GEORGIA STATE BOARD OF LONG-TERM CARE FACILITY ADMINISTRATORS

APPLICATION FOR INITIAL LICENSURE AS AN ASSISTED LIVING COMMUNITY ADMINISTRATOR OR PERSONAL CARE HOME ADMINISTRATOR

- This is **not** the correct application for those applying for a Georgia Assisted Living Community Administrator or Personal Care Home Administrator license by Endorsement/Reciprocity.

- The laws and rules governing the practice of Long-Term Care Facility Administrators in the State of Georgia are available on the Board's website at www.sos.ga.gov

- The Board will not process incomplete applications. If any item is missing, incomplete or incorrect, your application cannot be reviewed by the Board. Please review this application before you submit it to ensure that all required information and documentation is complete and correct. An incomplete application will result in delayed processing.

- Qualifications. Any applicant for licensure as an Assisted Living Community Administrator or Personal Care Home Administrator must meet one of the following qualifications:
    1. At least one year of full-time (a minimum of 1,560 hours in the 12 months preceding the date of this application) practical experience in a healthcare facility or managerial/supervisory experience outside of a healthcare facility prior to the date of the application AND certification from a nationally recognized program (e.g. Senior Living University), program accredited by the National Association of Long Term Care Administrator Boards (NAB), or any other program approved by the Board, which teaches the responsibilities of Assisted Living Community Administration, is a minimum of 14 hours in length, and requires passage of a written exam; or
    2. Hold a Health Services Executive (HSE) qualification from the National Association of Long-Term Care Administrator Boards (NAB) – *Note that you must transfer your HSE Application to this jurisdiction through NAB*; or
    3. Hold a masters degree in a health care related field that includes a minimum of 21 semester hours of coursework concentrated on the administration and management of health care services AND must pass the Resident Care/Assisted Living (RCAL) national examination administered by the National Association of Long Term Care Administrator Boards (NAB); or
    4. Hold an active, unencumbered Georgia license as a Nursing Home Administrator.

- If you are needing to take the Resident Care/Assisted Living (RCAL) national examination administered by the National Association of Long Term Care Administrator Boards (NAB), you must submit this completed application before you can be made eligible to test. You must take and pass the Resident Care/Assisted Living (RCAL) Line of Service (LOS) Exam AND the General Knowledge Exam for Long-Term Care Facility Administrators (CORE).

- Any official transcripts or certificates should be included in the application packet that is mailed to the Board (please note that original documents cannot be returned).

- The $100.00 application fee + $10 processing fee made payable to the Georgia State Board of Long-Term Care Facility Administrators MUST be included with application. Checks returned for insufficient funds will be assessed a service charge pursuant to O.C.G.A. §16-9-20. Application fees are non-refundable.

DO NOT WRITE IN THIS SECTION

RECEIPT # _____

AMOUNT _____

APPLICANT # _____

INITIAL _____ DATE _____

GEORGIA STATE BOARD OF LONG-TERM CARE FACILITY ADMINISTRATORS
237 Coliseum Dr., Macon, GA 31217
404-424-9966 - www.sos.ga.gov

APPLICATION for ASSISTED LIVING COMMUNITY ADMINISTRATOR or PERSONAL CARE HOME ADMINISTRATOR (initial licensure)

I am applying for the following license (check one):

☐ Assisted Living Community Administrator - $100.00 + $10 processing fee*

☐ Personal Care Home Administrator - $100.00 + $10 processing fee *

*** *Application fees are non-refundable***

☐ Please check this box if you are a military spouse or a transitioning service member of the United States armed forces, including the National Guard.

Name (first, middle, last, suffix): _____

_____/____/_____ Sex: ____ M ____ F ____/____/_____
*Social Security Number Date of Birth

**This information is authorized to be obtained and disclosed to state and federal agencies pursuant to O.C.G.A. 19-11-1 and O.C.G.A. 20-3-295, 42 U.S.C.A. 551 and 20 U.S.C.A.1001. It may also be disclosed to the National Practitioner's Databank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB) or other licensing boards, or other regulatory agencies for license tracking purposes*

Physical Address: _____
*(P.O. Box **not** acceptable)* Number and Street

_____
Apt. No City/State Zip

If you are granted a license, your name, mailing address and license number are public information and your mailing address will appear on the internet. Your physical address is required, if different than the mailing address. You must immediately notify the Board in writing of an address change.

Mailing Address: _____
(If different - PO Box **is** acceptable) Number and Street

_____
Apt. No City/State Zip

Phone: _____ Alternate Phone: _____

E-Mail: _____
(*Please print clearly)* Required for communication with Board staff. Your email will not be shared with third parties.

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BACKGROUND CHECK QUESTIONNAIRE

Please note that failure to disclose information requested in this application or giving any false statements / information can result in a disciplinary order and fine, and potentially denial of licensure.

If you answer yes to any of the following questions, you must attach a Letter of Explanation, relevant supporting documents and copies of any final disposition(s) indicating a description of the current status. For the purpose of the following questions, the terms "licensee," "registration," and "certification" are synonymous.

☐ Yes ☐ No Have you had revoked or suspended or otherwise sanctioned any license issued to you by any board or agency in Georgia or any other State?

☐ Yes ☐ No Were you denied issuance of or, pursuant to disciplinary proceedings, refused renewal of a of a license or the privilege of taking an examination by any state licensing board?

☐ Yes ☐ No Have you knowingly failed to renew a license during an investigation of disciplinary action?

☐ Yes ☐ No Have you been subject to disciplinary action or had your membership revoked by a professional organization governing the practice of that profession?

☐ Yes ☐ No Are you currently unable to practice with reasonable skill and safety by reason of illness or use of alcohol, drugs, narcotics, chemicals or any other type of material, or as a result of any mental or physical condition?

☐ Yes ☐ No Have you had any suit filed against you related to the practice of a profession?

☐ Yes ☐ No Have you ever had your Medicaid and/or Medicare privileges revoked or restricted?

☐Yes ☐ No Have you ever been arrested? **NOTE**: *The answer to this question is "YES" if an arrest or conviction has been pardoned, expunged, dismissed or deferred, you pled & completed probation under First offender and/or your civil rights have been restored and/or you have received legal advice that the offense will not appear on your criminal record.*

If "yes," please include a certified copy of the court records and final disposition from the court with your application. In the event the file no longer exists, you must submit documentation from the court stating that fact. Also include a personal letter of explanation regarding each incident.

Please complete the following if you currently hold, or have ever held, a professional license as a Long-Term Care Facility Administrator in another state or jurisdiction, or licensure in any other profession:

License Title_____ State_____

Date Issued_____ Expiration Date_____

License Title_____ State_____

Date Issued_____ ____Expiration Date_____
(request that issuing entity or regulatory body provide verification of the licensure to the GA Board, even if the license is not active.)

QUALIFICATIONS

Board Rule 393-3-.03 requires that applicants document one of the following:

I have at least one year of full-time (a minimum of 1,560 hours in the 12 months preceding the date of this application) practical experience in a healthcare facility or managerial/supervisory experience outside of a healthcare facility prior to the date of the application AND certification from a nationally recognized program (e.g. Senior Living University), program accredited by the National Association of Long Term Care Administrator Boards (NAB), or any other program approved by the Board, which teaches the responsibilities of Assisted Living Community Administration, is a minimum of 14 hours in length, and requires passage of a written exam:

☐Yes ☐ No

I hold a Health Services Executive (HSE) qualification from the National Association of Long-Term Care Administrator Boards (NAB):
Note that you must transfer your HSE Application to this jurisdiction through NAB

☐Yes ☐ No

I hold a masters degree in a health care related field that includes a minimum of 21 semester hours of coursework concentrated on the administration and management of health care services AND must pass the Resident Care/Assisted Living (RCAL) national examination administered by the National Association of Long Term Care Administrator Boards (NAB):

☐Yes ☐ No

I hold an active, unencumbered Georgia license as a Nursing Home Administrator.

☐Yes ☐ No

Employment History

Please complete the following concerning your employment history, beginning with your current or most recent employer:

Employer Name and Address	Location (City/State)	Is Employment in Healthcare? (Yes or No)	Position/Title	Dates of Employment (Month/Year to Month/Year)	Licensure Required? (Yes or No)	Numbers of Hours Worked

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Verification of Employment

Section I (To be completed by applicant) Submit this form to your employer to verify your employment and the numbers of hours worked. The name and address of your employer on this form must match the name and address you listed under "Employment History" on your application.		
Applicant Name:		
Physical Address:		
City:	State:	Zip:
Phone:		
I do hereby consent to and authorize the release of any and all records and information concerning my employment to the Georgia State Board of Long-Term Care Facility Administrators. I understand this information is required as part of the application for licensure process. _____ Applicant Signature _____ Date		

Section II (To be completed by employer) Please complete the form in its entirety. A separate form must be completed for each position held. Be sure to accurately document the employee's position/title. The completed and notarized form may be provided to the applicant or submitted directly to the Georgia State Board of Long-Term Care Facility Administrators by mail or email to Trades3@sos.ga.gov.		
Facility/Business/Employer Name:		
Physical Address:		
City:	State:	Zip:
Phone:	Email:	
Does the applicant work in a healthcare facility? ☐Yes ☐ No		
Applicant's Position/Title:	Is this a supervisory/managerial position? ☐Yes ☐ No	
If the applicant works at a different location than the employer listed on the first page, please identify the physical location where the applicant worked:		
Facility/Business/Employer Name:		
Physical Address:		
City:	State:	Zip:
Phone:	Email:	

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Dates of Employment:

Employed From _____ (Month/Year) to _____ (Month/Year)

Were there any periods of extended absence during employment? ☐ Yes ☐ No

If yes, please provide dates: _____ (Month/Year) to _____ (Month/Year)

Please complete the grid below:		
Year	**Hours Worked Per Year**	**Job Title/Description**

I hereby certify that I am the custodian of records at the facility listed on this form and the information submitted on this form are true and correct statements of this applicant's employment with our facility.

_____ _____

Employer Representative Printed Name Employer Representative Title

_____

Employer Representative Signature

Sworn to and Subscribed before me this ____ day of _____, 20_____.

_____ _____

Signature of Notary Public Commission Expiration Date

Notary Seal

THIS FORM MUST BE SIGNED IN THE PRESENCE OF A NOTARY

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Affidavit of Applicant

Please document with your initials that you have reviewed each of the resources listed below and have the affidavit notarized.
All statutory requirements are accessible via: http://www.lexisnexis.com/hottopics/gacode/Default.asp
All Rules and Regulations are accessible via: http://rules.sos.ga.gov/

____ Department of Community Health, Division of Medical Assistance, Nursing Facility Services Policy Manual - from https://www.mmis.georgia.gov/portal/default.aspx select "Provider Manuals" under the "Provider Information" tab.

_____ Georgia State Board of Long-Term Care Facility Administrators Law (OCGA § 43-27)

_____ Georgia statutes regarding Living Will, Durable Power of Attorney for Health Care, Withholding or withdrawal of life-sustaining procedures (OCGA § 31)

_____ Georgia statutes pertaining to Department of Community Health with particular attention to sections pertaining to Long Term Care Facilities (OCGA § 31)

_____ Fire Safety Codes (OCGA § 25-2-13)

_____ Disaster Preparedness Plans (Chapter 111-8-16)

_____ DHS Rules pertaining to Nursing Homes/Long-Term Care Facilities (290).

_____ Board Rules pertaining to Long-Term Care Facility Administrators (393).

_____ _____ _____
(Date) (PRINTED Name of Applicant) (Signature of Applicant)

Sworn to and subscribed before me this

____day of _____, 20_____

Signature of Notary Public_____

My commission expires: _____ *Notary Seal*

AFFIDAVIT

I hereby swear and affirm that all information provided in this application is true and correct to the best of my knowledge and belief. I further swear and affirm that I have read and understand the current state laws and rules and regulations of the Board for which I am applying for licensure and I agree to abide by these laws and rules.

By executing this affidavit under oath, as an applicant for a professional license, as referenced in O.C.G.A. § 50-36-1, administered by the Professional Licensing Boards Division, the undersigned applicant also verifies one of the following with respect to his/her application for a public benefit (check one):

1) _____ I am a United States citizen 18 years of age or older. **Submit a copy of your current Secure and Verifiable Document(s)** such as driver's license, passport, or other document. A listing of acceptable documents can be found on at www.sos.ga.gov.

2) _____ I am **not** a United States citizen, but I am either a legal permanent resident of the United States or I am a qualified alien or non-immigrant under the Federal Immigration and Nationality Act with an alien number issued by the Department of Homeland Security or other federal immigration agency. **Submit a copy of your current immigration document(s) which includes either your Alien number or your I-94 number and, if needed, SEVIS number.** A listing of acceptable documents can be found on the PLB website, www.sos.ga.gov.

The undersigned applicant also hereby verifies that he or she is 18 years of age or older and has provided at least one secure and verifiable document, as required by O.C.G.A. § 50-36-1(e)(1), with this affidavit.

In making the above representations under oath, I understand that any person who knowingly and willfully makes a false, fictitious, or fraudulent statement or representation in an affidavit shall be guilty of a violation of O.C.G.A. § 16-10-20, and face criminal penalties as allowed by such criminal statute. I also understand that any failure to make full and accurate disclosures may result in disciplinary action by the Board for which I am applying for licensure.

STATE OF GEORGIA
COUNTY OF _____

_____
SIGNATURE OF THE APPLICANT

SUBSCRIBED AND SWORN TO BEFORE ME THIS

_____
DATE

_____ DAY OF _____, _____

_____
NOTARY PUBLIC

MY COMMISSION EXPIRES: _____

Office of the Secretary of State

Name-Based Criminal History Record Information Consent/Inquiry Form

I hereby authorize the Georgia State Board of Long-Term Care Facility Administrators (Agency/Company) to conduct an inquiry for the purpose listed below and receive any Georgia and/or national criminal history record information as authorized by state and federal law.

Full Name (print)			
Address			
Sex	Race	Date of Birth	Social Security Number

Please check ONLY one of the boxes listed below:

☐ This authorization is valid for _____ days from date of signature.

☐ I, _____, give consent to the above-named entity to perform periodic criminal history background checks for the duration of my employment.

_____ _____

Signature Date

AREA BELOW IS FOR AGENCY USE ONLY

Date of Inquiry: _____ Time of Inquiry: _____ Operator's Initials: _____

Purpose Code Used: (check one)

NON-CRIMINAL JUSTICE PURPOSES	
	E - Employment
	M - Working with Mentally Disabled
	N - Working with Elderly
	W - Working with Children
	P - Public Records (no consent required)
	F – Probate Court / Weapons Carry License
PERSONAL REQUEST (INDIVIDUAL OR THEIR ATTORNEY)	
	U - Personal Copy
CRIMINAL JUSTICE	
	J - Civilian Criminal Justice Employment (State & III Info Received)
	Z - Sworn Criminal Justice Employment (State & III Info Received)

The inquiry resulted in the following: (check all that apply)

	No Criminal Record Available
	Criminal Record (Attached/Released)
	No NCIC/GCIC Warrant
	Possible NCIC/GCIC Warrant (List Wanting Agency Below)

Wanting Agency Name: _____

Wanting Agency Telephone: _____

Agency Designee Signature and Title: _____ Date: _____