



KENTUCKY BOARD OF LICENSURE FOR LONG-TERM CARE ADMINISTRATORS

P.O. Box 1360, Frankfort, Kentucky 40602 ~ 911 Leawood Drive, Frankfort, Kentucky 40601
(502)564-3296 Extension 226~ <http://ltca.ky.gov>

APPLICATION FOR LICENSURE INFORMATION SHEET / CHECKLIST (Check as Received) (Form KBLTCA-1)

.. TEMPORARY PERMIT

- \$175 Fee (\$100 Application Review Fee plus \$75 Temporary Permit Fee)
- Application
- Letter from Facility Ownership declaring its reason(s) for needing an emergency administrator
- Official Transcript

.. INITIAL LICENSURE CHECKLIST

- \$250 Fee (\$100 Application Review Fee plus \$150 Licensure Fee)
- Application
- Current Job Description
- Official Transcript
- Work Experience Verification Form
- Letter of Reference (2 professional and 2 personal)
- Upon taking and passing exam, submit NAB Score Report to board for review

TESTING PROCEDURES

Once the board has approved an application, the applicant will receive detailed information regarding Computer Based Testing for the National Association of Boards of Licensure for Long Term Care Administrators exam. With the computer based testing there are no set test dates; the approved applicant determines the test date.

.. LICENSURE BY ENDORSEMENT

- \$400 Fee (\$100 Application Review Fee plus \$300 Endorsement Fee)
- Application
- Endorsement Form from Each State in which you hold (or have held) a NHA/LTCA license
State:_____ State:_____ State:_____ State:_____
- Official Transcript
- Letter of Reference (2 professional and 2 personal)

.. LICENSURE REACTIVATION

- \$50 Reactivation Fee
- Application
- Evidence of completing at least 30 hours of approved Continuing Education within the past 24 months

.. LICENSURE REINSTATEMENT

- \$300 Reinstatement Fee
- Application
- Evidence of completing at least 30 hours of approved Continuing Education within the past 24 months

Rev. 1/2014

NOTICE TO ALL APPLICANTS:

The Board will **NOT** consider an application until **ALL** requirements for licensure are received and the file is complete. Please refer to the information sheet/checklist which is included with this application packet.

Information regarding your file will be given only to the applicant. Additionally, the Board office does not give information regarding the finding from a board meeting over the phone. Letters regarding the approval or denial of an application will be sent from our office approximately ten (10) business days following the meeting. Applications must be received at least ten (10) days prior to the Board meeting.

APPLICATION INSTRUCTIONS

1. This application is to be used with Adobe Reader.
2. Press the TAB key to skip to the next field.
3. Once you have completed the form, you must print the form, and apply your handwritten signature. Application forms submitted without the appropriate signatures will be returned.
4. Please attach the appropriate application fee. Application fees are non-refundable. Please make all checks or money orders payable to the Kentucky State Treasurer. **DO NOT SEND CASH.**
5. The completed application may be submitted to the Kentucky Board of Licensure for Long-Term Care Administrators either by mail to P.O. Box 1360, Frankfort, Kentucky 40602 or by delivery to 911 Leawood Drive, Frankfort, Kentucky 40601.



KENTUCKY BOARD OF LICENSURE FOR LONG-TERM CARE ADMINISTRATORS

P.O. Box 1360, Frankfort, Kentucky 40602 ~ 911 Leawood Drive, Frankfort, Kentucky
40601

(502)564-3296 Extension 226~ <http://ltca.ky.gov>

LICENSURE APPLICATION

NOTE: Please send the appropriate application fee as stated below, payable to the Kentucky State Treasurer, with this application in order to process. DO NOT SEND CASH

(Select One):

- \$175 - Emergency Temporary Permit for Long-Term Care Administrator*
- \$250 - Licensed Long-Term Care Administrator*
- \$400 - Licensed Long-Term Care Administrator by Endorsement*
- \$ 50 - Reactivation as a Licensed Long-Term Care Administrator
- \$300 – Reinstatement as a Licensed Long-Term Care Administrator

(*) – Includes \$100 Application Fee

1. _____ 2. / /

Name: Last First Middle Date of Birth

3. - -

Maiden or any other name used Social Security Number

4. _____

Home Mailing Address: City State Zip Code Home Phone
Street

5.				
	Business Name:	Street:	City:	State
	Business Phone			Zip Code

6. _____

Email Address Note: This field is not optional

7. Are you a U.S. Citizen? Yes No

8. List other states in which you have held or currently hold a Nursing Home Administrators license.

9. Have you made application for a Nursing Home Administrator's license in Kentucky or any other state?
 Yes No
 If yes, give explanation:
 If yes, has that license in Kentucky or any other state even been suspended, revoked, or disciplined? Yes No
 If yes, give explanation: You must send documentation of actions taken against your license for board review.

10. Do you hold a health professions license in Kentucky or any other state? Yes No List States:

If yes, has that license in Kentucky or any other state even been suspended, revoked, or disciplined? Yes No
 If yes, give explanation: You must send documentation of actions taken against your license for board review.

11. Have you ever been **convicted** of a felony or misdemeanor? Yes No
 If yes, you must provide date, nature of offense, and official report stating result of offense.
 (Do not list traffic offenses that do not involve alcohol or drugs)

Revised 8/2013

Applicant's Affidavit

I, the applicant named in the above, do hereby certify under penalty of law that the information contained herein is true, correct, and complete to the best of my knowledge and belief. I am aware that, should an investigation at any time disclose any such misrepresentation or falsification, my application could be rejected or my license revoked by the Kentucky Board of Licensure for Nursing Home Administrators.

Date: **Applicant's Signature:**

Additional Affidavit: Applicants for Reactivation or Reinstatement ONLY

I have earned _____ hours of continuing education within the twenty-four (24) months immediately preceding the date on which this request for reactivation/reinstatement is submitted to the board, and I am submitting with this application evidence of completion of those courses for the board to consider. I understand that the continuing education hours submitted for the purpose of reactivation/reinstatement shall be in addition to the number of continuing education hours required for renewal.

Date: **Applicant's Signature:**

EDUCATION

SCHOOL	NAME AND LOCATION	Dates Attended		Date of Graduation		Number of Hours or Credits	Degrees Obtained
		From	To	Month	Year		
Under-Graduate School							
Graduate School							

NOTE: All degrees applicable must be documented by a CERTIFIED TRUE COPY of the official transcript with the DEGREE CONFERRED and mailed from the university directly to this office. **Issued to student copy not acceptable.**

PLEASE NOTE: THE FOLLOWING SUPPLEMENTS MUST BE RECEIVED BEFORE YOUR APPLICATION WILL BE REVIEWED BY THE BOARD. NO ACTION WILL BE TAKEN UNTIL ALL REQUIREMENTS HAVE BEEN MET.

- Current Job Description
- Work Verification Form
- 4 Letters of reference: 2 Character references from business or professional persons and 2 Professional references from current or past employers.

(These are requested by you, and must be mailed directly to this office from the individual)

All applicants should become familiar with the state laws and regulations governing licensure. These may be found on our website at <http://ltca.ky.gov> or may be requested by calling 502.564.3296 X 226.

EMPLOYMENT HISTORY

Begin with your present or most recent job and list fully and accurately the details of each job you have held during the past three years. List all other administrative positions held in a health care field. The board requests an additional job description or resume along with your application.

Employed from:	Mo.	Yr.	To:	Mo.	Yr.
Title or Position:			Describe your duties:		
Name of Employer:					
Address of Employer:					

Employed from:	Mo.	Yr.	To:	Mo.	Yr.
Title or Position:			Describe your duties:		
Name of Employer:					
Address of Employer:					

Employed from:	Mo.	Yr.	To:	Mo.	Yr.
Title or Position:			Describe your duties:		
Name of Employer:					
Address of Employer:					

DO NOT WRITE BELOW THIS LINE – FOR BOARD AND OFFICE USE ONLY

- Approved
- Denied
- Deferred

Board Review Date: _____ Comments: _____

Signature: _____ Signature: _____

Revised 1/2014



KENTUCKY BOARD OF LICENSURE FOR LONG-TERM CARE ADMINISTRATORS

P.O. Box 1360, Frankfort, Kentucky 40602 ~ 911 Leewood Drive, Frankfort, Kentucky
40601

(502)564-3296 Extension 226~ <http://ltca.ky.gov>

WORK VERIFICATION FORM

Please have your **current** supervisor complete this form and submit it with your application for licensure. If your current supervisor cannot verify your management experiences, please have the supervisor of the health care system where your experience in each of the five domains required was obtained complete the form.

Name of Applicant

Name of Employer

Facility Type	Hospital	Home Nursing	Home Personal Care	Other
---------------	----------	--------------	--------------------	-------

Dates of Employment	From:	/	/	to	/	/
---------------------	-------	---	---	----	---	---

201 KAR 6:020. Section 1 (3) States that a person must have six (6) months of continuous management experience, or, if part-time, not less than 1,000 hours within a twenty-four (24) month period, with that experience to be completed in a long-term care facility. This experience shall be completed within two (2) years of the date of application. The management experience shall include evidence of responsibility for: 1. Personnel management; 2. Budget preparation; 3. Fiscal management; 4. Public relations; and 5. Regulatory compliance and quality improvement.

Detail below the work experience relative to the **APPLICANT** named above:

1. Personnel Management : (include number of individuals supervised)	Description of Experience:
2. Budget Preparation:	Description of Experience:
3. Fiscal Management:	Description of Experience:
4. Public Relations:	Description of Experience:
5. Regulatory Compliance and Quality Improvement:	Description of Experience:

Name of person completing form:	
Title:	
Address:	
Contact Phone:	
E-mail:	
Date:	
Signature:	