KANSAS DEPARTMENT FOR AGING AND DISABILITY SERVICES
Board of Adult Care Home Administrators
APPLICATION FOR
TEMPORARY Adult Care Home Administrator License

TYPE OF LICENSE

TEMPORARY: $100.00
**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

Name: ____
Last First Mi 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***)

FACILITY IN WHICH YOU ARE SEEKING EMPLOYMENT:

Facility Name: ______________________________________Facility Phone: ( ) ________________________

Address:____
Street / Route / Box / Apt # City State Zip

EDUCATION - List

	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.

FUTURE PLANS

I will seek full licensure. **Y / N**
I will plan to seek licensure based on licensure in another state. **Y / N**
I have held a license as a Kansas Adult Care Home Administrator. **Y / N**
If YES, License Number: ______________ Issue Date: ________________ Expiration Date: ________________
I have at least once failed the examination specified in KAR 28-38-18. **Y / N** Exam Date________________

LICENSE IN ANOTHER STATE

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

DOCUMENTATION OF NEED FOR TEMPORARY LICENSE

K.A.R. 28-38-21 requires that applicants provide written documentation from the board of directors, corporation or ownership of the facility that no licensed, qualified applicant is available to serve as administrator in the facility and written endorsement that the applicant is the most qualified applicant for the facility where the person is to be employed.

DISCIPLINARY ACTION

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***

Subscribed and sworn to me the undersigned
on this __________day of ____________________, 201__________

____
(Notary Public)

My appointment expires:_______________________________________

Submit application, fee and supporting documents to:

Health Occupations Credentialing
Kansas Department for Aging and Disability Services
612 S Kansas Ave
Topeka, Kansas 66603