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[~~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 – Initial or Renewal Licensed Long-Term Care Administrator*
- ☐ $400 - Licensed Long-Term Care Administrator by Reciprocity/Endorsement*
- ☐ $ 50 - Reactivation as a Licensed Long-Term Care Administrator
- ☐ $300 – Reinstatement as a Licensed Long-Term Care Administrator

(*) – Includes $100 Application Fee

Personal Information

1. Full Name: _____
   (Last) (First) (Middle)
2. Maiden and all other names used: _____

3[~~2~~]. Date of Birth: _____/_____/_____

4[~~3~~]. Social Security Number: _____

5[~~4~~]. Home Mailing Address: _____
(Street) (City) (State) (Zip Code)

6. Personal Phone Number: _____

7. Personal Email Address: _____

8[~~5~~]. Business Name: _____

9. Business Address: _____
(Street) (City) (State) (Zip Code)

10. Business Phone Number: _____

11[~~6~~]. Business Email Address: _____
Note: This field is not optional.

12[~~7~~].Are you a US Citizen? ☐ Yes ☐ No

a. If "No", do you have a green card? ☐ Yes ☐ No
b. If "No", have you filed an application for citizenship? ☐ Yes ☐ No

Other Applications and Licenses – You must send documentation of all disciplinary actions taken against your license.

[8. ~~List other states in which you have previously held or currently hold a Long-Term Care Administrator orsimilar 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.)]~~

13. Have you previously applied for a Long-Term Care Administrator's license in Kentucky?
☐ Yes ☐ No
If "yes", under what name, when did you apply, what is the status of the license, and if denied, state the reason for the denial:
_____
_____
_____

14. Do you hold or have you held a Long-Term Care Administrator license or similar license in any other state?
☐ Yes ☐ No
If "yes", under what name, when, what is the status of the license, and describe any discipline imposed on the license: _____
_____
_____

15. Have you previously applied for or are you currently applying for a Long-Term Care Administrator license in any other state?

☐ Yes ☐ No

If "yes", under what name, when did you apply, what is the status of the license, and if denied, state the reason for the denial:

_____

_____

_____

16[~~10~~].Do you currently hold a health professions license in Kentucky or any other state?

☐ Yes ☐ No

If "yes", please list what licenses are held, when they were held, in what states, and describe any discipline imposed: _____

_____

_____

[~~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.)]~~

17[~~10~~].Have you ever been **convicted** of a felony or a misdemeanor?

☐ Yes ☐ No

If "yes", provide date, nature of offense, and a copy of the judgment of conviction: _____

_____

_____

~~[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 educationhours required for renewal.~~

~~Date:_____ Applicant's Signature: _____~~~~]~~

Education and Experience

18. Do you currently hold a health services executive qualification (HSE) from the National Association of Long-Term Care Administrator Boards (NAB)?

☐ Yes ☐ No

a. If "yes", provide documentation of a current HSE qualification from NAB. Then advance to Question 23.
b. If "no", proceed to Question 19.

19. Please list your undergraduate school, including name, location, dates of attendance, number of credit hours, and degree(s) obtained.

Name	Location	Dates of Attendance	Number of Credit Hours	Degree(s) obtained

a. Is each of the school(s) accredited? ☐ Yes ☐ No
b. Provide a copy of an official transcript from each school attended. NOTE: All degrees applicable must be documented by a CERTIFIED 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

20. Did NAB certify the program in which your degree was obtained? Information regarding what programs are accredited can be found on their website - https://www.nabweb.org/ ☐ Yes ☐ No

21. If you answered "no" to Question 20, did the program include 1,000 hours of internship?

☐ Yes ☐ No

a. If "yes", provide documentation evidencing the 1,000 hours of internship.

22. If you answered "no" to Question 21, please complete the attached Form 2, "Work Verification Form" showing six (6) months continuous management experience described in 201 KAR 6:020(3)(a).

Examination

23. Have you passed the NAB exam? ☐ Yes ☐ No

If "yes", attach proof of having passed the NAB exam, or contact NAB and request that your score be transferred to Kentucky.

24. If "no", are you scheduled to take the exam? ☐ Yes ☐ No

If “yes”, when? _____

Letters of Reference

25. Provide two (2) professional letters of reference on official letterhead, dated, and signed with a signature.

Employment History

26. Begin with your present or most recent job and list fully and accurately the details of each job you have held since you obtained your degree. You may attach a resume in lieu of answering this question if it contains all of the required information.

Name of Employer	Address of Employer	Dates Employed	Title	Duties

FOR EMERGENCY TEMPORARY PERMIT APPLICATIONS ONLY

Please answers Questions 1-26 and the following questions:

27. Is the facility for which you are applying for a permit [~~for~~] without a licensed administrator?

☐ Yes ☐ No

28. Is a licensed administrator available to fill the position? ☐ Yes ☐ No

29. Have you previously been granted an Emergency Temporary Permit in Kentucky during the last 5 years? ☐ Yes ☐ No

30. Are you the spouse of an Active Military member? ☐ Yes ☐ No

a. If "yes", provide proof of:
   i. your marriage to an active military member;
   ii. assignment to a duty station in Kentucky; AND
   iii. a valid license or certificate for the profession issued by another state, the District of Columbia, or any possession or territory of the United States.

31. Have you completed all of the requirements listed in Questions 1-26 above except for the examination and the management experience, if required? ☐ Yes ☐ No

FOR REACTIVATION OR REINSTATEMENT APPLICATIONS ONLY

Please answers Questions 1-26 and the following question:

32. Have you completed thirty (30) hours of continuing education within the last twenty-four (24) months?

☐ Yes ☐ No

a. If "yes", provide proof of satisfactory completion of the required hours.
b. If "no", you have six (6) months from when the application is approved to obtain this continuing education pursuant to 201 KAR 6:070 Section 10.

FOR RECIPROCITY/ENDORSEMENT APPLICATIONS ONLY

Please answers Questions 1-26 and the following questions:

33. Are you currently designated as a certified long-term care administrator by the American College of Health Care Administrators (ACHCA)? ☐ Yes ☐ No

a. If "no", do you currently hold a Health Services Executive (HSE) qualification from the National Association of Long-Term Care Administrator Board (NAB)? ☐ Yes ☐ No
   [~~If "no", you have six (6) months from when the application is approved to obtain this continuing education pursuant to 201 KAR 6:070 Section 10.~~]

34. Are you currently licensed in another jurisdiction as a long-term care administrator? ☐ Yes ☐ No

a. Provide a copy of the license and other documentation from the appropriate long-term care licensing authority in the endorsing jurisdiction that confirms the following:
   i. That the license is active;
   ii. That the license is valid;
   iii. That the license is in good standing;
   iv. Does not have an unresolved complaint pending against it; and
   v. Has not been subject to disciplinary action during the five (5) years immediately preceding the application.

35. Does the other state maintain a system and standard of qualifications and examinations for a long-term care administrator substantially equivalent to those in Kentucky? ☐ Yes ☐ No

[~~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

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:	

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 havethe 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. Thisexperience 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. Budgetpreparation; 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:~~]	

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:

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

- ☐ Approved
- ☐ Denied
- ☐ Deferred

Board Review Date: _____ Comments: _____

Signature: _____ Signature: _____

[~~Rev.5/2018~~]