

**MAINE DEPARTMENT OF HEALTH AND HUMAN SERVICES
APPLICATION FOR CHANGE OF ADMINISTRATOR
ASSISTED HOUSING PROGRAMS**

PLEASE COMPLETE AND RETURN TO:

**Division of Licensing and Regulatory Services
Community Services Programs
State House Station # 11
41 Anthony Avenue
Augusta, ME 04333**

For Agency Use Only

SBI _____ **Prog. Spec.** _____
H.F.S. _____

- 1) THIS APPLICATION FORM MUST BE COMPLETE OR THE APPROVAL PROCESS COULD BE DELAYED.
- 2) FOR LEVELS I, II, III, AND IV RESIDENTIAL CARE FACILITIES **RETURN THIS APPLICATION AND RELATED DOCUMENTS, AND TWO (2) ADDITIONAL COPIES** TO THE ADDRESS ABOVE. FOR ASSISTED LIVING PROGRAMS **RETURN THIS FORM AND (1) ADDITIONAL COPY** TO THE ADDRESS ABOVE.
- 3) THIS APPLICATION MUST BE ACCOMPANIED BY THREE (3) LETTERS OF REFERENCE.
- 4) A RESUME MAY BE SUBMITTED IN LIEU OF COMPLETING THE SECTIONS ON EDUCATION, EXPERIENCE & EMPLOYMENT.
- 5) THIS APPLICATION MUST BE ACCOMPANIED WITH A **CHECK FOR THE AMOUNT OF \$ 31.00**. MAKE CHECKS PAYABLE TO: TREASURER STATE OF MAINE

FACILITY IDENTIFICATION: Level I _____ Level II _____ Level III _____ Level IV _____ (See Section 2.49)
 Level I (PNMI) _____ Level II (PNMI) _____ Level III (PNMI) _____ Level IV (PNMI) _____ (See Section 2.40)
 Assisted Living: Type I _____ Type II _____ (See Section 2.8)

Name of Facility _____

Mailing Address of Facility _____ Zip _____

Phone Number _____ 2nd Phone _____ FAX NUMBER _____

E-Mail Address _____

ADMINISTRATOR:

First Middle Last

(home address) Street Town State Zip Code

Phone Number Date of Birth Social Security Number

INDICATE OTHER NAMES KNOWN BY (I.E., MAIDEN NAME, ALIASES) _____

EDUCATION OF ADMINISTRATOR:

School Name	City/State	Last Grade Completed	Degree	Year

SPECIAL QUALIFICATIONS: (Enclose Copy of all pertinent Credentials)

Multi-Level Administrator's License Residential Care Administrator's License
 Registered Professional Nurse Licensed Practical Nurse
 Certified Nurse Aide Certified Residential Medication Aide
 Sign Language Other Language(s) Spoken _____
 CPR Resident Care Specialist I certified
 Personal Support Specialist Direct Support Specialist

Other (explain): _____

OTHER RELEVANT EXPERIENCE: Describe previous paid, volunteer, or family experiences or training in working with elderly or disabled populations. (Attach separate sheet, if necessary)

The following questions are used to help evaluate the safety and security of residents/consumers who will be living in the facility. Issues in the following areas do not automatically mean a license will be denied.

1) Have you ever been convicted of a criminal offense? _____

If so, explain. _____

2) Have you (or an employer, if applicable) ever had a license for any long term care facility denied, suspended or revoked in this state or any other state? _____

If so, by whom? Please explain. _____

3) Have you ever been *investigated* for child abuse or adult abuse? _____

If so, explain. _____

4) Have you ever been treated for drug/alcohol abuse? _____

If so, explain. _____

5) Have you ever been an inpatient in a mental health facility? _____

If so, explain. _____

EMPLOYMENT HISTORY:

Give last five years' employment history (attach separate sheet if necessary):

<u>Name and Address of Employer</u>	<u>Job Responsibilities</u>	<u>Dates</u> <u>From</u>	<u>To</u>	<u>Reasons For Leaving</u>

DATE OF HIRE OF NEW ADMINISTRATOR: _____

The Department of Health and Human Services reserves the right to request/review any additional information that will be necessary to determine the suitability of the applicant for administrator.

I, _____, being duly authorized to assume responsibility for the conduct of the assisted living facility herein described, do hereby certify that the above information is true and correct to the best of my knowledge. I/We understand that the signing of this application effectively serves as a release of information and gives permission to the Department to obtain any criminal history and Bureau of Motor Vehicle record which may be on file in any county or state office.

Signature of Owner: _____ Date: _____

Signature of Proposed Administrator: _____ Date: _____

I have received a copy of the regulations governing the facility which I will be administering and have reviewed the requirements of these regulations.

Signature of Proposed Administrator: _____

REFERENCES - INCLUDE THREE (3) WRITTEN LETTERS OF REFERENCE FOR THE PROPOSED ADMINISTRATOR FROM PERSONS WHO ARE NOT RELATED BY BLOOD OR MARRIAGE. THE QUESTIONNAIRE BELOW NEEDS TO BE COPIED AND GIVEN TO REFERENCES TO COMPLETE.

REFERENCE FOR ASSISTED HOUSING PROVIDERS

Name of Proposed Administrator: _____

Name of Facility: _____

Please respond to the following questions (use the back of this sheet, if necessary):

1. How long have you known the applicant?
2. In what capacity do you know this person?
3. Are you familiar with this person’s experiences in serving people who are elderly or disabled? If yes, please describe.
4. Describe this person’s ability to give care and services to people who are elderly or disabled.
5. Describe this person’s strengths and weaknesses in the following areas:
 - A. Coping with problems and stress:
 - B. Working with other people:
 - C. Decision-making:
 - D. Communication and listening skills:
 - E. Ability to work with outside resources such as social workers, medical professionals, state agencies, friends and families of residents/consumers, etc.:
6. Do you have any concerns about this person’s ability to work in an Assisted Housing Program?
 Yes No
7. Do you recommend that this person be given the opportunity to work in or operate an Assisted Housing Program?
 Yes No
8. Additional comments:

Reference Information

Name of person completing form: _____ Occupation: _____

Home address: _____ Telephone: _____

Signature: _____