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

Assisted Housing 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 ASSISTED HOUSING PROGRAM	
Background Check: ☐ 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

Office Use Only:
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:

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

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 two (2) copies 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**