ARKANSAS DEPARTMENT OF HUMAN SERVICES

**Division of Provider Services and Quality Assurance**

**Application for Nursing Home Administrators**

The information contained herein, together with all attached documents will be regarded as property of the Department. Release of this information is governed by the Freedom of Information Act.

Please indicate application type: New Applicant Reciprocity Applicant Previous Applicant

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **SECTION 1: PERSONAL INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | |
| Last Name |  | | | | | | First Name | | |  | | | | | | | | | Middle Initial | | | | |  |
| Mailing Address | |  | | | | | | | | | | | | | | | | | | | | | | |
| City | |  | | | | | | | | | | State | |  | | | Zip Code | | | | | |  | |
| Primary Telephone | |  | | | | | Cell | | Home | | | | Work | | | Date of Birth | | | | | |  | | |
| Email Address | |  | | | | | | | | | | | | | | Place of Birth (City, State) | | | | | |  | | |
| *Based on the Workforce Freedom Act of 2021, an occupational or professional licensing entity shall grant an occupational or professional license to an individual who fulfills the requirements of the occupation or profession in this state and is a person who holds a Federal Form I-766 United States Citizenship and Immigration Services-issued Employment Authorization Document, known as a “work permit.” Reference A.C.A.§17-1-110* | | | | | | | | | | | | | | | | | | | | | | | | |
| Are you a U.S. Citizen? | | | | Yes | | No | | | | I hold a Federal Form I-766 (please attach to application) | | | | | | | | | | | | | | |
| *The Arkansas Occupational Licensing of Uniformed Service Members, Veterans, and Spouses Act of 2021 removes occupational licensure barriers that may impede the launch and sustainability of civilian occupational careers and employment faced by uniformed service members, uniformed service veterans, and their spouses due to frequent uniformed service assignments. Reference A.C.A. §17-4-106* | | | | | | | | | | | | | | | | | | | | | | | | |
| Select military status, if applicable (please attach supporting documentation to application) | | | | | | | | | | | | | | | | | | | | | | | | |
| I am a uniformed service member stationed in the State of Arkansas.  I am a service veteran who resides in or establishes residency in the State of Arkansas and makes an application within one (1) year of discharge from uniformed service.  I am the spouse of:  a uniformed service member stationed in the State of Arkansas  a service veteran who resides in or establishes residency in the State of Arkansas  a uniformed service member who is assigned a tour of duty that excludes the uniformed service member’s spouse from accompanying the uniformed service member and the spouse relocates to the State of Arkansas; or  a uniformed service member who is killed or succumbs to injuries or illnesses in the line of dutyif the spouse establishes residency in the State of Arkansas | | | | | | | | | | | | | | | | | | | | | | | | |
| *The Workforce Expansion Act of 2021 allows a waiver option of initial licensing fees for indiviuals who receive assistance from the State of Arkansas. NOTE: The waiver of the initial fee does not include fees for a criminal background check, examination or testing fees, or a medical or drug test. Reference A.C.A. §17-5-104* | | | | | | | | | | | | | | | | | | | | | | | | |
| Select applicable assistance program, if applicable | | | | | | | | | | | | | | | | | | | | | | | | |
| Arkansas Medicaid Program  Supplemental Nutrition Assistance Program (SNAP)  Special Supplemental Nutrition Program for Women, Infants, and Children (SNAP-WIC)  Temporary Assistance for Needy Families Program (TANF)  Lifeline Assistance Program  Approved for unemployment within the last twelve (12) months  Income level that does not exceed two hundred percent (200%) of the federal poverty income guidelines (NOTE: to find federal poverty income guidelines, you can go to <https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines>) | | | | | | | | | | | | | | | | | | | | | | | | |
| If you are receiveing any of the above services, or qualify for a waiver under the above criteria, do you consent for DPSQA to complete a verification process of above selected services for your application? YES NO | | | | | | | | | | | | | | | | | | | | | | | | |
| **SECTION 2: RECIPROCITY STATUS** | | | | | | | | | | | | | | | | | | | | | | | | |
| *Per A.C.A. §20-10-406, applicants currently licensed as a Nursing Home Administrator in good standing within another state may be granted a nonrenewable temporary license not to exceed one hundred twenty (120) days upon condition of licensure fee payment and successfully passing the State of Arkansas licensure examination.* | | | | | | | | | | | | | | | | | | | | | | | | |
| Have you ever applied for a Nursing Home Administrator (NHA) license in another state? YES NO | | | | | | | | | | | | | | | | | | | | | | | | |
| Do you currently hold a NHA license, in good standing, in another state? YES NO | | | | | | | | | | | | | | | | | | | | | | | | |
| Please indicate which states and license number as applicable (please attach supporting documentation to application) | | | | | | | | | | | | | | | | | | | | | | | | |
| STATE OF NHA LICENSE | | | | | | | | | | | LICENSE NUMBER | | | | | | | | | | | | | |
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| Has your license, in any state listed above, ever been subject to discipline? YES NO | | | | | | | | | | | | | | | | | | | | | | | | |
| If yes, please explain and attach a copy of any settlement agreement, contract, etc. that you entered at the time of the discipline, if applicable: | | | | | | | | | | | | | | | | | | | | | | | | |
| Have you ever been denied licensure in another state? YES NO | | | | | | | | | | | | | | | | | | | | | | | | |
| If yes, please explain: | | | | | | | | | | | | | | | | | | | | | | | | |
| **SECTION 3: NURSING FACILITY EXPERIENCE** | | | | | | | | | | | | | | | | | | | | | | | | |
| Are you currently working in a nursing facility?  YES NO | | | | | | | | | Name of Facility: | | | | | | | | | | | | | | | |
| Position/Title: | | | | | | | | | | | | | | | |
| List Specific Job Duties: | | | | | | | | | | | | | | | | | | | | | | | | |
| Have you previously worked in a nursing facility? YES NO | | | | | | | | | | | | | | | | | | | | | | | | |
| Please enter information on facilities you have previously worked. Print additional pages if necessary. | | | | | | | | | | | | | | | | | | | | | | | | |
| Name of Facility: | | | | | | | | | | | | | | | | | | | | | | | | |
| Facility Address: | | | | | | | | | City/State/Zip: | | | | | | | | | | | | | | | |
| Position/Title: | | | | | | | | | Employment Dates: | | | | | | | | | | | | | | | |
| List Specific Job Duties: | | | | | | | | | | | | | | | | | | | | | | | | |
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| Name of Facility: | | | | | | | | | | | | | | | | | | | | | | | | |
| Facility Address: | | | | | | | | | City/State/Zip: | | | | | | | | | | | | | | | |
| Position/Title: | | | | | | | | | Employment Dates: | | | | | | | | | | | | | | | |
| List Specific Job Duties: | | | | | | | | | | | | | | | | | | | | | | | | |
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| Name of Facility: | | | | | | | | | | | | | | | | | | | | | | | | |
| Facility Address: | | | | | | | | | City/State/Zip: | | | | | | | | | | | | | | | |
| Position/Title: | | | | | | | | | Employment Dates: | | | | | | | | | | | | | | | |
| List Specific Job Duties: | | | | | | | | | | | | | | | | | | | | | | | | |
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| Name of Facility: | | | | | | | | | | | | | | | | | | | | | | | | |
| Facility Address: | | | | | | | | | City/State/Zip: | | | | | | | | | | | | | | | |
| Position/Title: | | | | | | | | | Employment Dates: | | | | | | | | | | | | | | | |
| List Specific Job Duties: | | | | | | | | | | | | | | | | | | | | | | | | |
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| Name of Facility: | | | | | | | | | | | | | | | | | | | | | | | | |
| Facility Address: | | | | | | | | | City/State/Zip: | | | | | | | | | | | | | | | |
| Position/Title: | | | | | | | | | Employment Dates: | | | | | | | | | | | | | | | |
| List Specific Job Duties: | | | | | | | | | | | | | | | | | | | | | | | | |
| **SECTION 4: EMPLOYMENT HISTORY** | | | | | | | | | | | | | | | | | | | | | | | | |
| Please provide your experience for the ten (10) year period prior to this application. Do not duplicate the information in Section 3 above. Print additional pages if necessary. | | | | | | | | | | | | | | | | | | | | | | | | |
| Name of Organization: | | | | | | | | | | | | | | | | | | | | | | | | |
| Address: | | | | | | | | | City/State/Zip | | | | | | | | | | | | | | | |
| Position/Title: | | | | | | | | | Name/Title of Supervisor: | | | | | | | | | | | | | | | |
| Employment Dates: | | | | | | | | | Reason for Leaving: | | | | | | | | | | | | | | | |
| List Specific Job Duties: | | | | | | | | | | | | | | | | | | | | | | | | |
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| Name of Organization: | | | | | | | | | | | | | | | | | | | | | | | | |
| Address: | | | | | | | | | City/State/Zip | | | | | | | | | | | | | | | |
| Position/Title: | | | | | | | | | Name/Title of Supervisor: | | | | | | | | | | | | | | | |
| Employment Dates: | | | | | | | | | Reason for Leaving: | | | | | | | | | | | | | | | |
| List Specific Job Duties: | | | | | | | | | | | | | | | | | | | | | | | | |
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| Name of Organization: | | | | | | | | | | | | | | | | | | | | | | | | |
| Address: | | | | | | | | | City/State/Zip | | | | | | | | | | | | | | | |
| Position/Title: | | | | | | | | | Name/Title of Supervisor: | | | | | | | | | | | | | | | |
| Employment Dates: | | | | | | | | | Reason for Leaving: | | | | | | | | | | | | | | | |
| List Specific Job Duties: | | | | | | | | | | | | | | | | | | | | | | | | |
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| Name of Organization: | | | | | | | | | | | | | | | | | | | | | | | | |
| Address: | | | | | | | | | City/State/Zip | | | | | | | | | | | | | | | |
| Position/Title: | | | | | | | | | Name/Title of Supervisor: | | | | | | | | | | | | | | | |
| Employment Dates: | | | | | | | | | Reason for Leaving: | | | | | | | | | | | | | | | |
| List Specific Job Duties: | | | | | | | | | | | | | | | | | | | | | | | | |
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| Name of Organization: | | | | | | | | | | | | | | | | | | | | | | | | |
| Address: | | | | | | | | | City/State/Zip | | | | | | | | | | | | | | | |
| Position/Title: | | | | | | | | | Name/Title of Supervisor: | | | | | | | | | | | | | | | |
| Employment Dates: | | | | | | | | | Reason for Leaving: | | | | | | | | | | | | | | | |
| List Specific Job Duties: | | | | | | | | | | | | | | | | | | | | | | | | |
| **SECTION 5: EDUCATIONAL RECORD** | | | | | | | | | | | | | | | | | | | | | | | | |
| *Per A.C.A. §20-10-403, success applicants must present satisfactory evidence of sufficient education, training, or experience; satisfactorily completed a course of instruction and training prescribed by the Department; or participated for one (1) year in an administrator-in-training- program approved by the Department.* | | | | | | | | | | | | | | | | | | | | | | | | |
| Please select the appropriate educational experience and attach supporting documentation and official transcripts to the application. | | | | | | | | | | | | | | | | | | | | | | | | |
| Baccalureate degree (BS or BA) or higher in Health Care Administration (HCA) or Long Term Care Administration (LTCA) with an internshp in a nursing home.  Baccalureate degree (BS or BA) in Health Care Administration (HCA) or Long Term Care Administration (LTCA) without an intership, plus three (3) months experience in a nursing home  Baccalureate degree (BS or BA) or higher in Nursing or Business which included basic core requirements (minmum 15 semester hours) in accounting, management, personnel, writing, and resident care, plus three (3) months intership or experience in nursing home  Baccalureate degree (BS or BA) or higher in other field which included basic core requirements (minmum 15 semester hours) in accounting, management, personnel, writing, and resident care, plus three (3) months internship or experience in nursing home  Associates degree in Health Care Adminstration (HCA) or Long Term Care Administration (LTCA) or an RN with associate degree or diploma which included basic core requirements (minmum 15 semester hours) in accounting, management, personnel, writing, and resident care, plus six (6) months internship or experience in a nursing home  Associates degree in other field which included basic core requirements (minmum 15 semester hours) in accounting, management, personnel, writing, and resident care, plus one (1) year internship or experience in a nursing home  Completion of one (1) year of a Department approved or adminstered Administrator-In-Training Program | | | | | | | | | | | | | | | | | | | | | | | | |
| Please complete the following educational record as applicable to your selection | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | HIGH SCHOOL | | | | | | COLLEGE | | | | | | | GRADUATE SCHOOL | | | | | OTHER | | | | |
| Name | |  | | | | | |  | | | | | | |  | | | | |  | | | | |
| Location | |  | | | | | |  | | | | | | |  | | | | |  | | | | |
| Dates of Attendance | |  | | | | | |  | | | | | | |  | | | | |  | | | | |
| Grades,Years, or Hours Completed | |  | | | | | |  | | | | | | |  | | | | |  | | | | |
| Type of Degree, Diploma, Certificate and Year Received | |  | | | | | |  | | | | | | |  | | | | |  | | | | |
| Field of Study | |  | | | | | |  | | | | | | |  | | | | |  | | | | |
| Please complete the basic core requirements information as applicable to your selection | | | | | | | | | | | | | | | | | | | | | | | | |
| CORE AREA | | | LIST COURSE NAME, WORKSHOP/SEMINAR, OR EXPERIENCE IN EACH AREA | | | | | | | | | | | | | | | | | | | | | |
| Accounting/Bookkeeping | | |  | | | | | | | | | | | | | | | | | | | | | |
| Management/Supervision | | |  | | | | | | | | | | | | | | | | | | | | | |
| Personnel | | |  | | | | | | | | | | | | | | | | | | | | | |
| Writing Skills | | |  | | | | | | | | | | | | | | | | | | | | | |
| Resident Care | | |  | | | | | | | | | | | | | | | | | | | | | |
| Please complete the AIT Program information as applicable to your selection | | | | | | | | | | | | | | | | | | | | | | | | |
| Name of AIT Program: | | | | | | | | | | | | | | | | | | | | | | | | |
| Program Location: | | | | | | | | | | | | | | | | | | | | | | | | |
| Program Begin Date: | | | | | | | | | | | Program End Date: | | | | | | | | | | | | | |
| Please include any additional licenses or certifications relevant to your application, if appliable | | | | | | | | | | | | | | | | | | | | | | | | |
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| **SECTION 6: REFERENCES** | | | | | | | | | | | | | | | | | | | | | | | | |
| Applicants must provide at least three (3) professional references, non-relatives, who have first-hand knowledge of the applicant’s character, work experience, conduct and abilities. Applicant must attach a Letter of Reference from each to the application. | | | | | | | | | | | | | | | | | | | | | | | | |
| NAME | | | | | ADDRESS | | | | | | HOW LONG HAVE THEY KNOWN YOU | | | | | | | PHONE NUMBER | | | | | | |
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| **SECTION 7: BACKGROUND** | | | | | | | | | | | | | | | | | | | | | | | | |
| Have you ever been convicted for any violation of any law other than minor traffic violation? YES NO | | | | | | | | | | | | | | | | | | | | | | | | |
| If yes, please explain the offense(s), charge(s), date(s), and disposition of the case(s) | | | | | | | | | | | | | | | | | | | | | | | | |
| Do you have any substantiated history of exclusion from Medicare or Medicaid programs? YES NO | | | | | | | | | | | | | | | | | | | | | | | | |
| *Per A.C.A. §17-3-102, an individual is not eligible to receive or hold a license issued by the licensing entity if that individual has plead guilty or nolo contendere to or been found guilty of offense noted within the statute by any court in the State of Arkansas or of any similar offense by a court in another state or of any similar offense by a federal court, unless the conviction was lawfully sealed under the Comprehensive Criminal Record Sealing Act of 2013.* | | | | | | | | | | | | | | | | | | | | | | | | |
| Have you been plead guilty, nolo contendere or been found guilty of any offense noted below? YES NO  **(1)** Capital murder;  **(2)** Murder in the first degree and second degree;  **(3)** Manslaughter;  **(4)** Negligent homicide;  **(5)** Kidnapping;  **(6)** False imprisonment in the first degree;  **(7)** Permanent detention or restraint;  **(8)** Robbery;  **(9)** Aggravated robbery;  **(10)** Battery in the first degree;  **(11)** Aggravated assault;  **(12)** Introduction of a controlled substance into the body of another person;  **(13)** Aggravated assault upon a law enforcement officer or an employee of a correctional facility, if a Class Y felony;  **(14)** Terroristic threatening in the first degree;  **(15)** Rape;  **(16)** Sexual indecency with a child;  **(17)** Sexual extortion;  **(18)** Sexual assault in the first degree, second degree, third degree, and fourth degree;  **(19)** Incest;  **(20)** Offenses against the family;  **(21)** Endangering the welfare of an incompetent person in the first degree;  **(22)** Endangering the welfare of a minor in the first degree;  **(23)** Permitting the abuse of a minor;  **(24)** Engaging children in sexually explicit conduct for use in visual or print media, transportation of minors for prohibited sexual conduct, pandering, or possessing visual or print media depicting sexually explicit conduct involving a child, or use of a child or consent to use of a child in a sexual performance by producing, directing, or promoting a sexual performance by a child;  **(25)** Computer child pornography;  **(26)** Computer exploitation of a child in the first degree;  **(27)** Felony adult abuse;  **(28)** Theft of property;  **(29)** Theft by receiving;  **(30)** Arson;  **(31)** Burglary;  **(32)** Felony violation of the Uniform Controlled Substances Act, § 5-64-101 et seq;  **(33)** Promotion of prostitution in the first degree;  **(34)** Stalking;  **(35)** Criminal attempt, criminal complicity, criminal solicitation, or criminal conspiracy | | | | | | | | | | | | | | | | | | | | | | | | |
| **CONSENT AND ACKNOWLEDGEMENTS** | | | | | | | | | | | | | | | | | | | | | | | | |
| By initialing next to each, you consent or attest to the statement | | | | | | | | | | | | | | | | | | | | | | | | |
| I agree to have and pay for a criminal background check as part of my application review.  I have read Arkansas Code Ann. § 20-10-401 *et. seq.* and the Rules and Regulations promulgated thereunder entitled “Rules and Regulations for the Licensure of Nursing Home Administrators.”  This application and all attached documents contain no willful misrepresentation of falsification, and the information given by me is true and complete to the best of my knowledge and belief. I am aware that should investigation by the Department disclose any such misrepresentations or falsifications, it may prevent me from becoming licensed or, if I am already licensed, cause my license as a nursing home administrator to be revoked. | | | | | | | | | | | | | | | | | | | | | | | | |
| **APPLICANT SIGNATURE AND NOTARIZATION** | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Siganature of Applicant (ink or indelible pencil)** | | | | | | | | | | | **Signature Date** | | | | | | | | | | | | | |
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| Sworn to and subscribed before me by the above this \_\_\_\_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_\_\_\_  **Notary Public** | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | |  | | | | | | | | |  | | | |
| **Signature** | | | | | | | | | | | | **County** | | | | | | | | | **State** | | | |
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| **Date My Commission Expires** | | | | | | | | | | | | |

The Americans with Disabilities Act ensures that any person with disabilities will be afforded reasonable accommodations for testing and/or examination purposes. If you have a disability and may require some accommodations in taking examinations, you must request a "Request for Accommodation" form to be filed along with this application. If accommodations are not requested forty-five (45) days in advance, we cannot guarantee the availability of accommodation on site. Contact the Office of Long-Term Care for the "Request for Accommodation" form.

If you are requesting consideration of your application for reciprocity under Section IV, Number 5 of this application, please submit the following documentation:

* + - * Form 9110AR- Out of State Employment Verification for AR Registry Renewal
      * Form DD214-DD 214/Separation Documents
      * Form APPS 6- Interstate Transfer Form/NHA Reciprocity Request.
      * Image/copy of individuals social security card
      * Image/copy of valid US government issued photo identification; and
      * Proof of service education, training, experience, and service-issued credentials by means of a Joint Service Transcript (JST).

The Department may require evidence of completion of continuing education before granting a subsequent NHA licensure or authorizing the renewal of a NHA licensure to allow full or partial exemption from continuing education requirements.

Approved Denied AIT

**OFFICE USE ONLY** Based on

Date Reviewed By