Kansas Department for Aging & Disability Services
Board of Adult Care Home Administrators
OUT OF STATE LICENSE VERIFICATION

APPLICANT: PLEASE MAKE COPIES OF THIS FORM AS NEEDED

An applicant who is licensed in another state as an adult care home administrator may be considered for licensure in Kansas upon determining that the applicant met licensing standards in other states that were not less than those standards for licensure in Kansas on the date of original licensure. To establish eligibility for licensure, this questionnaire must be completed by the applicant and licensing agency in each state in which a license was or is currently held.

Part I - Applicant: Complete, sign and date Part I of this application; forward it to the licensing agency in the state where you are/were licensed.

Name_____

Present Address_____

Name which appears on license, if different_____

Date of Birth_____Social Security No._____

State in which licensed_____License No._____

I hereby give permission to the authorized officer with the_____licensing agency to divulge examination
(State)
scores and other information pertinent to my adult care home administrators license issued by that state.

_____ _____
Signature of Applicant Date

Part II - State Licensing Agency: Please complete this section concerning the administrator named above.

Do your records agree with the information in Part I ____YES ____NO

If No, please explain:_____

_____

Date License was issued_____ Expiration date_____

Was your state the state of original licensure? ____YES ____NO

If No, which state is indicated as the state of original licensure?_____

Which written licensing examination did the applicant take?

PES____ NAB____ Other____ Date_____

Total raw score_____ Scaled Score_____

Was applicant required to complete:

a long-term care administrator practicum approved by an accredited college or university?

____YES ____NO If Yes, please state length of program _____

a long-term care administrator internship approved by a state board?

____YES ____NO If Yes, please state length of internship_____

Over

Is the applicant in good standing with your board at this time? ____YES ____NO
If No, please explain_____
_____

According to your records, has the applicant ever been disciplined by your board or other state agency?

____YES ____NO If Yes, please explain_____
_____

According to your records, has the applicant every been convicted of a crime by any court in the state of_____,

any court of any other state, or any federal court of the United States? ____YES ____NO

Do you favorably recommend the above applicant to be licensed by reciprocity by the State of Kansas?
____YES ____NO

Additional comments:_____
_____

Please return this form to:

Health Occupations Credentialing
Kansas Department for Aging & Disability Services
503 S Kansas Ave
Topeka KS 66603

_____
Signature

_____
Title

_____
Agency

_____ (PLACE SEAL HERE)
Address

_____
City State Date