

APPLICATION FOR ADMINISTRATOR INITIAL CERTIFICATION

- Adult Residential Facility Group Home Residential Care Facility for the Elderly

To receive your Administrator Certificate, applicant shall be at least 21 years of age, have a high school diploma or equivalent, such as a General Education Development (GED) certificate, and must submit the following:

- Complete & submit this application form (BOTH SIDES) within 30 days of receipt to: California Department of Social Services, Administrator Certification Section, 744 P Street, M.S. 9-14-47, Sacramento, CA 95814-6413.
- Submit a non-refundable processing fee of \$100 (payable to the Department of Social Services). Please include your administrator certificate number on your check. Paperclip your check to your documents; do not staple or glue.
- Submit a **copy** of the Certificate of Completion of the Initial Certification Training Program (provided by initial training vendor).
- Submit a **copy** of the Department's congratulatory letter verifying a passing test score. (Original is included in this package; keep original for your files.)
- If applicable, submit a **copy** of your current Nursing Home Administrators License (for RCFE applicants only).

All administrators must have the required criminal record clearances on file with the Department of Justice required by the Department of Social Services (DSS). If you plan to work in a facility among children, the Department also requires you to have a Child Abuse Central Index Check clearance. (If you already have the required clearances, this does not apply to you.) If you have never been fingerprinted for DSS, complete the enclosed Live Scan application and follow the instructions for scheduling an appointment.

If you have already been fingerprinted by Live Scan, attach a copy of the completed Request for Live Scan Service form, signed by the Live Scan operator. **YOU DO NOT NEED TO WAIT FOR YOUR LIVESCAN RESULTS BEFORE SUBMITTING YOUR APPLICATION.**

Please provide the following information: (Incomplete applications will be returned to the applicant resulting in a delay in processing your certificate)

PLEASE PRINT

NAME: _____
(LAST) (FIRST) (MIDDLE)

SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP CODE: _____

TELEPHONE NUMBER: _____ Cell: _____

BELOW, PLEASE INDICATE WHEN YOU WOULD LIKE YOUR CERTIFICATE TO EXPIRE: (Select only one box. If you do not make a selection, number #1 will be used.)

1. TWO YEARS FROM DATE OF CERTIFICATION ISSUANCE.
2. BIRTHDATE OF THE SECOND CALENDAR YEAR FOLLOWING CERTIFICATION (This irrevocable selection means your certificate will expire on your birthday, and may be less than two years from date of issuance.)

COMPLETE AND SUBMIT BOTH SIDES OF THIS APPLICATION

APPLICATION FOR ADMINISTRATOR INITIAL CERTIFICATION (continued)

NAME (Please print): _____
(LAST) (FIRST) (MIDDLE)

1. Do you currently possess or have you previously held a license, certification or other approval as a professional in a specified field? If yes, please indicate the type of license or certificate and license number(s);

Yes No License Number: _____ Certificate Number: _____

2. Do you currently hold or have you previously held a government issued facility license to operate or provide services to individuals? If yes, please indicate the type of license or certificate and license number(s);

Yes No License Number: _____ Certificate Number: _____

Issuing Government Agency: _____

3. Are you currently or were you previously employed by a licensed community care facility? If yes, please indicate the facility name(s) and license number(s);

Yes No Facility Name: _____ License Number: _____

Facility Name: _____ License Number: _____

Facility Name: _____ License Number: _____

4. Have you been the subject of any administrative, legal or other action involving licensure, certification or other approvals as specified in (1), (2) or (3) above? If yes, please explain and provide dates. If additional space is needed, please attach to this application form.

Yes No

I declare under penalty of perjury that the foregoing information is true and correct to the best of my knowledge.

Applicant Signature (MANDATORY): _____

Date: _____

If you have any questions regarding this form, please contact the Community Care Licensing Division, Administrator Certification Section at (916) 653-9300.