Licensure Unit, PO Box 94986, Lincoln NE 68509-4986
Phone (402) 471-2115 Fax (402)471-1066
Licensure Verification: http://www.nebraska.gov/LISSearch/seach.cgi
Applications: http://www.dhhs.ne.gov/crl/profindex1.htm

Nebraska Department of Health and Human Services

Division of Public Health

State of Nebraska

Dave Heineman, Governor

NOTICE OF MEDICATION AIDE ELIGIBILITY REQUIREMENT CHANGE

TO: ALL PROVIDERS
FROM: MARLETTA STARK, RN, BSN
DATE: SEPTEMBER 23, 2009

During the last legislative session, LB 403 was passed. This bill and the resulting statutes (Neb. Rev. Stat. §§4-108 through 4-114) prohibit state agencies from providing public benefits to a person not lawfully present in the United States. Public benefits include any professional license. The Department has determined that Medication Aides and Medication Aides 40 Hour are subject to the provisions of Neb. Rev. Stat §§4-108 through 4-114, thereby, making confirmation of lawful presence a requirement for registration as a Medication Aide.

The requirement is effective **October 1, 2009**.

In order for Nursing Support to comply with the requirements, all Medication Aide Applications and Renewal Applications for registration have been revised to include the Attestation language required. Copies of each are enclosed. Please destroy any other copies and begin using these immediately. The applications and renewal application are each two pages and contain the previous application questions/sections, the Attestation of Lawful Presence section, and the Documentation of Competency. Both pages of the appropriate application must be completed correctly and submitted in order for the application and/or renewal to be processed.

For those who recently completed applications and renewal applications, a separate Attestation of Lawful Presence form has been included. Please make copies as needed. If an individual completed an application, but was not issued a registration or renewal before **October 1, 2009**, the individual will need to complete the Attestation form and submit it to the address on the form. **Please Note:** This is a temporary form and should not be used with the revised application forms. It is only to be used for those applications and renewal applications begun prior to **October 1, 2009**.

Medication Aide applications and or renewals received after **October 1, 2009** cannot be processed without completing the Attestation section of the revised application and/or renewal.

Please make sure your staff and employees are using the revised applications. Due to the specificity of the Attestation requirement, we will no longer accept application forms created by the Providers. The enclosed forms are the only application forms we will accept after September 30, 2009.

Please Note: The Department has determined that placement on the Nurse Aide Registry is **NOT** subject to the provisions of Neb. Rev. Stat. §§4-108 through 4-114.

Please check the medication aide web site periodically to make sure you are using the most current forms. We are still receiving applications on forms that were used in 2001. We will return those applications and require that the current forms be submitted. The web site is maintained for your convenience as a way of quickly accessing forms and information. The web site address is **www.dhhs.ne.gov/crl/nursing/ma/ma.htm**

If you cannot find the answer to your questions on the web site, the following staff is available by phone to assist you:

Teresa Luse	402-471-4910	Medication Aide Applications and Renewals
Kathy Eberly	402-471-4364	Medication Aide Registry and 40 Hour Exams
Marletta Stark	402-471-4969	Program Manager, Medication Aide Program

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Department of Health & Human Services Licensure Unit
Office of Nursing &Nursing Support, PO Box 94986
Lincoln NE 68509-4986
Telephone #’s (402)471-4364 or (402)471-4910 or fax (402)471-1066

APPLICATION FOR REGISTRATION: ☐ **MEDICATION AIDE**
(Check which category you are applying for) ☐ **MEDICATION AIDE- 40 HOUR**

Personal Information:

(Please note that in order to change a name that is already on our system, we must have documentation of proof of name change.)

Name____
(Last) (First) (Middle) (Maiden) (Previously used names)

Address:____
(Street) (City) (State) (Zip)

Telephone #: (H)______________________ (W)______________________

Date of Birth ____________ Place of Birth ______________ Social Security # ____________

You Must Answer the Following Question:

If you fail to answer this question, your application will not be processed and will be returned to you as incomplete.

Have you been convicted of a misdemeanor or felony other than a minor traffic violation?	☐ Yes	☐ No

If you answered YES to the above, you **MUST** complete this section:

List the type of conviction(s) along with the date of occurrence and county/state in which the conviction occurred. Please include a brief description of the conviction including what the conviction was for, what happened and who was involved. Attach additional sheet of paper if necessary. Please note that a conviction is not necessarily a disqualification for placement on the registry. You **Must** submit **certified** copies of the following for each conviction: All Charges; All Pleas; All Sentencing & Probation Orders; and All Documentation pertaining to completion of probation requirements. If you do not submit the documents, your application will not be processed and will be returned to you as incomplete.

Date of Conviction County/State Type of Conviction

____

____

____

A complete application includes:

1. **Application for Registration containing the required information.**
2. **Fee of $18.00 – non-refundable.**
3. **Attestation of Lawful Presence and Documentation of Competency Assessment.**
4. **Certified copies of court records identified in Title 172 NAC 96 Section 96-003.**
5. **Documentation of 40 hour course completion or additional 20 hour course (only required for Medication Aide – 40 hour)**
6. **Application for Testing Registration (only required for Medication Aide – 40 hour)**

See other side for Attestation of Lawful Presence in the United States and Documentation of Competency Assessment Form
If you fail to complete the Attestation of Lawful Presence or if the Competency Assessment is not completed correctly, your medication aide application will not be processed and will be returned to you as incomplete.

Applicant's Attestation of Lawful Presence in the United States:

For the purpose of complying with §§4-108 through 4-114, I attest as follows:

Please check the appropriate choice below:

_____ I am a citizen of the United States

_____I am a qualified alien under the Federal Immigration and Nationality Act, my Immigration status and alien number are as follows ______________________________________, and I agree to provide a copy of my United States Citizenship and Immigration Services documentation upon request.

I hereby attest that my response and the information provided on this form and any related applications for public benefits are true, complete and accurate and I understand that this information may be used to verify my lawful presence in the United States.

Application Attestation: I further attest that:

1. I have read the application or have had the application read to me;
2. All statements on the application are true and complete; and
3. I am of good moral character

Print Name: ______________________________________

Signature: ______________________________________ Date: ______________________

Documentation of Competency Assessment
This is to certify that

______________________________________ ______________________________

Name of Medication Aide Social Security #

has successfully demonstrated each of the competencies as identified in Title 172 NAC 96, Section 005
on ___________________________
(Date)

PLEASE READ THE FOLLOWING SECTIONS CAREFULLY BEFORE COMPLETING

To be completed by Licensed Health Care Professional conducting the competency assessment and/or directing a registered Medication Aide to conduct the competency assessment

____ _________ _____________
Signature of Licensed Health Care Professional Profession License #

____
Place of employment of Licensed Health Care Professional

____
Work telephone number of Licensed Health Care Professional

IF APPLICABLE to be completed by registered Medication Aide conducting the competency assessment

____ ______________
Signature of registered Medication Aide conducting the competency assessment Registry #:

____
Place of employment of Medication Aide conducting the competency assessment

____
Work telephone number of Medication Aide conducting the competency assessment

Department of Health & Human Services
Division of Public Health, Licensure Unit
PO Box 94986, Lincoln NE 68509-4986
Telephone # 402-471-4910 or 402-471-4364 – Fax # 402-471-1066

State of Nebraska
DHHS Division of Public Health, Office of Nursing and Nursing Support
P.O. Box 94986 - Lincoln, NE 68509-4986
Telephone: (402) 471-4910

RENEWAL NOTICE

Your registration as a The renewal fee of **$18.00,** this renewal notice and documentation of competency are required for renewal.

Registration # **:**

TWO YEAR RENEWAL

YOU MUST CHECK A BOX BELOW:

☐ ACTIVE $18.00

☐ INACTIVE No fee

Name & Address Changes: If your name or address is incorrect, cross out incorrect information and print correction. For name changes, you must submit a photocopy of marriage certificate, court order, etc. If not submitted, the registration will be issued in the name as printed above.

Internet: All Nebraska Credentialing Information is public information, and is now on the Internet under **http://www.dhhs.ne.gov/lis/lisindex.htm**

Make Checks Payable to: LICENSURE UNIT **- SUBMIT FEE AND THIS RENEWAL NOTICE IN THE ENCLOSED ENVELOPE.**

Expired Registration: You may not function as a after your registration has expired on . To ensure renewal of your registration before the expiration date submit required fee, renewal notice and documentation of competency assessment at least 30 days prior to expiration

You Must Answer the Following Question:

If you fail to answer this question, your renewal will not be processed and will be returned to you as incomplete. This question relates to the time since you signed the last application or renewal application.

Have you been convicted of a misdemeanor or felony other than a minor traffic violation?	☐ Yes	☐ No

If you answered YES to the above, you **MUST** complete this section:

List the type of conviction(s) along with the date of occurrence and county/state in which the conviction occurred. Please include a brief description of the conviction including what the conviction was for, what happened and who was involved. Attach additional sheet of paper if necessary. Please note that a conviction is not necessarily a disqualification for placement on the registry. You **Must** submit **certified** copies of the following for each conviction: All Charges; All Pleas; All Sentencing & Probation Orders; and All Documentation pertaining to completion of probation requirements. If you do not submit the documents, your renewal will not be processed and will be returned to you as incomplete.

Date of Conviction County/State Type of Conviction

____

____

Please verify the following information so we may update and/or correct our current Credentialing Information:

Social Security Number: ______________________________
Date of Birth: ______________________________
Place of Birth: ______________________________
Telephone Number: ______________________________

See other side for Attestation of Lawful Presence in the United States and Documentation of Competency Assessment Form.
If you fail to complete the Attestation of Lawful Presence or if the Competency Assessment is not completed correctly, your renewal will not get processed and will be returned to you as incomplete.

Applicant's Attestation of Lawful Presence in the United States:

For the purpose of complying with §§4-108 through 4-114, I attest as follows:

Please check the appropriate choice below:

_____ I am a citizen of the United States

_____ I am a qualified alien under the Federal Immigration and Nationality Act, my Immigration status and alien number are as follows ______________________________________, and I agree to provide a copy of my United States Citizenship and Immigration Services documentation upon request.

I hereby attest that my response and the information provided on this form and any related applications for public benefits are true, complete and accurate and I understand that this information may be used to verify my lawful presence in the United States.

Application Attestation: I further attest that:

1. I have read the application or have had the application read to me;
2. All statements on the application are true and complete; and
3. I am of good moral character

Print Name: ______________________________________

Signature: ______________________________________ Date: _____________________

Documentation of Competency Assessment
This is to certify that

____ ____________________________
Name of Medication Aide Social Security #

has successfully demonstrated each of the competencies as identified in Title 172 NAC 96, Section 005
on _________________________
(Date)

PLEASE READ THE FOLLOWING SECTIONS CAREFULLY BEFORE COMPLETING

To be completed by Licensed Health Care Professional conducting the competency assessment and/or directing a registered Medication Aide to conduct the competency assessment

_______________________________________ _________ ____________
Signature of Licensed Health Care Professional Profession License #

____
Place of employment of Licensed Health Care Professional

____
Work telephone number of Licensed Health Care Professional

IF APPLICABLE to be completed by registered Medication Aide conducting the competency assessment

____ ___________
Signature of registered Medication Aide conducting the competency assessment Registry #:

____
Place of employment of Medication Aide conducting the competency assessment

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Work telephone number of Medication Aide conducting the competency assessment

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