GEORGIA STATE BOARD OF LONG-TERM CARE FACILITY ADMINISTRATORS

APPLICATION FOR REINSTATEMENT OF AN ASSISTED LIVING COMMUNITY ADMINISTRATOR OR PERSONAL CARE HOME ADMINISTRATOR LICENSE

- This application is for anyone who has held a Georgia license as an Assisted Living Community Administrator or Personal Care Home Administrator and is wishing to reinstate that license.
- 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/plb.
- 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.
- Please refer to Board Rule 393-5-.03 for the requirements and supplemental documents to be submitted with this application for reinstatement. Board Rules can be found on the Board's website at www.sos.ga.gov/plb.
- 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).
- Reinstatement of a lapsed or revoked license is at the discretion of the Board.
- The $200.00 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/plb/nursinghome

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

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

☐ Assisted Living Community Administrator #_____ - $200.00 + $10 processing fee *

☐ Personal Care Home Administrator #_____ - $200.00 + $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.

GEORGIA STATE BOARD OF LONG-TERM CARE FACILITY ADMINISTRATORS

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 healthcare 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.)

- Reason(s) for non-renewal of license: _____

_____
_____
_____

- Describe your professional activities for the past two years: _____
_____
_____
_____

- Have you completed your Continuing Education Hours for the reinstatement of a license, if required, pursuant to Board Rule 393-5-.03 as required by the Board? Verification of CE Hours must be submitted with this application. ☐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

Affidavit of Applicant

GEORGIA STATE BOARD OF LONG-TERM CARE FACILITY ADMINISTRATORS

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/plb.

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/plb.

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: _____

GEORGIA STATE BOARD OF LONG-TERM CARE FACILITY ADMINISTRATORS

Georgia Bureau of Investigation
Georgia Crime Information Center

CONSENT FORM

I hereby authorize **The Georgia State Board of Long-Term Care Facility Administrators** to receive any Georgia criminal history record information pertaining to me which may be in the files of any state or local criminal justice agency in Georgia.

____
Full Name (Print)

____
Address, City, State, County, Zip

Sex	Race	Date of Birth	Social Security Number

By signing this form, I acknowledge that I have been informed of the Non-Criminal Justice applicant's Privacy Rights and the Privacy Act Statement (title 28 United States Code § 534).

____
Signature

____
Date

- -

Special employment provisions (check if applicable):

__ Employment with mentally disabled (Purpose code "M")
__ Employment with elder care (Purpose code "N")
__ Employment with children (Purpose code "W")

Select one of the following (required):

☐ This authorization is valid for __90 days / __180 days / ____ days from date of signature.

☐ I, ______________________________, give consent to the above named to perform periodic criminal history background checks for the duration of my employment with this company.

2.2021