

**KANSAS DEPARTMENT FOR AGING & DISABILITY SERVICES**  
**Board of Adult Care Home Administrators**  
**APPLICATION FOR**  
**RECIPROCAL ADULT CARE HOME ADMINISTRATOR LICENSE**

K.A.R. 28-38-22 outlines requirements for obtaining Kansas licensure through reciprocity. Please review the regulations the Reciprocity Application Instructions for details.

The three options for reciprocal license are briefly described below and impact how this application is completed.

- Option A** Documentation that the criteria of the licensing State in which the applicant is currently licensed are substantially equivalent to the current Kansas examination, education, training and experience criteria, OR
- Option B** Documentation that the applicant has been continuously licensed during the preceding five years during which time the applicant annually attained at least 2,080 hours of experience as an administrator of record of a licensed adult care home or a licensed long-term care unit of a hospital, OR
- Option C** Minimum baccalaureate degree and completion of an approved 480 hour AIT practicum.

**LICENSE FEE**  
Reciprocal: \$ 220.00 \*\*

\*\*Fees pro-rated for partial year licenses. Enclose non-refundable fee: Payable to KDADS. Personal checks are accepted. Visa or Master Card may be used for payment of fees. Credit Card Authorization Form must be completed and signed to utilize this option.

**APPLICANT INFORMATION**  
(All applicants must complete this section)

Name: \_\_\_\_\_  
Last First MII Other

Address: \_\_\_\_\_  
Street / Route / Box / Apt # City State Zip

Email: \_\_\_\_\_

Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SSN \_\_\_\_\_

Phone: work \_\_\_\_\_ home \_\_\_\_\_ cell \_\_\_\_\_

**(attach a copy of your Social Security Card or document bearing your name and Social Security number)**

**LICENSE IN ANOTHER STATE**  
(All applicants must complete this section)

List all states in which you have ever held an adult care home administrator license:

State: \_\_\_\_\_ State: \_\_\_\_\_ State: \_\_\_\_\_  
State: \_\_\_\_\_ State: \_\_\_\_\_ State: \_\_\_\_\_

For each state, complete Part I of the verification of license, request that the state Board complete Part II and return verification to this Board.

**REFERENCES**  
(All applicants must submit two letters of reference)

K.A.R. 28-38-20 requires that each licensure applicant submit, on Board approved forms, one letter of reference from a licensed adult care home administrator, in state or out of state, and one letter of reference from another person not related to the candidate as defined under "nepotism" in K.A.R. 28-38-29(h).

K.A.R. 28-38-29(h) defines "nepotism" to mean favoritism shown to a relative on the basis or relationship as a family member or as a member of a household. For the purposes of this definition "family member" means any of the following: (1) A spouse, parent, child or sibling; (2) a sibling as denoted by the prefix "half"; (3) a parent, child, or sibling as denoted by the prefix "step"; (4) a foster child; (5) an uncle, aunt, nephew, or niece; (6) any parent or child of a preceding or subsequent generation as denoted by the prefix "grand" or "great"; or (7) a parent, child, or sibling related by marriage as denoted by the suffix "in-law". For the purposes of this definition, "member of a household" means a person having legal residence in, or living in, and individual's place of residence.

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**EDUCATION**

(Applies only to applicants applying using Option C)

College/University	Degree	Date Conferred
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

If applicable, transcripts must be sent by the college or university directly to Health Occupations Credentialing. If you are filing for testing under KSA-65-3504(b), request, complete, and submit Application for Exemption of Formal Education.

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**PRACTICUM**

(Applies only to applicants applying using Option C)

Each applicant utilizing Option C must satisfactorily complete a board approved long-term care administration practicum of not less than 480 hours.

Practicum Sponsor \_\_\_\_\_ Coordinator \_\_\_\_\_  
College/University/Sponsor

Preceptor \_\_\_\_\_ Preceptor# \_\_\_\_\_

Practicum Beginning Date \_\_\_\_\_ Ending Date \_\_\_\_\_

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**WORK EXPERIENCE**

(Applies only to applicants applying using Option B)

K.A.R. 28-38-22 allows Kansas licensure through reciprocity for applicants who have been continuously licensed during the preceding five years and during that time, the applicant annually attained at least 2,080 hours of experience as an administrator of record of a licensed adult care home or a licensed long-term care unit of a hospital.

If utilizing Option B for reciprocal licensure please list the relevant employment information for the preceding five years:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

The applicant shall also provide documentation of the work experience listed above as required by K.A.R. 28-38-22.

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**EQUIVALENT LICENSE REQUIREMENTS**

(Applies only to applicants applying using Option A)

K.A.R. 28-38-22 allows Kansas licensure through reciprocity for applicants who provide documentation that the criteria of the licensing State are substantially equivalent to the current Kansas examination, education and training experience as specified in K.A.R 28-38-18 and K.A.R. 28-38-19.

Please carefully review the regulations listed above to determine if Option A is the appropriate choice for your reciprocity application. A brief summary of current Kansas license requirements follows:

- Passing score on the NAB examination and State law examination.
- Minimum baccalaureate or higher degree from an accredited college or university.
- Completion of a 480 hour long-term care administration practicum conducted by a board approved provider

If utilizing Option A please list below the State in which you are/were licensed which has substantially equivalent requirements to current Kansas licensure requirements:

\_\_\_\_\_ Licensing State

Documentation that the criteria of the licensing State are substantially equivalent to the current Kansas exam, education and training experience must also be provided.

**DISCIPLINARY ACTION**

(All applicants must complete this section)

Has disciplinary action ever been taken against an adult care home administrator license, a professional or occupational health care license, a mental health care license or a social worker license held by you, whether issued by this state or another state or jurisdiction?

**Y / N**

If YES, please provide specific details and copies of all relevant documents.

**Please read carefully before answering**

Have you ever been convicted of a crime by any court (including Kansas), or any federal court of the United States? This includes any felony, misdemeanor, or DUI convictions.

**Y / N**

If YES, please indicate:

Date of conviction: \_\_\_\_\_

City, County and state of conviction: \_\_\_\_\_

Crime of which convicted: \_\_\_\_\_

**NOTE:** Pursuant to state regulations, the Board requires that you provide all reports and court documents related to the conviction. Materials should be submitted to Health Occupations Credentialing. Please note, any and all costs for obtaining such reports/documents are your responsibility. You are also invited to submit a letter and any other additional supporting information or documents to the Board explaining the circumstances surrounding the case, complete resolution of the issue (including final probation, community corrections or parole documents), and how/why this situation is not expected to occur again. The candidate shall have the burden of proving that the candidate has been rehabilitated and warrants the public trust.

I do hereby attest that the information supplied in this application and any attachment is accurate and complete to the best of my knowledge. I do hereby give permission to the Board to verify any information provided in this application and attachments. I understand that the application fee is non-refundable should I not meet licensure qualifications.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**PLEASE NOTE: YOUR SIGNATURE MUST BE NOTARIZED**

<p>SUBSCRIBED AND SWORN TO before me, the undersigned authority,  on this _____ day of _____, 20_____  _____  (Notary Public)  My appointment expires:_____</p>
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Submit application, fee and supporting documents to:  
**Health Occupations Credentialing**  
**Kansas Department For Aging and Disability Services**  
**612 S Kansas Ave**  
**Topeka, Kansas 66603**