



# 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 filed 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 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.)

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** or 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 education hours 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.

<u>Name</u>	<u>Location</u>	<u>Dates of Attendance</u>	<u>Number of Credit Hours</u>	<u>Degree(s) obtained</u>

- 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.

<u>Name of Employer</u>	<u>Address of Employer</u>	<u>Dates Employed</u>	<u>Title</u>	<u>Duties</u>

**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 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.**

**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.

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

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

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

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

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

<b>Employed from:</b>	Mo.	<b>Yr. To:</b>	Mo.	Yr.
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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 have the supervisor of the health care system where your experience in each of the five domains required was obtained complete the form.

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Name of Applicant
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Name of Employer
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Facility Type	Hospital <input type="checkbox"/>	Nursing Home <input type="checkbox"/>	Personal Care Home <input type="checkbox"/>	Other
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Dates of Employment	From:        /        /        to        /        /
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**~~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:}	

**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**

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**Date:** \_\_\_\_\_ **Applicant's Signature:** \_\_\_\_\_

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

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- Approved
- Denied
- Deferred

Board Review Date: \_\_\_\_\_

Comments: \_\_\_\_\_

Signature: \_\_\_\_\_

Signature: \_\_\_\_\_

[Rev. 5/2018]