KANSAS DEPARTMENT FOR AGING AND DISABILITY SERVICES
HEALTH OCCUPATIONS CREDENTIALING
APPLICATION FOR
ADULT CARE HOME OPERATOR REGISTRATION

K.S.A. 39-923 outlines requirements for obtaining Kansas Registration. Please review the statutes.

The three options for obtaining registration are briefly described below and impact how this application form is completed. Please circle the option under which you are applying for registration.

Option A  Possess a Baccalaureate degree in any area of study
Option B  Possess an Associate's degree in a relevant field as determined by the Secretary
Option C  Possess a high school diploma or equivalent, with one year relevant experience as determined by the Secretary

REGISTRATION FEES
**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.

Operator Registration: $65

APPLICANT INFORMATION
(All applicants must complete this section)

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)

COLLEGE EDUCATION
(Applies to applicants using Option A or B)

Transcripts must be sent by the college or university directly to Health Occupations Credentialing.

<table>
<thead>
<tr>
<th>College/University</th>
<th>Degree</th>
<th>Date Conferred</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
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<td>2.</td>
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<td>3.</td>
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HIGH SCHOOL DIPLOMA OR EQUIVALENT
(Applies to applicants using Option C)

Verification of high school diploma or equivalent must accompany this application.
WORK EXPERIENCE
(Applies to applicants using Option C)

Please list the Employer(s), your job title(s), and employments date(s) below for the work experience being utilized to meet the requirement of ONE YEAR relevant experience. VERIFICATION of the work experience is also required.

_________________________________________________________________________________________________________
_________________________________________________________________________________________________________
_________________________________________________________________________________________________________

DISCIPLINARY ACTION/CONVICTIONS
(Applies to all applicants)

Pursuant to K.S.A. 39-923, has disciplinary action ever been taken against an Operator credential or a professional or occupational health care license held by you, whether issued by this state or another state or jurisdiction and/or have you had a finding of Abuse, Neglect or Exploitation against a resident of an adult care home as defined in K.S.A. 39-1401 and amendments thereto?

Please Circle:  YES  NO

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

Pursuant to K.S.A. 39-923, 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.

Please Circle:  YES  NO

If YES, please indicate:

Date of Conviction: ________________________________

City, County, and State of Conviction: ________________________________________________________

Crime of which Convicted: _________________________________________________________________

NOTE: Candidate shall provide all reports and court documents related to the conviction. The candidate shall have the burden of proving 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 agency to verify any information provided in this application and attachments.

__________________________________________________________  ______________________________
SIGNATURE OF APPLICANT      DATE

PLEASE NOTE: Your signature must be notarized

SUBSCRIBED AND SWORN TO before me, the undersigned authority, on this ________ day of ___________________________ 20_________

_____________________________________________________________
(Notary Public)

My appointment expires: ________________________________
LAST NAME ______________________  FIRST NAME ___________________  MIDDLE NAME ___________________  SUFFIX ___________________

OTHER LAST NAMES EVER USED: _______________________________________________________
                                                                                       
                                                                                       
SOCIAL SECURITY NUMBER ___________________________  DATE OF BIRTH ______________________

GENDER __________________________  RACE ______

ONE OF THE FOLLOWING MUST BE SELECTED
A – ASIAN OR PACIFIC ISLANDER
B – BLACK
I – NATIVE AMERICAN/ALASKAN NATIVE
W – WHITE

ADDRESS ___________________________  PO BOX (IF APPLICABLE) __________________________

CITY ___________________________  STATE ______  ZIP __________________________

HOME PHONE __________________________

CELL PHONE __________________________

WORK PHONE __________________________
This charge is for: _____________________________________________________________________

Please Print Facility Name / Name of individual for Certification or Licensing

As payment of fees for:

SELECT APPROPRIATE OPTION

<table>
<thead>
<tr>
<th>Certification</th>
<th>Criminal Record Check</th>
</tr>
</thead>
<tbody>
<tr>
<td>Course #: ____________</td>
<td>Number of names checked:</td>
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<tr>
<td></td>
<td>x $10.00 per name = $</td>
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<tr>
<td></td>
<td>Total paid</td>
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<tr>
<td>Certified Nurse Aide</td>
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<td>Certified Home Health Aide</td>
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<td>Certified Medication Aide</td>
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<td>Reschedule State Test</td>
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<tr>
<td>Fee amount paid</td>
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Certification #

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<thead>
<tr>
<th>Licensing</th>
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<tr>
<td>Speech-Language Pathology</td>
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<td>Audiology</td>
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<tr>
<td>Dietitian</td>
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<tr>
<td>Adult Care Home Administrator</td>
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<tr>
<td>Operator Registration</td>
</tr>
<tr>
<td>$</td>
</tr>
<tr>
<td>Fee amount paid</td>
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</tbody>
</table>

Credit Card company service fee of 3.04% will be added to the total

VISA Card number (required) __________________________________________________________
Expiration Date (required) ________________

OR

MASTERCARD Number (required) __________________________________________________________
Expiration Date (required) ________________

Name of Cardholder (required) ____________________________ Signature (required) ________________

FOR OFFICE USE ONLY:

AMOUNT__________    SERVICE FEE_________  TOTAL CHARGED__________________