



**STATE OF MAINE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF LICENSING AND REGULATORY SERVICES**

**Adult Day Services Program
Change of Administrator Application**

SECTION 1: Program Information			
Program Name:			
Mailing Address:			
City:	State:	Zip:	County:
Physical Address:			
City:	State:	Zip:	County:
Telephone No.: ()		Fax No.: ()	
Email Address:			

SECTION 2: Fees	
APPLICATION FOR ADULT DAY SERVICES PROGRAM	
Background Check: <input type="checkbox"/> Administrator (fee \$31)	
Total Fee Enclosed for background checks	\$ _____
Make check or money order payable to "Treasurer, State of Maine". Do not send Cash. Credit Cards are not accepted at this time.	
Total Check/Money Order enclosed =	\$ _____

For questions regarding this program and/or application, please contact the following:

Department of Health and Human Services
 Licensing and Regulatory Services
 Adult Day Services Program
 41 Anthony Ave; 11 State House Station
 Augusta, ME 04333-0011

Tel: (207) 287-9300 Fax: (207) 287-2671 Toll Free: 1-800-791-4080 TTY users call Maine relay 711
 Email: dlrs.info@maine.gov

<i>Office Use Only:</i>			
Check# _____	MO # _____	Amount \$ _____	Initials: _____ License# _____
SBI _____	Prog. Spec _____	HFS _____	

SECTION 3: Program Administrator Information (to be completed by the Administrator)
A Résumé may be submitted in lieu of completing the sections on education, experience and employment.

Legal Name: _____ Date of Hire: _____

Familiar Names (i.e. maiden name, aliases): _____

Home Address: _____

City: _____ State: _____ Zip: _____ County: _____

Date of Birth: _____ Social Security Number: _____

Telephone No.: () _____ Fax No.: () _____

Email Address: _____

Education:

School Name	City/State	Last Grade Completed	Degree	Year
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Special Qualifications: Enclose a copy of all pertinent credentials.

Please check all that apply:

<input type="checkbox"/> Multi-Level Administrator's License	<input type="checkbox"/> Licensed Practical Nurse
<input type="checkbox"/> Registered Professional Nurse	<input type="checkbox"/> Certified Residential Medication Aide
<input type="checkbox"/> Certified Nurse's Aide	<input type="checkbox"/> Residential Care Specialist I certified
<input type="checkbox"/> Sign Language	<input type="checkbox"/> Direct Support Specialist
<input type="checkbox"/> Other Spoken Language: _____	<input type="checkbox"/> Personal Support Specialist
<input type="checkbox"/> CPR	<input type="checkbox"/> Other, explain: _____
<input type="checkbox"/> Residential Care Administrator's License	

Employment History: Provide the last five (5) years of employment history (attach separate sheet if necessary).

Name and Address of Employer	Job Responsibilities	Dates From To	Reason(s) for Leaving
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Other Relevant Experience:

Describe previous paid, volunteer, or family experiences or training in working with elderly or disabled populations. (use back of page, if necessary). _____

Safety and Security

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

Have you ever been convicted of a criminal offense?

- No
- Yes, please explain: _____

Have you ever had a license for any long term care facility, assisted housing program (including residential care facilities and assisted living programs) denied, suspended, or revoked in this state or any other state?

- No
- Yes, please explain: _____

Have you been investigated for child or adult abuse, neglect and/or exploitation?

- No
- Yes, please explain: _____

Have you ever been treated for drug/alcohol abuse?

- No
- Yes, please explain: _____

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

- No
- Yes, please explain: _____

Professional References: Submit attached completed references with application.

Name	Address	Daytime Telephone
_____	_____	_____
_____	_____	_____
_____	_____	_____

SECTION 4: Submission

Submit your completed application, the following additional information and one (1) copy of your application and additional information:

- A copy of the Administrator's Résumé, if not completing the education, experience and employment sections.
- Three (3) written references for the applicant and administrator from persons who are not related by blood or marriage (Please see attached questionnaire for completion by references)
- A copy of all pertinent credentials for the Administrator

Failure to submit the required information will delay the processing of your application.

SECTION 5: Declaration

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 licensure.

- The provider certifies that all information contained in this application is true and correct to the best of his/her knowledge.
- I/We, being duly authorized to assume responsibility for the Adult Day Services Program 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 criminal history and Bureau of Motor Vehicle records, which may be on file in any county or state office.

Print name of Applicant/Provider

Signature of Applicant/Provider

Date

Print name of Proposed Administrator

Signature of Proposed Administrator

Date

Reference Form for Adult Day Services Program Providers

Name of Proposed Administrator/Applicant: _____

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/administrator: _____
2. In what capacity do you know this applicant/administrator: _____

3. Are you familiar with this person's experiences in serving people who are elderly or disabled?
 No
 Yes, Please describe: _____

4. Describe this person's ability to give care and services to people who are elderly or disabled: _____

5. Describe this applicant's/administrator'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 resident, etc. : _____

2. Do you have any concerns about this person's ability to work in or operate an Adult Day Services Program?
 No
 Yes, please explain: _____
2. Do you recommend that this person be given the opportunity to work in or operate an Adult Day Services Program?
 Yes
 No, please explain: _____
3. Additional Comments: _____

Reference Information

Name of person completing this form: _____ Telephone: _____

Home Address: _____

Occupation: _____

Signature of Reference

Date