Medication Aide Program Checklist

- ☐ Form 5538-MA: Understanding of Required Background Check
- ☐ Fingerprints must be submitted through the Department of Public Safety's vendor. To obtain the required service code, email medication_aide_program@hhs.texas.gov
- ☐ Form 5537-MA: Request for Criminal History Evaluation Letter for Medication Aide Permit. (***This is to be completed if there is anything that comes back on your background check***)
- ☐ Form 5534: General Statement Enrollment
- ☐ Form 5523: Medication Aide Experience Documentation
- ☐ Current Shot Records as required by the Department of State Health Services at the time of enrollment MMR (2); Tetanus (<10 years); Varicella (2); and Hepatitis B Series (2 of 3 doses – must be completed)
- ☐ Certified copy of high school diploma/transcript or high school equivalency; or certified transcript from college or university with credit classes.

All of these requirements must be complete to be approved to register for the Vernon College Medication Aide Program. If any of these items are not returned and/or completed, you will not be approved to take the course.

Packet DUE by 5:00 PM January 8, 2025

Registration & Payment DUE by 5:00 PM on January 14, 2025

TEXAS
Health and Human Services

Form 5538-MA
April 2021-E

Understanding of Required Criminal Background Check

I _____ , prospective Medication Aide student, understand that I am required to complete
and pay for a Texas Department of Public Safety (DPS) fingerprint criminal background check to determine my eligibility to take the Medication Aide examination.

I also understand that I may request a Criminal Background Check Evaluation Letter from Texas Health and Human Services Commission (HHSC) prior to enrolling in a training program to determine if I am eligible for a permit. I understand that the Evaluation Letter will not address all exam eligibility requirements and is not a guaranty of eligibility.

In addition, I understand I must request the criminal background check through DPS at https://www.dps.texas.gov/administration/ crime_records/pages/FASTSubLoc.htm.

_____ _____
Signature of Prospective Medication Aide Student Date

Training Program Name: Vernon College

TEXAS Health and Human Services

Form 5537-MA
February 2021-E

Request for Criminal History Evaluation Letter for Medication Aide Permit

Complete this form if you are requesting Texas Health and Human Services Commission (HHSC) to issue a criminal history evaluation letter regarding your eligibility for permitted medication aide.

I, _____ will enroll, or am enrolled, in an educational program in preparation for, or plan to take, the examination for an initial:

☐ Certified Medication Aide (CMA) Permit

I understand that I may be ineligible for a permit because of my conviction or deferred adjudication for the following felony or misdemeanor offenses:

Name (Last, First, Middle)	Maiden Name	Other Surnames	Sex

Street Address	City	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	Social Security No.	Area Code and Phone No.

Email Address

I request a criminal history evaluation letter determining whether I am eligible for a permit based on the fingerprint-based criminal history check results I must provide to HHSC. I understand that the evaluation letter may not address issues I do not disclose on this request, issues that were not reasonably available to HHSC at the time of my request, and eligibility requirements unrelated to criminal history.

I understand I must request the fingerprint-based criminal history check at https://uenroll.identogo.com to obtain the service code for the check.

Contact the Criminal Background Check program at: LTCR_Criminal_Background_Checks@hhs.texas.gov.

_____ _____
Signature Date

Allow two weeks for processing.

Submit by Email

Texas Health and Human Services Commission
Criminal Background Check Program
P.O. Box 149030, Mail Code W-422
Austin, Texas 78714-9030

TEXAS Health and Human Services

Form 5534
May 2021-E

Medication Aide Program

General Statement Enrollment

All required forms must be completed and returned to the above address **no later than 20 days** after the date of the first scheduled class in which you are enrolled. Include a $25.00 nonrefundable combined application and examination fee made payable to Texas Health and Human Services Commission (HHSC).

If any portion of the application is incomplete, if fee is not included or if documentation is missing, the application cannot be processed.

1. Name (last, first, middle initial)	2. Social Security No.		
3. Email Address	4. Home Phone No. (Including Area Code)		
5. Mailing Address (Street or P.O. Box)	City	State	ZIP Code
6. Date of Birth (mm/dd/yyyy)	7. Name of Approved Training School		
8. City of Approved Training School	City	State	ZIP Code

9. Date of First Scheduled Class of Instruction (mm/dd/yyyy): _____

10. Are you able to read, write, speak and understand English? ○ Yes ○ No

11. Are you at least 18 years old? ○ Yes ○ No

12. Submit an Experience Documentation Report form documenting current employment of the first official day of the training program in a facility licensed under Health and Safety Code Chapter 242 in the capacity of a certified nurse aide or in an assisted living facility licensed under Health and Safety Code 247, state supported living center, or ICF-IDD facility as a non-licensed direct care staff person. (home health are not licensed facilities under the medication aide regulations).

13. Submit an Experience Documentation Form documenting 90 days of employment in an assisted living facility licensed under Health and Safety Code 247, state supported living center or ICF-IDD facility as non-licensed direct care staff. This employment must have been completed. Within the 12-month period preceding the first official class date. **An applicant employed as a certified nurse aide is exempt from the 90-day requirement.**

14. Submit a certified copy or a photocopy which has not been notarized as a true copy of an unaltered original of a high school graduation diploma or transcript or a general equivalency diploma.

15. Before HHSC can approve your application for examination, all applicants must request a fingerprint based criminal history check from the Texas Department of Public Safety (DPS). For instructions on how an individual can obtain a fingerprint based criminal history check, visit https://www.dps.texas.gov/section/crime-records-service or call Fingerprint Applicant Services of Texas (FAST) at 888-467-2080. To obtain the service code, contact the Medication Aide Program at Medication_Aide_Program@hhs.texas.gov. Failure to complete a fingerprint criminal history check will delay the process and may result in denial.

16. Are you, to the best of your knowledge, free of contagious diseases and in suitable physical and emotional health to safely administer medications? ○ Yes ○ No

17. Are you listed on the Employee Misconduct Registry (EMR) as unemployable? ◯ Yes ◯ No

18. Have you been convicted of a criminal offence listed in Texas Health and Safety Code §250.006? ◯ Yes ◯ No

If yes, list date _____ and conviction _____

19. Have you received a copy of the Medication Aide Training Program Rules? ◯ Yes ◯ No

If no, obtain a copy from the training program or call this office.

With few exceptions, you have the right to request and be informed about the information that THHSC obtains about you. You are entitled to receive and review the information upon request. You also have the right to ask THHSC to correct information that is determined to be incorrect. (Government Code Sections 552.021, 552.023, 559.004) To find out about your information and your right to request correction, please contact this office.

Please Read Carefully

In making application to the HHSC Medication Aide Program for the issuance of a permit as a Medication Aide, I have read and agree to abide by the Medication Aide Training Program rules. I also agree to complete all application requirements and take all examinations necessary for the processing of my application. Upon issuance of a permit, I agree to be bound by the Allowable and Prohibited Practices of a Permit Holder (TAC 557.105). I further understand that the materials submitted for consideration become the property of the department and are nonreturnable. I am aware of the schedule of fees (TAC 557.109(c)) and understand that additional fees must be paid to keep the permit current I further agree that if issued a permit, upon the denial, suspension or revocation of that permit, I shall return the permit to the department.

The information that I have provided in this application is truthful. I understand that to falsify any information submitted to the HHSC may result in voiding of this application, failure to be granted a permit or the revocation of my permit.

_____ _____

Signature — Applicant Date

The State of _____

County of _____

_____

BEFORE ME, the undersigned authority, on this day personally appeared , known to me to be the person whose name is subscribed to the foregoing instrument, and having been by me first duly sworn on oath, acknowledged that he/she had executed the same for the purposes and consideration therein expressed and the foregoing statements are true and correct.

Given under my hand seal of office, this ____day of _____, 20 ____

Notary Public in and for _____ County, Texas or_____

_____

Signature — Notary

Place Notary Seal or Stamp Here

_____

Printed Name — Notary

_____

Commission Expiration Date

Medication
Aide Program
P. O. Box
149030
Mail Code E-416 Austin, Texas 78714-9030

With a few exceptions, you have the right to request and be informed about the information that the HHSC obtains about you. You are entitled to receive and review the information upon request. You also have the right to ask HHSC to correct information that is determined to be incorrect (Government Code, Sections 552.021, 552.023, 559.004). To find out about your information and your right to request correction, please contact the Long Term Care Regulatory Medication Aide Program at 512-438-2025.

TEXAS
Health and Human Services

Form 5523
November 2020-E

Medication Aide Program

Medication Aide Experience Documentation Report

1. Applicant Name (last, first, middle initial)			2. Social Security No.
3. Applicant Job Title			
4. Place of Employment			
5. Address (Street or P.O. Box)	6. City	7. State	8. ZIP Code
9. Phone Number (Including Area Code)			
10. Type of Facility	11. Applicant Job Title	12. Nurse Aide Certification No. (if Applicable)	13. Type of Work Performed
14. Facility Administrator/Program Director/DON			

I, _____ (Facility Administrator/Program Director/DON), certify that I have employed _____ (Applicant) from _____ to _____

and that I know of my own knowledge that said person was employed continuously in this facility which is licensed under Health & Safety Code Chapter 242, as a certified nurse aide, or in this facility which is a licensed Personal Care Facility under Health & Safety Chapter 247, or in this State Supported Living Center, ICF-IDD as a nonlicensed direct care staff person under the direct supervision of a licensed nurse on duty or on call.

On this _____ day of _____, 20 _____, in _____

I certify under penalty of perjury that the information submitted is true and correct.

_____ Signature — Facility Administrator/Program Director/DON

_____ Facility Vendor No.

The State of _____

County of _____

Before me, a notary public in _____ County, Texas on this day personally appeared

_____ (Facility Administrator/Program Director/DON)

whose name is subscribed to the foregoing instrument and acknowledged to me that he executed the same for the purposes and consideration therein expressed.

Given under my hand seal of office, this _____ day of _____, 20 _____

_____ Signature — Notary

Place Notary Seal or Stamp Here

_____ Printed Name — Notary

_____ Commission Expiration Date