completed application by e-mail or mail to:

OHCC.CHW@state.or.us
Oregon Home Care Commission
Community Health Worker
550 Capitol Street NE, Basement level Salem, OR 97301

For additional information about Community Health Workers and Oregon's Traditional Health Worker program, visit:

http://www.oregon.gov/DHS/SENIORS-DISABILITIES/HCC/PSW-HCW/Pages/Traditional-Health-Worker.aspx

http://www.oregon.gov/DHS/SENIORS-DISABILITIES/HCC/PSW-HCW/Pages/Community-Health-Worker.aspx

http://www.oregon.gov/oha/oei/Pages/thw-resources.aspx

For more information or help, please e-mail or call:

OHCC.CHW@state.or.us 503-378-3121 or 877-880-8071, option 1

_____ _____

Signature *(Type name if returning by email)* Date

Office use only					
Interested date: _____	Application sent: ☐	Application received: ☐
Application approved: ☐	Training completed: ☐	Training incomplete: ☐

You can get this document in other languages, large print, braille or a format you prefer. Contact Oregon Home Care Commission at 877-624-6080.