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

Personal checks are accepted but must be mailed with app; license may be subject to action if checks are found invalid or insufficient. Visa or MasterCard may be used for payment of fees. Charge authorization form must be completed and signed to utilize this option.

Military Considerations

(For military applicants and spouses - please provide a copy of your United States Uniformed Services Identification Card)

Are you the spouse of an active-duty military service member and wish to receive expedited processing on that basis? _____

Are you an active-duty military service member? _____

Are you a former military service member? _____
If yes, please provide a copy of your DD214 form with Characterization of Service.

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 either by email to KDADS.Licensure@ks.gov or to the mailing address provided below. 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 26-38-4. **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: _____

Request each state send a verification of licensure directly to this Board address or email it to KDADS.Licensure@ks.gov

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DOCUMENTATION OF NEED FOR TEMPORARY LICENSE

K.A.R. 26-38-6 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

If you answer yes to any misdemeanor/felony/disciplinary question(s) on the application the required documentation must be received by this Board, or your application will be considered incomplete and cannot be processed. If you have questions about the conviction or disciplinary action requirements, please contact Karen Torbert at 785.296.0061 or Karen.Torbert@ks.gov. Review the information for an explanation regarding the documentation that must be submitted if you answer "yes" to any of the following questions.

Have you ever been convicted of a felony? **Yes** _____ **No** _____

Have you ever been convicted of a Class A misdemeanor? **Yes** _____ **No** _____
(any crimes as listed in K.A.R.26-38-5)

Have you had a judgement of settlement in civil record? **Yes** _____ **No** _____
(as described in K.A.R. 26-38-5)

Do you have any pending criminal case against you for a felony or Class A misdemeanor offense? **Yes** __ **No** __

Do you presently have any physical or mental conditions or use of drugs or alcohol that could affect your ability to competently and safely practice as an Administrator of record for an Adult Care Home? **Yes** _____ **No** _____
(if yes, submit an explanatory letter and physician's release)

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?
Yes _____ No _____
(If yes, please provide specific details and copies of all relevant documents.)

Have you ever had an Adult Care Home Administrator license denied, revoked, limited, suspended, or publicly or privately censured by a licensing authority? **Yes _____ No _____**
(If yes, please provide specific details and copies of all relevant documents.)

Are you registered, certified, or licensed in any other profession? **Yes _____ No _____**
If yes, please list: _____

Have you ever voluntarily surrendered any professional license while an investigation or discipline case was pending?
Yes _____ No _____

Have you ever allowed any professional license to expire while an investigation or discipline was pending? **Yes __ No __**

Do you have any pending investigations or disciplinary cases against you or your license, certification, or registration by a professional licensing authority? **Yes _____ No _____**

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.

I declare under penalty of perjury under the laws of the State of Kansas that the information provided above is true and correct to the best of my knowledge.

Signature: _____ Executed on: _____
(date)

Submit application, fee and supporting documents to:
KDADS.Licensure@ks.gov
or
Health Occupations Credentialing
Kansas Department for Aging and Disability
Services 503 S Kansas Ave, Suite 300C
Topeka, Kansas 66603-3404

KDADS HEALTH OCCUPATIONS CREDENTIALING

Adult Care Home Administrator Checklist for Submission

Temporary License

- ○ Complete and sign application
  - Found at www.kdads.ks.gov/hoc
  - Select Applications & Forms from left side menu
  - Scroll to Adult Care Home Administrator
  - Select Temporary Application Pack
- ○ Include payment for application fee
  - $100
  - Found at www.kdads.ks.gov/hoc
  - Select Application & Forms from the left side menu
  - Select Credit Card Fee Payment from Universal Forms heading
    - *For payment by VISA or MASTERCARD ONLY
- ○ Request official transcript (minimum bachelor's degree) to be submitted
- ○ Request to take the State Exam
- ○ Submit a letter from the facility to meet KAR 26-38-6(a) and (a)(2)

All materials can be sent via email to:
KDADS.Licensure@ks.gov
or regular mail to:
Health Occupations Credentialing
503 S Kansas Ave, Suite 300c
Topeka, KS 66603-3414

KANSAS DEPARTMENT FOR AGING AND DISABILITY SERVICES
SURVEY, CERTIFICATION AND CREDENTIALING COMMISSION
HEALTH OCCUPATIONS CREDENTIALING
CREDIT CARD AUTHORIZATION FOR VISA OR MASTERCARD

NAME OF INDIVIDUAL: _____
Please Print

As payment of fees for:

Certification CNA/CMA/HHA ONLY	
Course #	_____
_____	Certified Nurse Aide
_____	Interstate
_____	Certified Home Health Aide
_____	Certified Medication Aide
_____	CMA Renewal
_____	Reschedule State Test
_____	Allied
	Fee amount paid

Licensing - SLP, Audiology, Diet, Admin, Operator	
Circle Type to Select	enter credential number if known or X if new
Temporary	
Initial/Full	_____ Speech Language Pathologist
Reciprocal	_____ Audiologist
Renewal	_____ Dietitian
Reinstatement	_____ Adult Care Home Administrator
	_____ Operator Registration
$	Fee amount paid

FACILITY USE ONLY
FACILITY NAME AND ID FOR CRC: _____

Criminal Record Check - Facility Use Only	
Number of names checked:	
$10.00 per name	
Total Paid $	

VISA OR MASTERCARD NUMBER: _____ _____ _____ _____ EXPIRATION _____/_____

_____ _____
PRINTED NAME OF CARD HOLDER (REQUIRED) AUTHORIZED SIGNATURE (REQUIRED)

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

FOR OFFICE USE ONLY:		
AMOUNT:	SERVICE FEE:	TOTAL CHARGED

wj 9.22.22