KANSAS DEPARTMENT FOR AGING AND DISABILITY SERVICES

APPLICATION PROCESS FOR

ADULT CARE HOME OPERATOR REGISTRATION

In this section you will find all the materials necessary to apply for an Operator Registration in the state of Kansas. It is the desire of the Kansas Department for Aging and Disability Services to make the application process as convenient and effective as possible. Please understand that in all cases the burden of proof in meeting the requirement for registration is upon the applicant; therefore, you will find it worth your time to carefully review the information and forms. Receipt of information necessary to efficiently process and evaluate application is of the utmost importance.

STEPS TO APPLY FOR REGISTRATION

1. **Download application forms**: [www.kdads.ks.gov/hoc](http://www.kdads.ks.gov/hoc)
2. **Complete and submit application materials**. Completed notarized application should be submitted along with a copy of the Operator Course Certificate of Completion to HEALTH OCCUPATIONS CREDENTIALING 612 S. KANSAS AVE TOPEKA KS 66603.
3. **Criminal Records Check**. The Criminal Record Check Request form must be completed and submitted as part of the application materials.
4. **Pay Fees**. The Fees document outlines the pro-rated fees for Registrations in effect for less than 24 months. Fees are non-refundable. Checks should be made payable to KDADS. Visa or MasterCard may be utilized for payment of fees. If so, the Credit Card Authorization form must be completed and signed.
5. **Verify Education**. There are three options for meeting the education requirements to obtain Registration:
   a. possess a baccalaureate degree (original sealed transcripts or e-transcripts must be sent by the college or university directly to Health Occupations Credentialing); or
   b. possess an associate’s degree in a *relevant field, as determined by the Secretary (original sealed transcripts must be sent by the college or university directly to Health Occupations Credentialing); or
   c. possess a high school diploma or equivalent, with one year *relevant experience, as determined by the Secretary (high school diploma or equivalent must accompany the application along with verification of relevant work experience)

*Relevant experience and fields: Kanas adult care home Operators are responsible to direct the day-to-day functions of the facility in accordance with current federal, state, and local standards, guidelines and regulations that govern adult care homes. Responsibilities may include:

- Planning, developing, organizing and implementing and directing the facility’s programs and activities
- Delegation or development of written policies and procedures that govern the operation of the facility
- Maintaining a liaison with families and residents
- Preparation of operating budgets
- Ensuring resident rights to fair and equitable treatment, self-determination, individuality, privacy, property, and civil rights are well established and maintained
- Documentation, including charting and resident records
- Admission, transfer and discharge of residents; and understanding of Advance Directives
- Understand the issues involved in abuse/neglect and exploitation, including prevention and reporting requirements
- Understand basic principals in providing for the nutritional needs of older adults and safe food service management
- Knowledge of infection control practices
- Responsibilities in medication management
- Have a basic understanding of fire safety and emergency procedures
- Develop strategies for helping residents deal with behavioral symptoms, including those of dementia
- Understand the role of the surveyor
- Basic knowledge of needs which may develop as a result of the aging process and common chronic diseases found in older adults

Experience should be relevant to these activities. Associate degree fields should be relevant to these activities and responsibilities.

Expiration of License/Renewal – Full Licensure

All Operator Registrations will expire on April 30 of the year that is less than two years from issuance. Thereafter, the license will expire biennially. Acquisition of 30 clock hours of continuing education in the “core of knowledge” subject area will be required to renew. Administration – 15 hours minimum, Resident Care - 10 hours minimum, Elective – 5 hours MAXIMUM.

Note: Each licensee whose initial licensure period is less than 24 months shall be required to obtain pro-rated continuing education for each month in the initial registration period.

Fees

A full registration period begins May 1st for a two-year period which expires on April 30th. Initial registrations issued on May 1st of any registration period will be for two full years. Initial registrations issued at any time during the registrations period will be less than two years.

### PRO-RATED FEE SCHEDULE

<table>
<thead>
<tr>
<th>Month</th>
<th>Fee</th>
<th>Month</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>May (24 month)</td>
<td>$65.00</td>
<td>Nov (18 month)</td>
<td>$47.00</td>
</tr>
<tr>
<td>June (23 month)</td>
<td>$62.00</td>
<td>Dec (17 month)</td>
<td>$44.00</td>
</tr>
<tr>
<td>July (22 month)</td>
<td>$59.00</td>
<td>Jan (16 month)</td>
<td>$41.00</td>
</tr>
<tr>
<td>Aug (21 month)</td>
<td>$56.00</td>
<td>Feb (15 month)</td>
<td>$38.00</td>
</tr>
<tr>
<td>Sept (20 month)</td>
<td>$53.00</td>
<td>Mar (14 month)</td>
<td>$35.00</td>
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<tr>
<td>Oct (19 month)</td>
<td>$50.00</td>
<td>Apr (13 month)</td>
<td>$32.00</td>
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Enclose non-refundable fee: Payable to KDADS. Personal checks are accepted. Visa or Master Card may be used for payment of fees. Charge authorization form must be completed and signed to utilize this option.

If you have questions regarding any phase of the registration process, please contact Wendy Davis at wendy.davis@ks.gov or 785.296.0061.
KANSAS DEPARTMENT FOR AGING AND DISABILITY SERVICES
HEALTH OCCUPATIONS CREDENTIALING
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

*Fees pro-rated for partial year licenses. Enclose non-refundable fee: Payable to KDADS. Personal checks are accepted. Visa or Master Card may be used for payment of fees. Credit Card Authorization Form must be completed and signed to utilize this option.

Operator Registration: $65

APPLICANT INFORMATION
(All applicants must complete this section)

Name:___________________________________________________________________________________________________
Last     First   Mi  Other

Address:__________________________________________________________________________________________________
Street / Route / Box / Apt #   City   State  Zip

Email: __________________________________________________________________

Birthdate:_____________________      SSN___________________________________________

Phone: work ____________________     home ___________________        cell _________________________
(attach a copy of your Social Security Card or document bearing your name and Social Security number)

COLLEGE EDUCATION
(Applies to applicants using Option A or B)

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

<table>
<thead>
<tr>
<th>College/University</th>
<th>Degree</th>
<th>Date Conferred</th>
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</thead>
<tbody>
<tr>
<td>1.</td>
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<td>2.</td>
<td></td>
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<tr>
<td>3.</td>
<td></td>
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</table>

HIGH SCHOOL DIPLOMA OR EQUIVALENT
(Applies to applicants using Option C)

Verification of high school diploma or equivalent must accompany this application.
WORK EXPERIENCE
(Appplies to applicants using Option C)

Please list the Employer(s), your job title(s), and employments 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.

_________________________________________________________________________________________________________
_________________________________________________________________________________________________________
_________________________________________________________________________________________________________

DISCIPLINARY ACTION/CONVICTIONS
(Appplies 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.

Pursuant to K.S.A. 39-923, have you ever been convicted of a crime by any court (including Kansas), or any federal court of the United States? This includes any felony, misdemeanor, or DUI convictions.

Please Circle:    YES  NO

If YES, please indicate:

Date of Conviction: ________________________________
City, County, and State of Conviction: ________________________________________________________
Crime of which Convicted: _________________________________________________________________

NOTE: Candidate shall provide all reports and court documents related to the conviction. The candidate shall have the burden of proving the candidate has been rehabilitated and warrants the public trust.

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.

__________________________________________________________  ______________________________
SIGNATURE OF APPLICANT      DATE

PLEASE NOTE: Your signature must be notarized

SUBSCRIBED AND SWORN TO before me, the undersigned authority, on this ______ day of ___________________________ 20_________

_____________________________________________________________
(Notary Public)

My appointment expires: ______________________________________
HEALTH OCCUPATIONS CREDENTIALING
612 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 ____________________________ RACE ________

ONE OF THE FOLLOWING MUST BE SELECTED

A – ASIAN OR PACIFIC ISLANDER

B – BLACK

I – NATIVE AMERICAN/ALASKAN NATIVE

W – WHITE

ADDRESS ___________________________________________ PO BOX (IF APPLICABLE) ___________

CITY ___________________________________________ STATE ___________ ZIP ___________

HOME PHONE ___________________________________________

CELL PHONE ___________________________________________

WORK PHONE ___________________________________________
This charge is for: __________________________________________________________

Please Print Facility Name / Name of individual for Certification or Licensing

As payment of fees for:

SELECT APPROPRIATE OPTION

<table>
<thead>
<tr>
<th>Certification</th>
<th>Criminal Record Check</th>
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<tbody>
<tr>
<td>Course #: __________</td>
<td>Number of names checked: _____ x $10.00 per name = $</td>
</tr>
<tr>
<td></td>
<td>Total paid</td>
</tr>
<tr>
<td>Certified Nurse Aide</td>
<td></td>
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<tr>
<td>Certified Home Health Aide</td>
<td></td>
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<tr>
<td>Certified Medication Aide</td>
<td></td>
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<tr>
<td>Reschedule State Test</td>
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<tr>
<td>$</td>
<td>Fee amount paid</td>
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</table>

<table>
<thead>
<tr>
<th>Licensing</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Credential #</td>
<td>Speech-Language Pathology</td>
</tr>
<tr>
<td></td>
<td>Audiology</td>
</tr>
<tr>
<td></td>
<td>Dietitian</td>
</tr>
<tr>
<td></td>
<td>Adult Care Home Administrator</td>
</tr>
<tr>
<td></td>
<td>Operator Registration</td>
</tr>
<tr>
<td>$</td>
<td>Fee amount paid</td>
</tr>
</tbody>
</table>

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__________________