KENTUCKY BOARD OF LICENSURE FOR LONG-TERM CARE ADMINISTRATORS

P.O. Box 1360, Frankfort, Kentucky 40602 - 500 Mero St., 2SC32, Frankfort, Kentucky 40601
(502) 892-4255 - http://ltca.ky.gov

APPLICATION FOR LICENSURE

INFORMATION SHEET / CHECKLIST

(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
- ☐ Two Professional Letters of Reference
- ☐ Upon taking and passing exam, submit NAB Score Report to board for review
- ☐ Proof of current HSE qualification, if applicable

TESTING PROCEDURES

Once the board has approved an application, the applicant will receive detailed information regarding Computer Based Testing for the National Association of Long-Term Care Administrator Boards 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:_____
- ☐ Official Transcript
- ☐ Two Professional Letters of Reference
- ☐ Proof of ACHCA certification / HSE qualification, if applicable

☐ 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

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 500 Mero St., 2SC32, Frankfort, Kentucky 40601.

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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: Street City State Zip Code Home Phone

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

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 previously held or currently hold a Long-Term Care Administrator or similar license: _____

9. Have you made application for a Long-Term Care Administrator's license in Kentucky or any other state?
☐ Yes ☐ No If yes, give explanation:_____.
*If yes, has the license ever been suspended, revoked, or disciplined? ☐ Yes ☐ No
*If yes, give explanation: _____.
(You must send documentation of all disciplinary actions taken against your license.)

10. Do you currently hold a health professions license in Kentucky or any 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 all disciplinary actions taken against your license.)

10. Have you ever been **convicted** of a felony or misdemeanor? ☐ Yes ☐ No
*If yes, provide date, nature of offense, and a certified copy of the judgment of conviction from the issuing court.

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 Long-Term Care 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 not be applied in addition to the number of continuing education hours required for renewal.

Date: _____ **Applicant's Signature:** _____

EDUCATION

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

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

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
- 2 Professional references from current or past employers.

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.

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:				

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: ____________________________________

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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 ☐	Nursing Home ☐	Personal Care Home ☐	Other

Dates of Employment	From: / / to / /

201 KAR 6:020. Section 1(3) requires six (6) months or, if part-time, not less than 1,000 hours within a twenty-four (24) month period, of continuous management experience, 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 or within one (1) year after the filing of the 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. Use additional work verification forms, if necessary, to document the required amount of experience.

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:	