FOR OFFICE USE ONLY
Application Approved:
License Number:
Issue Date:
ID#:
Receipt #:

Rhode Island Department of Health
Room 104
3 Capitol Hill
Providence, RI 02908-5097

Instructions and Application For

License As An

Assisted Living Residence Administrator

☐ By Examination ☐ By Endorsement

☐ By Rhode Island Nursing Home Administrator License

MILITARY STATUS ELIGIBILITY *(Documentation Required) see instructions*

Please check ONE of the following criteria for expedited application:

- ☐ I am in active military duty or a reservist
- ☐ I am a military veteran with honorable discharge
- ☐ I am the spouse of someone in active military duty or the spouse of a reservist

Applicant - Print Name

LAST NAME	***FIRST NAME***	***MI***

Phone: (401) 222-2828 **TTY/TDD: (800) 745-5555** **Fax: (401) 222-1272**

Revised 10/26/2018 jcp

LICENSURE REQUIREMENTS

By Examination

☐ Completed Application with Cover Page - Applications are valid for 1 year from the day they are received at RIDOH. If you are not licensed within the year you must submit a new application.

☐ Check or money order (preferred), made payable (in U.S. funds only) to the RI General Treasurer in the amount of **$220.00** and attached to the upper left-hand corner of the first (Top) page of the application. THIS APPLICATION FEE IS NONREFUNDABLE.

☐ **Original** BCI check from the RI Attorney General's Office; if positive BCI, a detailed explanation is required.

☐ Completion of a Department approved training program, which includes:

- RIALA's Certificate,
- RIALA's letter with examination results, and
- AIT Certification Form, for 80 hours field experience within a 12 month period in a RI licensed ALR facility; **OR**

☐ Completion of Degree in health care-related field, which includes:

- Official school transcript(s), with registrar's signature and school seal
- Examination results, and
- AIT Certification Form, for 80 hours field experience within a 12 month period in a RI licensed ALR facility; **OR**

☐ Active Rhode Island Nursing Home Administrator license in good standing.
NHA Number _____

☐ Two original letters of good moral character on company letterhead.

By Endorsement

☐ Completed Application with Cover Page - Applications are valid for 1 year from the day they are received at RIDOH. If you are not licensed within the year you must submit a new application.

☐ Check or money order (preferred), made payable (in U.S. funds only) to the RI General Treasurer in the amount of **$220.00** and attached to the upper left-hand corner of the first (Top) page of the application. THIS APPLICATION FEE IS NONREFUNDABLE.

☐ A brief history of prior experience in Assisted Living or related industry.

☐ **Original** BCI check from the RI Attorney General's Office; if positive BCI, a detailed explanation is required.

☐ Official school or training transcript(s), with registrar's signature and school seal;

☐ Two original letters of good moral character on company letterhead;

☐ If you have ever been licensed in another state, license verification(s) must be sent directly from the state(s) in which you hold or have held a license. (Interstate Verification Form included in this application can be used for that pur pose)

☐ If applying for expedited military status you must include one of the following: Leave Earning Statement (LES), Letter from Command, Copy of Orders or DD-214 showing honorable discharge.

Licensure Information

Please visit the RIDOH website at **http://www.health.ri.gov/licenses** to Verify your license, download Rules and Regualtions/Laws for your profession, download change of address forms, other licensing forms or obtain our contact information. HEALTH will not, for any reason, accelerate the processing of one applicant at the expense of others.

License Certificates

RIDOH will be providing wallet license cards ONLY on issuance of licenses. If you wish to receive a license certificate, suitable for framing, please check the box below and attach a separate check in the amount of $30.00 made payable to RI General Treasurer.

☐ I would like to receive a license certificate. I have enclosed a separate check in the amount of $30.00

State of Rhode Island

Application for License as an Assisted Living Residence Administrator

Refer to the Application Instructions when completing these forms. Type or block print only. Do not use felt-tip pens.

1. Name(s)

This is the name that will be printed on your License/Certificate.

Title (i.e., Mr., Mrs., Ms., etc.)

First Name

Middle Name

Surname, (Last Name)

Suffix (i.e., Jr., Sr., II, III)

Maiden, if applicable

Name(s) under which originally licensed in another state, if different from above (First, Middle, Last).

2. Social Security Number

U.S. Social Security Number

"Pursuant to Title 5, Chapter 76, of the Rhode Island General Laws, as amended, I attest that I have filed all applicable tax returns and paid all taxes owed to the State of Rhode Island, and I understand that my Social Security Number (SSN) will be transmitted to the Divison of Taxation to verify that no taxes are owed to the State."

3. Gender

Male Female X Choose Not To Answer

4. Date of Birth

Month Day Year

5. Home Address

It is your responsibility to notify HEALTH of all address changes.

1st Line Address (Apartment/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City State Zip Code

Country, If NOT U.S. Postal Code, If NOT U.S.

Home Phone Home Fax

Email Address

6. Business Address (ONLY if it is RELATED to your license.)

It is your responsibility to notify HEALTH of all address changes.

This address will appear on the Health web site.

Name of Business/Work Location

1st Line Address (Department/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City State Zip Code

Country, If NOT U.S. Postal Code, If NOT U.S.

Business Phone Extension Business Fax

Applicant: Print your complete last name >

7. Preferred Mailing Address

Please check ONE

☐ Please use my **Home Address** as my preferred mailing address

☐ Please use my **Business Address** as my preferred mailing address

8. Qualifying Education

Please list the name and information about the school that you attended that qualifies you for this license.

Type of School (University, College, Technical School, etc.)

Name of School

Date Graduated: Month Year

Degree Received (Bachelor of Arts, Master of Science, Diploma, etc.)

9. Other State License(s)

Please answer the question and list state(s), if applicable

Have you ever held, or do you currently hold, a license in another state? ☐ Yes ☐ No

If the answer to this question is ***"yes"***, enter all other state licenses in Question 10 (below):

10. Licensure

List all states or countries in which you are now, or ever have been licensed to practice your profession.

State/Country:			State/Country:		
_____	☐ Active	☐ Inactive	_____	☐ Active	☐ Inactive
_____	☐ Active	☐ Inactive	_____	☐ Active	☐ Inactive
_____	☐ Active	☐ Inactive	_____	☐ Active	☐ Inactive

11. Criminal Convictions

Respond to the question at the top of the section, then list any criminal conviction(s) in the space provided.

If necessary, you may continue on a separate 8½ x 11 sheet of paper

Have you ever been convicted of a violation, plead Nolo Contendere, or entered a plea bargain to any federal, state or local statute, regulation, or ordinance or are any formal charges pending? ☐ Yes ☐ No

Abbreviation of State and Conviction[1] (e.g. CA - Illegal Possession of a Controlled Substance):

	Month	Year
_____		
_____		
_____		

12. Disciplinary Questions

Check either Yes or No for each question.

1. Has any Health Professional license, certificate, registration, or permit you hold or have held, been disciplined, or are formal charges pending? ☐ Yes ☐ No

2. Have you ever been denied a license, certificate, registration or permit in any state? ☐ Yes ☐ No

Note: If you answer "Yes" to any question, you are **required** to furnish complete details, including date, place, reason and disposition of the matter. You may use a separate sheet of paper.

13. Affidavit of Applicant

Complete this section and sign.

I, _____, being first duly sworn, depose and say that I the person referred to in the foregoing application and supporting documents.

I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice as an Assisted Living Residence Administrator in the State of Rhode Island.

I understand that this is a continuing application and that I have an affirmative duty to inform HEALTH of any change in the answers to these questions after this application and this affidavit is signed.

_____ _____

Signature of Applicant Date of Signature (MM/DD/YY)

_____ _____

Name of Notary (Print, Type or Stamp) Signature of Notary

_____ _____

Notary No./Commission No. Commission Expiration Date (MM/DD/YY)

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ALRA Field Experience Hourly Tracking

Please Note: If you are training at multiple facilites, you will need to submit this form in addition to the signed and notarized AIT Certification Form (page 8) from each training Administrator in order to receive credit for your internship hours.

Date	Department	# of Hours	Residence	Admin. Signature
Sub Total				

Substitute forms are not acceptable, copy this form as needed.

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Documentation of Eighty (80) Hours of Field Experience

(AIT Certification Form)

Print/Type Applicant's Full Name _____ Social Security Number _____ Date of Birth _____

R23-17.4-ALA "Rules and Regulations for the Certification of Administrators of Assisted Living Residences" - Section 3.0, "Qualifications for Licensure" - requires successful completion of a degree in a health-care related field from an accredited College or University ***and*** *requires satisfactory completion of a field experience of at least eighty (80) hours, within a twelve (12) month period, in a training capacity in a licensed assisted living/nursing facility that shall include training in the following areas: Administration, Nursing, Activities Department, Admissions, Human Resources, Business Office, Dietary Department, Environment/Maintenance and Housekeeping/ Laundry. At the conclusion of the field experience, the administrator of the licensed assisted living/nursing facilty where the field experience was performed must attest that the training included each area.*

I hereby attest that _____ has satisfactorily completed eighty (80) hours of Field Experience in the following areas:

Number of Hours		Number of Hours		Number of Hours	
☐	**Administration**	☐	**Nursing**	☐	**Human Resources**
☐	**Activities Department**	☐	**Admissions**		
☐	**Dietary Department**	☐	**Environment/Maintenance**		
☐	**Housekeeping/Laundry**	☐	**Business Office**		
☐	**Other, Explain:** _____				
☐	**Total number of hours in AIT Training Program (if hours are obtained at more than one facility, please make photocopies of this form)**				

_____
Name of Rhode Island Assisted Living Residence Facility

_____ _____
Signature of Rhode Island Assisted Living Residence Administrator Print or Type Name of ALRA

_____ _____
Date of Signature RI ALRA License Number

The foregoing instrument was acknowledged before me this _____ day of _____, 20_____, by _____, who is personally known to me or has produced _____ as documentation and did / did not take an oath.

_____ _____
Name of Notary (Print, Type or Stamp) Signature of Notary

Notary Seal

_____ _____
Notary No/Commission No. Commission Expiration Date (MM/DD/YY)

Substitute forms are not acceptable, copy this form as needed.

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INTERSTATE VERIFICATION FORM - OTHER STATE LICENSE(S)

I am applying for a license to practice as an Assisted Living Residence Administrator in the State of Rhode Island. The Rhode Island Board of Assisted Living Residence Administrator Certification requires that the following form be completed by the jurisdiction(s) in which I hold or have held a license. This constitutes authority for you to release all information in your files, favorable or otherwise, directly to the Rhode Island Board of Assisted Living Residence Administrator Certification at the above address.

Print/Type Full Name _____ Signature _____ Date _____

Previous Names Used _____ Social Security Number _____ Date of Birth _____

License Number _____ Date Issued _____

THIS SECTION TO BE COMPLETED BY THE ASSISTED LIVING RESIDENCE BOARD

Assisted Living Residence Administrator Program Completed:	**Location:**	**Graduation Date:**

Licensed by Examination? ☐ Yes ☐ No	**Applicant has completed and passed the National Certification Exam:** ☐ Yes ☐ No

License Status: ☐ Active ☐ Inactive ☐ Lapsed	**Original Date Issued:**	**Expiration Date:**

Questions:

1. Has this licensee ever been investigated by your Board? ☐ Yes ☐ No
2. Has this licensee incurred any disciplinary proceedings in your state, or is any action pending? ☐ Yes ☐ No
3. Has the applicant's license ever been denied, surrendered, reprimanded, suspended, revoked or placed on probation? ☐ Yes ☐ No
4. Do you know of any information that may discredit this person? ☐ Yes ☐ No

If you answer "Yes" to questions 1-4, please provide a written explanation below, and attach a copy of all supporting documentation (e.g., Board order, complaint, etc.).

_____

_____

_____

Certification:

Signature _____ Date _____

Type or Print Name _____

Title _____

Full Name and State of Licensing Board _____

Please Affix
Board Seal Here

Please return directly to HEALTH at the above address. Thank you for your prompt cooperation.