

## VENDOR APPLICATION/RENEWAL ADMINISTRATOR CERTIFICATION PROGRAM

**Instructions:** To apply to become (or to renew as) a course vendor for this Program, submit this completed application and a check or money order for the applicable processing fee to CDSS, ACS, 744 "P" Street, MS 9-14-47, Sacramento, CA 95814. Submit a separate vendor application and check or money order for each type of program (ARF, GH, RCFE) and vendorship (ICTP or CEU).

(1) **Type of Application:** (Check one box only. If renewing, provide vendor number and expiration date, and attach LIC 9139 if renewing courses.)

**New**    **Renewal** Vendor # \_\_\_\_\_ Expires: \_\_\_\_\_ LIC 9139 attached?    YES    NO

(2) **Type of Program:** (Check one box only; if applying for more than one, submit separate application for each.)

ARF (Adult Residential Facility)    GH (Group Home)    RCFE (Residential Care Facility for the Elderly)

(3) **Type of Vendor:** (Check one box only; if applying for both types, submit separate applications.)

**ICTP** (Initial Certification Training Program) Vendor (\$150 Fee)    **CEU** (Continuing Education) Vendor (\$100 Fee)

(4) **Applicant Information:** (Please print.)

Organization/Vendor Business Name: \_\_\_\_\_

Address (Street Address, City, State, Zip): \_\_\_\_\_

Authorized Representative/Contact Person (Name): \_\_\_\_\_

Business Phone Number: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

Company Website: \_\_\_\_\_

Company Type: (Check one box. Provide documentation of authority to conduct business in California (e.g., certificate of status from CA Secretary of State).

Individual                       University, College or School                       Provider Association

Partnership                       Non-Profit Organization                       Corporation

Government Agency                       Other: \_\_\_\_\_

List each individual authorized representative/contact person (e.g., partner, Executive Director, and/or board members) and their titles. Each

Name	Title/Position	Sec's 6-10 Completed ?

person listed in this section must complete and sign Sections 6-10 on page 2 of this form. (Copy page 2 as needed).

Signature of Vendor/Authorized Representative	Printed Name of Vendor/Authorized Representative
Title	Date

**DO NOT WRITE BELOW THIS LINE**

Application/Renewal has been <input type="checkbox"/> approved OR <input type="checkbox"/> disapproved by:	Date:
Approved Vendor Number	Expiration Date:

<b>Printed Name:</b>	<b>Social Security Number:*</b>
<p>(6) Do you currently hold or have you previously held a license, certification or other approval as a professional in a specified field (e.g., RN, NHA)? If yes, please list the type(s) of license(s) or certificate(s) and their number(s). <i>(Include any Administrator Certificates.)</i> <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>(7) Do you currently hold or have you previously held a State-issued care facility license? If yes, please list the type of license(s) and license number(s). <i>(Include any community care facility licenses.)</i> <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>(8) Are you currently employed or were you previously employed by a State-licensed care facility? If yes, please list the facility name(s) and license number(s). <i>(Place an * by those where currently employed.)</i> <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>(9) Have you been the subject of any legal, administrative, or other action involving licensure, certification or other approvals as specified in (6), (7), and (8) above? If yes, please explain and provide the date(s). <i>(Include any Administrative Actions. Attach additional pages if more space is needed.)</i> <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p><b>(10) I declare that the foregoing information is true and correct to the best of my knowledge.</b></p>	
Signature	Date

<b>Printed Name:</b>	<b>Social Security Number:*</b>
<p>(6) Do you currently hold or have you previously held a license, certification or other approval as a professional in a specified field (e.g., RN, NHA)? If yes, please list the type(s) of license(s) or certificate(s) and their number(s). <i>(Include any Administrator Certificates.)</i> <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>(7) Do you currently hold or have you previously held a State-issued care facility license? If yes, please list the type of license(s) and license number(s). <i>(Include any community care facility licenses.)</i> <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>(8) Are you currently employed or were you previously employed by a State-licensed care facility? If yes, please list the facility name(s) and license number(s). <i>(Place an * by those where currently employed.)</i> <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>(9) Have you been the subject of any legal, administrative, or other action involving licensure, certification or other approvals as specified in (6), (7), and (8) above? If yes, please explain and provide the date(s). <i>(Include any Administrative Actions. Attach additional pages if more space is needed.)</i> <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p><b>(10) I declare that the foregoing information is true and correct to the best of my knowledge.</b></p>	
Signature	Date

<b>Printed Name:</b>	<b>Social Security Number:*</b>
<p>(6) Do you currently hold or have you previously held a license, certification or other approval as a professional in a specified field (e.g., RN, NHA)? If yes, please list the type(s) of license(s) or certificate(s) and their number(s). <i>(Include any Administrator Certificates.)</i> <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>(7) Do you currently hold or have you previously held a State-issued care facility license? If yes, please list the type of license(s) and license number(s). <i>(Include any community care facility licenses.)</i> <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>(8) Are you currently employed or were you previously employed by a State-licensed care facility? If yes, please list the facility name(s) and license number(s). <i>(Place an * by those where currently employed.)</i> <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>(9) Have you been the subject of any legal, administrative, or other action involving licensure, certification or other approvals as specified in (6), (7), and (8) above? If yes, please explain and provide the date(s). <i>(Include any Administrative Actions. Attach additional pages if more space is needed.)</i> <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p><b>(10) I declare that the foregoing information is true and correct to the best of my knowledge.</b></p>	
Signature	Date

\* Optional but requested for CDSS use only to assist in verifying identity and licensing affiliations. Federal law (at Title 5 United States Code Section 552a Note) states that: Any federal, state, or local government agency which requests an individual to disclose his social security account number shall inform that individual whether that disclosure is mandatory or voluntary, by what statutory or other authority such number is solicited, and what uses will be made of it.