KANSAS DEPARTMENT FOR AGING AND DISABILITY SERVICES
Health Occupations Credentialing, 503 S Kansas Avenue, Topeka KS 66603

# APPLICATION FOR ADULT CARE HOME OPERATOR REGISTRATION

K.S.A. 39-923 outlines requirements for obtaining Kansas Registration. Please review the statutes.

The three options for obtaining registration are briefly described below and impact how this application form is completed. **Please circle the option under which you are applying for registration.**

**Option A** Possess a Baccalaureate degree in any area of study
**Option B** Possess an Associate's degree in a relevant field as determined by the Secretary
**Option C** Possess a high school diploma or equivalent, with one-year relevant experience as determined by the Secretary.

**REGISTRATION FEES**
Please see fee schedule as fees are pro-rated for partial year licenses. Payment can be submitted by a check made payable to KDADS or by using Visa or MasterCard. Charge authorization form must be completed and signed to utilize this payment option.

## Military Considerations

(For military applicants and spouses - please provide a copy of your United States Uniformed Services Identification Card)

Are you the spouse of an active-duty military service member and wish to receive expedited processing on that basis? _____

Are you an active-duty military service member? _____

Are you a former military service member? _____
If yes, please provide a copy of your DD214 form with Characterization of Service.

## APPLICANT INFORMATION

(All applicants must complete this section)

**Name:** _____
Last, First, Middle (other names used)

**Address:** _____

**Phone:** work ( ) home ( ) cell ( )

**Email Address:** _____

**Date of Birth:** _____ **Social Security Number** _____

## OPERATOR COURSE INFORMATION

(Applies to all applicants)

Please provide a copy of the certificate issued by the school/organization that provided the Operator training course.
List organization which provided the Operator Course and date of course completion below:

_____

## APPLICANTS USING OPTION A OR B
## COLLEGE EDUCATION

Transcripts must be sent by the college or university directly to Health Occupations Credentialing.

| College/University | Degree | Date Conferred |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**APPLICANTS USING OPTION C**

**HIGH SCHOOL DIPLOMA OR EQUIVALENT**
Verification of high school diploma or equivalent must accompany this application.

**WORK EXPERIENCE**
Please list the Employer(s), your job title(s) and employment date(s) below for the work experience being utilized to meet the requirement of one-year relevant experience. **Verification of the work experience is also required.**

_____

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**DISCIPLINARY ACTION/CONVICTIONS**
(Applies to all applicants)

Pursuant to K.S.A. 39-923:
has disciplinary action ever been taken against an Operator credential, or a professional or occupational health care license held by you, whether issued by this state or another state or jurisdiction and/or have you had a finding of Abuse, Neglect or Exploitation against a resident of an adult care home as defined in K.S.A. 39-1401 and amendments thereto?

**Please Circle: YES NO**

**If YES, please provide specific details and copies of all relevant documents.**

If you answer yes to any misdemeanor/felony/disciplinary question(s) on the application the required documentation must be received by this Board, or your application will be considered incomplete and cannot be processed. If you have questions about the conviction or disciplinary action requirements, please contact Wendy Jacobs at 785.296.0061 or wendy.jacobs@ks.gov. Review the information for an explanation regarding the documentation that must be submitted if you answer "yes" to any of the following questions.

Have you ever been convicted of a felony? **Yes _____ No _____**

Have you ever been convicted of a Class A misdemeanor? **Yes _____ No _____**
**(any crimes as listed in K.A.R.26-38-5)**

Have you had a judgement of settlement in civil record? **Yes _____ No _____**
**(as described in K.A.R. 26-38-5)**

Do you have any pending criminal case against you for a felony or Class A misdemeanor offense? **Yes _____ No _____**

Do you presently have any physical or mental conditions or use of drugs or alcohol that could affect your ability to competently and safely practice as an Operator for an Adult Care Home? **Yes _____ No _____**
**(if yes, submit an explanatory letter and physician's release)**

Has disciplinary action ever been taken against an adult care home operator registration, administrator license, a professional or occupational health care license, a mental health care license or a social worker license held by you, whether issued by this state or another state or jurisdiction?
**Yes _____ No _____**
**(If yes, please provide specific details and copies of all relevant documents.)**

Have you ever had an Operator Registration or Adult Care Home Administrator license denied, revoked, limited, suspended, or publicly or privately censured by a licensing authority? **Yes _____ No _____**
**(If yes, please provide specific details and copies of all relevant documents.)**

Are you registered, certified, or licensed in any other profession? **Yes _____ No _____**

**If yes, please list: _____**

Have you ever voluntarily surrendered any professional license while an investigation or discipline case was pending?

Yes _____ No _____

Have you ever allowed any professional license to expire while an investigation or discipline was pending? **Yes _____ No _____**

Do you have any pending investigations or disciplinary cases against you or your license, certification, or registration by a professional licensing authority? **Yes _____ No _____**

**NOTE:** Pursuant to state regulations, the agency requires that you provide all reports and court documents related to the conviction. Materials should be submitted to Health Occupations Credentialing. Please note, any and all costs for obtaining such reports/documents are your responsibility. You are also invited to submit a letter and any other additional supporting information or documents to the agency explaining the circumstances surrounding the case, complete resolution of the issue (including final probation, community corrections or parole documents), and how/why this situation is not expected to occur again. The candidate shall have the burden of proving that the candidate has been rehabilitated and warrants the public trust.

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I do hereby attest that the information supplied in this application and any attachment is accurate and complete to the best of my knowledge. I do hereby give permission to the agency to verify any information provided in this application and attachments. I understand that the application fee is non-refundable should I not meet licensure qualifications.

I declare under penalty of perjury under the laws of the State of Kansas that the information provided above is true and correct to the best of my knowledge.

**Signature**: _____ Executed on: _____
(date)

Submit application, fee and supporting documents to:
**Health Occupations Credentialing**
**Kansas Department for Aging and Disability Services**
**503 S Kansas Ave, Suite 300C**
**Topeka, Kansas 66603-3404**

HEALTH OCCUPATIONS CREDENTIALING
503 S KANSAS AVE TOPEKA KS 66603
Adult Care Home
OPERATOR
CRIMINAL RECORD CHECK REQUEST

_____ _____ _____ _____
LAST NAME FIRST NAME MIDDLE NAME SUFFIX

OTHER LAST NAMES EVER USED: _____

_____

_____

SOCIAL SECURITY NUMBER _____ DATE OF BIRTH _____

GENDER _____

| ONE OF THE FOLLOWING MUST BE SELECTED |
| --- |
| A – ASIAN OR PACIFIC ISLANDER |
| B – BLACK |
| I – NATIVE AMERICAN/ALASKAN NATIVE |
| W - WHITE |

RACE_____

_____ _____
ADDRESS PO BOX (IF APPLICABLE)

_____ _____ _____
CITY STATE ZIP

_____
HOME PHONE

_____
CELL PHONE

_____
WORK PHONE

KANSAS DEPARTMENT FOR AGING AND DISABILITY SERVICES
SURVEY, CERTIFICATION AND CREDENTIALING COMMISSION
HEALTH OCCUPATIONS CREDENTIALING
CREDIT CARD AUTHORIZATION FOR VISA OR MASTERCARD

This charge is for: _____

Please Print Facility Name for CRC OR Name of individual for Certification/Licensing

As payment of fees for:

| Certification CNA/CMA/HHA ONLY | |
|---|---|
| Course # | _____ |
| _____ | Certified Nurse Aide |
| _____ | Interstate |
| _____ | Certified Home Health Aide |
| _____ | Certified Medication Aide |
| _____ | CMA Renewal |
| _____ | Reschedule State Test |
| _____ | Allied |
| | Fee amount paid |

| Licensing - SLP, Audiology, Diet, Admin, Operator | | |
|---|---|---|
| Circle Tpe to Select | enter credential number if known or X if new | |
| Temporary | _____ | Speech Language Pathologist |
| Initial/Full | _____ | Audiologist |
| Reciprocal | _____ | Dietitian |
| Renewal | _____ | Adult Care Home Administrator |
| Reinstatement | _____ | Operator Registration |
| $ | Fee amount paid | |

| Criminal Record Check - Facility Use Only | |
|---|---|
| Number of names checked: | |
| $10.00 per name | |
| Total Paid $ | |

*Credit Card company service fee of 3.04% will be added to the total*

VISA Card number (required) _____

Expiration Date (required) _____

OR

MASTERCARD Number (required) _____

Expiration Date (required) _____

_____ _____

Name of Cardholder (required) Signature (required)

| FOR OFFICE USE ONLY: | | |
|---|---|---|
| AMOUNT: | SERVICE FEE: | TOTAL CHARGED |
| | | |

*wj 4.9.21*