

# Group Home (GH) 40-Hour Initial Certification Core of Knowledge Guideline\*

Adopt

6-Hours	4-Hours	4-Hours	4-Hours	3-Hours	2-Hours	6-Hours	5-Hours	4-Hours	1-Hour	1-Hour
<b>LAW &amp; REGULATIONS</b> Health and Safety Code 1522.41 Regulations Title 22, Div 6, Chapter 1 & 6 • Administrative responsibility/accountability • Mandated reporting • Confidentiality • Personal rights • Complaint procedures State Fire Code Regulations • R2 Occupancies Clear understanding of rate calculations Non-Profit law W&I Code 300/600/632	<b>BUSINESS OPERATIONS</b> Liability issues Budgeting and fiscal documentation Monitoring of ongoing operations Funding sources Overview of labor laws Marketing a facility Rate setting/record keeping Other agencies • IRS • EDD • INS Contract compliance Audits: • Program • Financial Accounting & tax filing requirements Fund raising: • What's legal? • Audits • How to mix with other funds	<b>MANAGEMENT/ SUPERVISION OF STAFF</b> Staffing requirement/ ratio Hiring practices: • Criminal background requirements • Use of volunteers/ interns • EEO requirements • Job descriptions • Federal/ State requirements Performance evaluations Personnel policy manual Personnel records requirements Admin/staff training requirements • First Aid/CPR • Immunizations and health • Water safety • Cal-OSHA • Illness/injury prevention plan • Staff Duties/responsibilities • Employer responsibilities • Staffing patterns	<b>PSYCH/SOCIAL &amp; EDUCATION NEEDS</b> Identifying characteristics and special needs of client population Family involvement/participation and dynamics Bereavement/stress issues Activities Education: • General requirements • Understanding of special education • Administrator responsibilities • Assessment • Educational choices	<b>COMMUNITY &amp; SUPPORT SERVICES</b> Responsibility & expectations of referral agencies Overview of courts, welfare, probation, mental health Mental health managed care Parental relation-ships: • Extended Family • Siblings • Caregiver Collaboration/role with: • Police • Fire Dept. • Sheriff • Emergency medical response teams • Business sector Other resources	<b>PHYSICAL NEEDS</b> OSHA requirements Illness/injury plan Disaster plan Food Managed Care Recreation Community integration CCL physical plant requirements	<b>MEDICATION</b> Administration of medication • Technical aspects Regulatory requirements: • Storage • Documentation • Disposal Role of medications in treatment plan, including typical interactions & staff's role Communication with pharmacists, MDs Drug interaction/pharmacodynamics Common medications: • Infection control • Seizure disorder • Psychotropic Medi-Cal Medical/dental funding	<b>ADMISSION &amp; ASSESSMENT RETENTION NON-DISCRIMINATION</b> Program Statement Allowable vs. Prohibited conditions/ IMS Needs and services plan: • Development • Review Charting and documentation Admission agreements Termination Graduation Emancipation: Independent living Transition housing Discharge/ After care Client satisfaction Program outcome Age exceptions Non-discrimination or Harassment Client's rights	<b>EMERGENCY INTERVENTION NON-VIOLENT</b> Special incident reporting 5150 Overview of behavior: • Management systems • Modification Emergency intervention regulations Other resources	<b>SAFETY OF FOSTER YOUTH</b> CA Student Safety & Violence prevention Act of 2000 Resolving Conflict • Early prevention • Bullying • Affects Statistics Cyber-bullying • Mediation techniques	<b>CULTURAL COMPETENCY</b> LGBT • Ethics & values • Self-awareness • Education/Skills/Resources/ • Advocacy • Staff Training Requirements



Adult Residential Facility (ARF) 35-Hour Initial Certification Training Program  
Core of Knowledge Guideline\*

6-Hours	3-Hours	3-Hours	4-Hours	3-Hours	4-Hours	4-Hours	3-Hours	4-Hours	EMERGENCY INTERVENTION NON-VIOLENT	1-Hour
<b>LAW &amp; REGULATIONS</b> Health and Safety Code 1520 Regulations Title 22, Div 6, Chapters 1 & 6 • Administrator qualifications, responsibilities, and accountability • Mandated reporting • Confidentiality • Personal rights • Complaint procedures • Civil Penalties & Appeals • Ongoing monitoring visits and audits • Inspections • Corrective Action Plans State Fire Code Regulations • R2 Occupancies • R3.1 Occupancies Conservatorship • Full & Limited Power of Attorney SSA Representative Payee • Limits of Physical Plant • Building Permits • Building & Grounds • Alterations to Existing Facilities • ADA Accessibility Department of Labor • Labor Laws related to health insurance • Overtime • FLSA Equal Employment Opportunity Commission (EEOC)	<b>BUSINESS OPERATIONS</b> Liability Issues Budgeting and fiscal documentation Monitoring of ongoing operations Funding sources Marketing a facility Record keeping Rate setting by agencies or organizations Basic services Other agencies • IRS • EDD • Homeland Security (I.C.E.) • SSA Audits: • Program • Financial Accounting & tax filing requirements Fund raising: • What's legal? • Audits • How to mix with other funds Itemization and protection of client property Neighborhood relations and business practices Personal and incidental client funds accounting • Comingling of funds	<b>MANAGEMENT &amp; SUPERVISION OF STAFF</b> Staffing requirement/ ratio Hiring practices: • Criminal background requirements and exemptions • Use of volunteers/ interns • EEO requirements • Job descriptions • Federal/ State requirements • Third Party Contractors Performance evaluations Staff Terminations Personnel policy manual Personnel records requirements On-call / Emergency coverage Overnight shifts and working off-the-clock Managing Overtime Admin/ staff training requirements • First Aid/CPR • Immunizations and health • Water safety • Cal-OSHA • Illness/injury prevention plan • Staff Duties/ responsibilities • Employer responsibilities • Staffing patterns • Staff professional relationships and boundaries with clients	<b>PSYCHOSOCIAL NEEDS</b> Identifying characteristics, common stigmas, and special needs of client populations • Developmental Disabilities - Autism - Cerebral Palsy - Down Syndrome - Epilepsy - Fetal Alcohol Syndrome - Fragile X Syndrome - Intellectual Disability - Prader-Willi Syndrome - Schizophrenia - Schizo-Affective - Bi Polar Disorder - Depression & Anxiety • Dementia • Mental Health Issues - Drug and alcohol abuse - Bereavement and stress issues Caring for and respecting clients' dignity Client rights Family involvement / participation and dynamics Resident Councils Religion and spirituality Value and requirements for activities Micro Enterprise Vendorization with DOS Regional Centers	<b>COMMUNITY &amp; SUPPORT SERVICES</b> Responsibilities & expectations of referral agencies Overview of courts, welfare, probation, and mental health Community integration, personal safety Ombudsman Adult Protective Services County mental health services • Non-emergency Educational/library programs Day treatment programs Collaboration/ role with: • Police • Fire Dept. • Sheriff • Emergency medical response teams • Business sector • Local advocacy groups Transportation Other resources	<b>PHYSICAL NEEDS</b> Food Services • Nutrition • Food storage • Menu Planning • Special Diets Specific health conditions • Epilepsy • Obesity • Diabetes • Deaf/blind • Postural Supports Managed care Medi-Cal coverage ADA Accessibility Reporting physical injuries & follow-up Pressure ulcers Wound care Assisting with ADLs Individual health care needs • Dental • Vision • Podiatry • Hearing • Physical limitations • Hospice care Universal precautions Sexuality	<b>MEDICATION</b> Administration of medication • Technical aspects Regulatory requirements: • Storage • Documentation • Disposal Role of medications in treatment plan, including typical interactions & staff's role Communication with pharmacists, MDs Drug interaction/ pharmacodynamics Common medications: • Infection control • Seizure disorder • Psychotropic Use of chemical constraints Medi-Cal Medical/dental funding	<b>ADMISSION &amp; RETENTION</b> Program Statement Appraisals: • Pre-admission • Physician's report • Functional • Social • Ongoing Medical/dental funding/Medi-Cal Needs and services plan: • Development • Observations • Review • Conservator	<b>4-Hours</b> Special Incident reporting 5150 Overview of behavior: • Management • t systems • Modification • Management • t of aggression • Behavior • Intervention • Plans Use of physical restraints specific to Title 17 & 22 under age exceptions Other waivers • Seat belts • Half rails Awareness of public's and law enforcement's perception of client behaviors Overview of available crisis programs • Pro-Act • CPI • PCMA • MANDT Other resources	<b>1-Hour</b> <b>CULTURAL COMPETENCY</b> AB 663 Issues related to the underserved lesbian, gay, bisexual, and transgender (LGBT) community • Ethics & values • Self-awareness • Gender identity • Education • Skills • Resources • Advocacy Staff Training Requirements Equality of care HIV Confidentiality	

\*Subtopics within the basic curriculum may include, but are not limited to, the topics specified in this ARF Core of Knowledge Guideline.









Use this additional space for Instructor(s):

NAME OF INSTRUCTOR

SOCIAL SECURITY NUMBER\*

(5) Does the instructor currently possess or previously have held a license, certification or other approval as a professional in a specified field? If Yes, please indicate the type of license or certificate and number(s).  YES  NO

LICENSE NUMBER

CERTIFICATE NUMBER

(6) Does the instructor currently hold or previously have held a community care facility license, or has she/he been employed by a licensed community care facility? If Yes, please indicate the facility name and license number(s).  YES  NO

(7) Has the instructor been the subject of any administrative, legal or other action involving licensure, certification or other approvals as specified in (5) or (6) above? If Yes, please explain and provide dates. If additional space is needed, please attach to this application.  YES  NO

I declare under penalty of perjury that the foregoing information is true and correct to the best of my knowledge.

SIGNATURE

DATE

NAME OF INSTRUCTOR

SOCIAL SECURITY NUMBER\*

(5) Does the instructor currently possess or previously have held a license, certification or other approval as a professional in a specified field? If Yes, please indicate the type of license or certificate and number(s).  YES  NO

LICENSE NUMBER

CERTIFICATE NUMBER

(6) Does the instructor currently hold or previously have held a community care facility license, or has she/he been employed by a licensed community care facility? If Yes, please indicate the facility name and license number(s).  YES  NO

(7) Has the instructor been the subject of any administrative, legal or other action involving licensure, certification or other approvals as specified in (5) or (6) above? If Yes, please explain and provide dates. If additional space is needed, please attach to this application.  YES  NO

I declare under penalty of perjury that the foregoing information is true and correct to the best of my knowledge.

SIGNATURE

DATE

\* 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.

\* Disclosure of Social Security Number(s) is optional.

**VENDOR APPLICATION/RENEWAL**  
**ADMINISTRATOR CERTIFICATION PROGRAM**

Old Form

Fill the application and fee to CDSS, ACS 744 "P" Street, M.S. 19-47, Sacramento, CA 95814

(1) Type of Program: (Check one box only, if applying for more than one program, submit applications separately)

RCFE

ARF

GH

(2) Type of Application: (Check one box only) (IF RENEWAL, PROVIDE VENDOR APPROVAL NUMBER)

Initial

Renewal

(3) Type of Vendor: (Check one box only)

35/40 Hour Vendor (\$150 Processing Fee)

CEU Vendor (\$100 Processing Fee)

(4) Name of Vendor (5) Phone Number

(6) Vendor Mailing Address

(7) Vendor is a/an

Individual

University, College or School

Provider Association

Partnership

Licensee/Administrator

State Employee

Corporation

Government Agency

Other: \_\_\_\_\_

(8) Please print or type name(s) of individual, partners, board members: Each person listed in this section must complete (11) through (14). Additional space is provided on the back of this form. (9) Title (10) Social Security Number\*

(11) Do you currently possess or have you previously held a license, certification or other approval as a professional in a specified field? If yes, please indicate the type of license or certificate and license number(s):

Yes

No

License Number: \_\_\_\_\_

Certificate Number: \_\_\_\_\_

(12) Do you currently hold or have you previously held a community care facility license, or were or are you employed by a licensed community care facility? If yes, please indicate the facility name and license number(s):

Yes

No

License Number: \_\_\_\_\_

Facility Name: \_\_\_\_\_

(13) Have you been the subject of any administrative, legal or other action involving licensure, certification or other approvals as specified in (11) OR (12)? If yes, please explain and provide dates. If additional space is needed, please attach to this application.

Yes

No

(14) I declare under penalty of perjury that the foregoing information is true and correct to the best of my knowledge.

(15) Printed Name of Applicant/Vendor (16) Signature of Vendor/Authorized Representative (17) Title (18) Date

DO NOT WRITE BELOW THIS LINE

Application/Renewal has been approved by: \_\_\_\_\_ Date \_\_\_\_\_

Approval Number# \_\_\_\_\_ Expires \_\_\_\_\_

Application/Renewal has been disapproved by: \_\_\_\_\_ Date \_\_\_\_\_

\* 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.

\* Disclosure of Social Security Number(s) is optional.

\* Add attached language.

Use this additional space for persons listed in section (8)

NAME (PLEASE PRINT)

(11) Do you currently possess or have previously held a license, certification or other approval as a professional in a specified field? If Yes, please indicate the type of license or certificate and license number(s);  YES  NO

License Number: \_\_\_\_\_ Certificate Number: \_\_\_\_\_

(12) Do you currently hold or previously have held a community care facility license, or were/are you employed by a licensed community care facility? If Yes, please indicate the facility name and license number(s):  YES  NO

Facility Name: \_\_\_\_\_ License Number: \_\_\_\_\_

(13) Have you been the subject of any administrative, legal or other action involving licensure, certification or other approvals as specified in (11) or (12)? If Yes, please explain and provide dates. If additional space is needed, please attach to this application.  YES  NO

(14) I declare under penalty of perjury that the foregoing information is true and correct to the best of my knowledge.

SIGNATURE

DATE

NAME (PLEASE PRINT)

(11) Do you currently possess or have previously held a license, certification or other approval as a professional in a specified field? If Yes, please indicate the type of license or certificate and license number(s);  YES  NO

(12) Do you currently hold or previously have held a community care facility license, or were/are you employed by a licensed community care facility? If Yes, please indicate the facility name and license number(s):  YES  NO

(13) Have you been the subject of any administrative, legal or other action involving licensure, certification or other approvals as specified in (11) or (12)? If Yes, please explain and provide dates. If additional space is needed, please attach to this application.  YES  NO

(14) I declare under penalty of perjury that the foregoing information is true and correct to the best of my knowledge.

SIGNATURE

DATE

NAME (PLEASE PRINT)

(11) Do you currently possess or have previously held a license, certification or other approval as a professional in a specified field? If Yes, please indicate the type of license or certificate and license number(s);  YES  NO

License Number: \_\_\_\_\_ Certificate Number: \_\_\_\_\_

(12) Do you currently hold or previously have held a community care facility license, or were/are you employed by a licensed community care facility? If Yes, please indicate the facility name and license number(s):  YES  NO

Facility Name: \_\_\_\_\_ License Number: \_\_\_\_\_

(13) Have you been the subject of any administrative, legal or other action involving licensure, certification or other approvals as specified in (11) or (12)? If Yes, please explain and provide dates. If additional space is needed, please attach to this application.  YES  NO

(14) I declare under penalty of perjury that the foregoing information is true and correct to the best of my knowledge.

SIGNATURE

DATE

**ROSTER OF PARTICIPANTS--FOR VENDOR USE ONLY--35/40 HOUR INITIAL OR CEU COURSES**  
**ADMINISTRATOR CERTIFICATION PROGRAM**

Old Form

- Provide the information requested below for all participants who have completed the required hours of classroom instruction.
- Mail a copy of this roster within 5 days of completion of required classroom instruction to the Administrator Certification Section at:  
 744 "P" Street, M.S. 19-47, Sacramento, CA 95814
- Mail the original of this completed roster to the District Office for testing purposes: Please submit a separate roster for each course program type.

(1) Course Program Type (Check one box):  
 RCFE Initial 40-Hour Course     ARF Initial 35-Hour Course     GH Initial 40-Hour Course  
 RCFE CEU     ARF CEU     GH CEU

(2) Vendor Name \_\_\_\_\_ (3) Vendor # \_\_\_\_\_ (4) Date \_\_\_\_\_  
 \_\_\_\_\_ (6) CEU Course # \_\_\_\_\_

Last Name of Participant		Middle Initial	Location of Course	Facility Name or Facility License #
Address		City	Zip Code	Phone Number
Last Name of Participant		Middle Initial	Location of Course	Facility Name or Facility License #
Address		City	Zip Code	Phone Number
Last Name of Participant		Middle Initial	Location of Course	Facility Name or Facility License #
Address		City	Zip Code	Phone Number
Last Name of Participant		Middle Initial	Location of Course	Facility Name or Facility License #
Address		City	Zip Code	Phone Number
Last Name of Participant		Middle Initial	Location of Course	Facility Name or Facility License #
Address		City	Zip Code	Phone Number

(7) Name of Vendor's Authorized Representative \_\_\_\_\_ (8) Title of Authorized Representative \_\_\_\_\_ (9) Signature of Authorized Representative \_\_\_\_\_ (10) Date \_\_\_\_\_







**REQUEST FOR COURSE APPROVAL**  
ADMINISTRATOR CERTIFICATION PROGRAM**New Form**

**INSTRUCTIONS:** At least 60 days before the planned offering of an ICTP or CEU course for facility administrators, vendors must submit this completed application with a check or money order for the applicable fee to CDSS, ACS, 744 "P" Street, MS 9-14-47, Sacramento, CA 95814. Submit a separate application and fee for each type of program (ARF, GH, RCFE) and vendorship (ICTP or CEU).

**(1) Type of Program and Vendorship:** (Select one box.)

ARF ICTP (735-1)     GH ICTP (730-1)     RCFE ICTP (740-1)     ARF CEU (735-2)     GH CEU (730-2)     RCFE CEU (740-2)

**(2) Vendor Information:** (Please print.)

Vendor Number: \_\_\_\_\_

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

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

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

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

**(3) Course Information:** (Please print.) Course Number (if updating a previously approved one): \_\_\_\_\_

Proposed Course Title: \_\_\_\_\_

Total Classroom Hours: \_\_\_\_\_ Date(s) to be Offered (if known): \_\_\_\_\_ Fee: \_\_\_\_\_

For CEU courses: Format: (Check one box.)  Classroom  Conference  Online  Webinar

Core of Knowledge category: \_\_\_\_\_

If online course or Webinar provide the necessary log-on information for course review: \_\_\_\_\_

Is this course proposed for co-location with another CEU course?  YES  NOIf yes, list the other course number, if already approved \_\_\_\_\_ or check  that other course application included.**(4) Proposed Course Outline.** (Attach a document including the following information.)

**Instructor(s) Qualifications:** Include a current resume of work experience, and complete Sections 6 – 10 on page 2 of this form for each proposed instructor. Instructors must have knowledge and/or experience in the subject area to be taught per one of the following criteria (check applicable one(s)):

- Possession of a bachelor's or higher degree and 2 years' experience relevant to the course to be taught, or  
 Four years' experience relevant to the course to be taught, or  
 Be a professional, in a related field, with a valid current license to practice in California, and 2 years' related experience, or  
 Have at least 4 years' experience in California as an administrator of a facility in substantial compliance, within the last 6 years, and 2 years' training in the subject to be taught.

**Description of Course:** Briefly summarize the course including how it relates to the business operations and/or the care of residents in the facility.

**Objective(s) of Course:** Identify what the student is expected to know upon completion of this course.

**Teaching Methods:** Explain the types of teaching methods to be used.

**Course Content:** Outline the course content with hour-by-hour detail, and including the proposed instructor for each segment.

**Method of Course Evaluation by Participants:** Explain how participants will evaluate the course. Attach copy of proposed form if available.

**Method of Evaluating Participants:** Explain how you will evaluate the participants. Attach copy of proposed post-test if applicable.

**Method of Verifying Active Student Participation for Course Duration (for online courses only).**

**Types of Records to be Maintained and Address Where Records are Maintained.**

**Address and/or Locality(ies) Where the Course Will Be Presented.**

**Make Up Policy (for ICTPs only).**

**(5) Vendor Certification:** I declare that the foregoing information is true and correct to the best of my knowledge.

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

**DO NOT WRITE BELOW THIS LINE**

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

<b>Printed Name:</b>	Social Security Number:*
(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). (Include any Administrator Certificates.) <input type="checkbox"/> YES <input type="checkbox"/> NO	
(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). (Include any community care facility licenses.) <input type="checkbox"/> YES <input type="checkbox"/> NO	
(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). (Place an * by those where currently employed.) <input type="checkbox"/> YES <input type="checkbox"/> NO	
(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). (Include any Administrative Actions. Attach additional pages if more space is needed.) <input type="checkbox"/> YES <input type="checkbox"/> NO	
<b>(10) I declare that the foregoing information is true and correct to the best of my knowledge.</b>	
<b>Signature</b>	<b>Date</b>

<b>Printed Name:</b>	Social Security Number:*
(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). (Include any Administrator Certificates.) <input type="checkbox"/> YES <input type="checkbox"/> NO	
(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). (Include any community care facility licenses.) <input type="checkbox"/> YES <input type="checkbox"/> NO	
(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). (Place an * by those where currently employed.) <input type="checkbox"/> YES <input type="checkbox"/> NO	
(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). (Include any Administrative Actions. Attach additional pages if more space is needed.) <input type="checkbox"/> YES <input type="checkbox"/> NO	
<b>(10) I declare that the foregoing information is true and correct to the best of my knowledge.</b>	
<b>Signature</b>	<b>Date</b>

<b>Printed Name:</b>	Social Security Number:*
(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). (Include any Administrator Certificates.) <input type="checkbox"/> YES <input type="checkbox"/> NO	
(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). (Include any community care facility licenses.) <input type="checkbox"/> YES <input type="checkbox"/> NO	
(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). (Place an * by those where currently employed.) <input type="checkbox"/> YES <input type="checkbox"/> NO	
(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). (Include any Administrative Actions. Attach additional pages if more space is needed.) <input type="checkbox"/> YES <input type="checkbox"/> NO	
<b>(10) I declare that the foregoing information is true and correct to the best of my knowledge.</b>	
<b>Signature</b>	<b>Date</b>

\* 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.

**REQUEST TO ADD OR REPLACE INSTRUCTOR**

ADMINISTRATOR CERTIFICATION PROGRAM

**Adopt**

**INSTRUCTIONS:** At least 30 days before planning to add or replace an instructor for an approved course, vendors must submit this completed form and the required supporting documentation to CDSS, ACS, 744 "P" Street, M.S. 9-14-47, Sacramento, CA 95814.

(1) **Type of Application:** (Select applicable box(es).)  **Add** Instructor  **Replace** Instructor

(2) **Vendor Information:** (Please print.) Vendor Number: \_\_\_\_\_

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

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

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

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

**(3) Program Information:**

Type: (Check one box only.)  CEU  ICTP

If CEU, Course Title: \_\_\_\_\_ Course Number: \_\_\_\_\_

If ICTP, select the component(s) of the training the instructor is being proposed to teach.

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Law & Regs             | <input type="checkbox"/> Community & Support Svcs | <input type="checkbox"/> Cultural Competency            | <input type="checkbox"/> Residents' Rights  |
| <input type="checkbox"/> Business Operations    | <input type="checkbox"/> Physical Needs           | <input type="checkbox"/> Emerg. Intervention/NonViolent | <input type="checkbox"/> Physical Environment                                     |
| <input type="checkbox"/> Management/Supervision | <input type="checkbox"/> Medication               | <input type="checkbox"/> Safety of Foster Youth         | <input type="checkbox"/> Postural Supports, Hospice,<br>& Restricted health cond. |
| <input type="checkbox"/> Psych/Social Needs     | <input type="checkbox"/> Admission & Assessment   | <input type="checkbox"/> Alzheimer's & Dementia         |   |

If ICTP, check if  proposed and/or  replaced instructor is/was fulfilling requirements of 22 CCR 84090(i)(1)(A), 85090(i)(a)(A), or 87785(i)(8).

**(3) Instructor Information:** (Attach the proposed instructor's resume of work experience.)

Name of Instructor to be Replaced: \_\_\_\_\_

Name of Proposed Instructor: \_\_\_\_\_ Social Security Number\*: \_\_\_\_\_

- (a) Does the individual currently hold or 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). (Include any Administrator Certificates.)  YES  NO
- (b) Does the individual currently hold or previously held a State-issued care facility license? If yes, please list the type of license(s) and license number(s). (Include any community care facility licenses.)  YES  NO
- (c) Is the individual currently employed or previously employed by a State-licensed care facility? If yes, please list the facility name(s) and license number(s). (Place an \* by those where currently employed.)  YES  NO
- (d) Has the individual been the subject of any legal, administrative, or other action involving licensure, certification or other approvals as specified in (a), (b), and (c) above? If yes, please explain and provide the date(s). (Include any Administrative Actions. Attach additional pages if more space is needed.)  YES  NO

**(4) Vendor Certification:** I declare that the foregoing information is true and correct to the best of my knowledge.

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

**DO NOT WRITE BELOW THIS LINE**

Request has been <input type="checkbox"/> approved OR <input type="checkbox"/> disapproved by:	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.



**VENDOR APPLICATION/RENEWAL**  
ADMINISTRATOR CERTIFICATION PROGRAM**New Form**

**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 94814. 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 certificate, 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 person listed in this section must complete and sign Sections 6-10 on page 2 of this form. (Copy page 2 as needed).

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

(5) **Applicant Certification:** I declare that the foregoing information is true and correct to the best of my knowledge.

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>	Social Security Number:*
----------------------	--------------------------

(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). (Include any Administrator Certificates.)  YES  NO

(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). (Include any community care facility licenses.)  YES  NO

(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). (Place an \* by those where currently employed.)  YES  NO

(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). (Include any Administrative Actions. Attach additional pages if more space is needed.)  YES  NO

(10) I declare that the foregoing information is true and correct to the best of my knowledge.

<b>Signature</b>	<b>Date</b>
------------------	-------------

<b>Printed Name:</b>	Social Security Number:*
----------------------	--------------------------

(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). (Include any Administrator Certificates.)  YES  NO

(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). (Include any community care facility licenses.)  YES  NO

(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). (Place an \* by those where currently employed.)  YES  NO

(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). (Include any Administrative Actions. Attach additional pages if more space is needed.)  YES  NO

(10) I declare that the foregoing information is true and correct to the best of my knowledge.

<b>Signature</b>	<b>Date</b>
------------------	-------------

<b>Printed Name:</b>	Social Security Number:*
----------------------	--------------------------

(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). (Include any Administrator Certificates.)  YES  NO

(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). (Include any community care facility licenses.)  YES  NO

(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). (Place an \* by those where currently employed.)  YES  NO

(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). (Include any Administrative Actions. Attach additional pages if more space is needed.)  YES  NO

(10) I declare that the foregoing information is true and correct to the best of my knowledge.

<b>Signature</b>	<b>Date</b>
------------------	-------------

\* 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.

**ROSTER OF PARTICIPANTS--FOR VENDOR USE ONLY-- ICTP OR CEU COURSES**  
**ADMINISTRATOR CERTIFICATION PROGRAM**

**New Form**

**Instructions:** Within seven (7) days of completing an ICTP or CEU course, or upon ACS request, vendors must submit a copy of the complete roster of participants to CDSS, ACS, 744 "P" Street, MS 9-14-47, Sacramento, CA 95814. Copy this form as needed for additional space. For ICTPs, have a separate roster for each day. Keep the originals for your files.

(1) Type of Program and Vendorship: (Select one box.)  ARF ICTP (735-1)  GH ICTP (730-1)  RCFE ICTP (740-1)  ARF CEU (735-2)  GH CEU (730-2)  RCFE CEU (740-2)

(2) Vendor and Course Information: (Please print.) Organization/Business Name: \_\_\_\_\_ Vendor #: \_\_\_\_\_

Course Name: \_\_\_\_\_ Date: \_\_\_\_\_ Location: \_\_\_\_\_

Instructor Names(s): \_\_\_\_\_ CEU Course #: \_\_\_\_\_

**(3) Participant Roster: (Please print.)**

Last Name of Participant (Print)	First Name & Middle Initial of Participant	City	Zip Code	Phone Number	Facility Name or Facility License #	Time In	Time Out
Address					E-mail Address		
Last Name of Participant (Print)	First Name & Middle Initial of Participant	City	Zip Code	Phone Number	Facility Name or Facility License #	Time In	Time Out
Address					E-mail Address		
Last Name of Participant (Print)	First Name & Middle Initial of Participant	City	Zip Code	Phone Number	Facility Name or Facility License #	Time In	Time Out
Address					E-mail Address		
Last Name of Participant (Print)	First Name & Middle Initial of Participant	City	Zip Code	Phone Number	Facility Name or Facility License #	Time In	Time Out
Address					E-mail Address		
Last Name of Participant (Print)	First Name & Middle Initial of Participant	City	Zip Code	Phone Number	Facility Name or Facility License #	Time In	Time Out
Address					E-mail Address		

**(4) Vendor Certification:** I declare that the foregoing information is true and correct to the best of my knowledge.

Signature of Vendor/Authorized Representative	Printed Name of Vendor/Authorized Representative	Title	Date	Total # Roster Pages enclosed:
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**ROSTER OF PARTICIPANTS--FOR EXAM PROCTORING ONLY**  
**ADMINISTRATOR CERTIFICATION PROGRAM**

Adopt

**Instructions:** Within two (2) days of offering an exam, proctors for the Administrator Certification exam must submit the completed roster of participants and the original exam answer sheets to CDSS, ACS, 744 "P" Street, Sacramento, CA 95814. Include the identifying exam information on each page of roster, and total roster pages on first page. Keep a copy for your records for at least 90 days.

(1) Type of Program: (Select one box.)  ARF  GH  RCFC

(2) Exam Information: (Please print.) Exam Date and Time: \_\_\_\_\_ Location: \_\_\_\_\_ Reg. Office #: \_\_\_\_\_

Proctor Name(s): \_\_\_\_\_ Total # Roster Pages: \_\_\_\_\_

**(3) Participant Roster: (Please print.)**

Last Name of Participant (Print)	First Name & Middle Initial of Participant	Phone Number	DOB (MM/DD/YY)	SSN# *	Test #
Address	City	Zip Code	E-mail Address		
Last Name of Participant (Print)	First Name & Middle Initial of Participant	Phone Number	DOB (MM/DD/YY)	SSN# *	Test #
Address	City	Zip Code	E-mail Address		
Last Name of Participant (Print)	First Name & Middle Initial of Participant	Phone Number	DOB (MM/DD/YY)	SSN# *	Test #
Address	City	Zip Code	E-mail Address		
Last Name of Participant (Print)	First Name & Middle Initial of Participant	Phone Number	DOB (MM/DD/YY)	SSN# *	Test #
Address	City	Zip Code	E-mail Address		
Last Name of Participant (Print)	First Name & Middle Initial of Participant	Phone Number	DOB (MM/DD/YY)	SSN# *	Test #
Address	City	Zip Code	E-mail Address		

\* 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.



**REQUEST FOR LIVE SCAN SERVICE - COMMUNITY CARE LICENSING****Adopt**

Applicant Submission

1. ORI: <b>A0448</b>			
2. Working Title: (Check <input checked="" type="checkbox"/> one)			
<input type="checkbox"/> Adult Resident other than Client <input type="checkbox"/> Employee <input type="checkbox"/> License, Certification, Applicant <input type="checkbox"/> Volunteer			
3. Authorized Applicant Type - Enter from list on Page 2, "DOJ Abbreviated CCLD Facility Type."			
4. Agency Address Set Contributing Agency:			
<b>CA Dept of Social Services</b>		<b>03502</b>	
Agency authorized to receive criminal history information		Mail Code (five-digit code assigned by DOJ)	
<b>PO BOX 944243</b>		<b>Mail Station 9-15-62</b>	
Street No.		Street or PO Box	
<b>Sacramento,</b>		<b>CA</b>	
City		State	
<b>94244-2430</b>		<b>94244-2430</b>	
Zip Code		Zip Code	
		( )	
		<b>N/A</b>	
		Contact Telephone No.	
5. Applicant Information:			
Name of Applicant: (Please print)			
LAST		FIRST	
MI		MI	
AKA's:		CDL No.	
LAST		FIRST	
DOB:		SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female	
		Misc. No. <b>BIL -</b>	
		AGENCY BILLING NUMBER (IF APPLICABLE)	
HT:		WT:	
		Misc. No.:	
		ALIEN REGISTRATION, OUT OF STATE DRIVER'S LICENSE OR I.D.	
EYE Color:		HAIR Color:	
		Home Address: (All applicants must complete)	
POB:		STREET OR PO BOX	
SOC:		CITY, STATE AND ZIP CODE	
(See Privacy Statement on Page 4)			
6. Facility Number:		Level of Service <input checked="" type="checkbox"/> DOJ <input checked="" type="checkbox"/> FBI	
If resubmission for fingerprint quality (select R2), list Original ATI No. _____			
7. Employer: (Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)			
Employer Name			
Street No.		Street or PO Box	
City		State	
		Zip Code	
		Mail Code (five digit code assigned by DOJ)	
		Agency Telephone No. (Optional)	
8.			
Live Scan Transaction Completed By:		Date	
		Name of Operator	
Transmitting Agency		LSID#	
		ATI No.	
		Amount Collected/Billed	

**GUIDELINES FOR COMMUNITY CARE LICENSING (CCLD) APPLICANTS WHO  
USE A LIVE SCAN SITE (CCLD or DOJ SITE) FOR FINGERPRINTING  
Instructions for the LIC 9163**

1. **Originating Response Indicator (ORI):** Preprinted
2. **Working Title:** Check the appropriate box
3. **Authorized Applicant Type:** Indicate the facility type where you will be working.

Select your licensed facility type from the left column, and in the right column find its corresponding DOJ abbreviated facility type. **Enter the corresponding DOJ abbreviated facility type on this line.**

**Note:** In the following table you may be able to identify yourself with more than one facility type within each category. Please select only one facility type in any category using the facility that you are most associated with on a day-to-day basis.

**If this is your applicable facility type      ⇨ Enter this abbreviated facility type on your application.**

<b>CCLD Facility Type by Category</b>	<b>DOJ Abbreviated CCLD Facility Type</b>
Adult Day Care Facility Adult Day Support Center Adult Residential Facility	Adult Day/Resident/Rehab
Child Care Center Infant Center Mildly Ill Center School Age Child Care Center	Day Care Cent more/6 Child
Family Child Care Home	Family Day Care
Foster Family Agency Foster Family / Adoptions Agency Foster Family Agency Sub Office	Foster Family / Adopt Emp.
Foster Family Agency - Certified Home Foster Family Home	Foster Family Home
Group Home (6 or less children)	Group Home 6 / child less
Group Home (7 or more) Community Treatment Facility	Group Home more / 6 child
Residential Care Facility for the Chronically Ill Residential Care Facilities for the Elderly	Residentl Care Fac Elderly
Small Family Home Transitional Housing Placement Program	Resid Child Care 6 / less
Social Rehabilitation Facility	Adult Day / Resident / Rehab

4. Agency Address Set Contributing Agency:

Agency authorized to receive criminal history information:

The following information is pre-printed:

Agency: CA Dept of Social Services Mail Code: 03502

Street No.: P.O. BOX 944243, M.S. 9-15-62 Contact Name: N/A

City, State, Zip: Sacramento, CA 94244-2430 Contact Telephone No.: N/A

5. Applicant Information: Print your full name (last, first, middle initial).

AKA's: Other names the applicant has used CDL No: CA Drivers License or CA ID

DOB: Date of Birth SEX: Male or Female MISC No: BIL - Enter the agency billing number, if applicable

HT: Height WT: Weight MISC No.: Enter any other identification numbers  
(ALIEN REGISTRATION, OUT OF STATE DRIVER'S LICENSE OR I.D.)

EYE Color: Color of eyes HAIR Color: Color of hair Home Address: Applicant's home address

POB: State or Country of Birth

SOC: Social Security Number (optional) (See Privacy Statement on Page 4)

6. Facility Number: Enter the facility number or assigned OCA number (Agency Identifying Number).

Level of Service: **Preprinted**

Note: If a Child Abuse Central Index (CACI) check is required, it will automatically be completed by DOJ and all applicable fees will be charged. There is no entry necessary on the applicant's part.

If resubmission for fingerprint quality, list Original Applicant Tracking Information (ATI) No.: If your fingerprints were rejected and this is a resubmission of your prints, enter the original ATI number provided on the reject notice to avoid paying an additional processing fee.

7. Employer: Enter the facility name and address for which you are being printed.

Employer Name:	<u>Enter the facility name.</u>
Street No.:	<u>Enter the facility address.</u>
Mail Code:	<u>Enter the facility mail code (if applicable).</u>
City, State, Zip:	<u>Enter the facility city, state and zip.</u>
Agency Telephone No.:	<u>Enter the facility phone number.</u>

8. Live Scan Transaction Completed By: This section will be completed by the Live Scan operator.

Take this form with you the day you are fingerprinted. The Live Scan Operator will complete section 8. If the Live Scan Operator is IBT - L1, they will return the completed form to you. Retain this form for your records.

If you use a Live Scan Operator other than IBT - L1, you will need to take 2 copies of this form. One copy will be retained by the Operator and the other you may retain for your records.

## PRIVACY STATEMENT

Pursuant to the Federal Privacy Act (P.L. 93-579) and the Information Practices Act of 1977 (Civil Code section 1798 et seq.), notice is given for the request of the Social Security Number (SSN) on this form. The California Department of Justice uses a person's SSN as an identifying number. The requested SSN is voluntary. Failure to provide the SSN may delay the processing of this form and the criminal record check.

In order to be licensed, work at, or be present at, a licensed facility, the law requires that you complete a criminal background check. (Health and Safety Code sections 1522, 1568.09, 1569.17 and 1596.871). The Department will create a file concerning your criminal background check that will contain certain documents, including information that you provide. You have the right to access certain records containing your personal information maintained by the Department (Civil Code section 1798 et seq.). Under the California Public Records Act, the Department may have to provide copies of some of the records in the file to members of the public who ask for them, including newspaper and television reporters.

### NOTE: IMPORTANT INFORMATION

The Department is required to tell people who ask, including the press, if someone in a licensed facility has a criminal record exemption. The Department must also tell people who ask the name of a licensed facility that has a licensee, employee, resident, or other person with a criminal record exemption.

If you have any questions about this form, please contact your local licensing regional office.

# CRIMINAL RECORD STATEMENT

Adopt

State law requires that persons associated with licensed facilities be fingerprinted and disclose any conviction. A conviction is any plea of guilty or nolo contendere (no contest) or a verdict of guilty. The fingerprints will be used to obtain a copy of any criminal history you may have.

**Have you ever been convicted of a crime in California ?** .....  YES  NO

You need not disclose any marijuana-related offenses covered by the marijuana reform legislation codified at Health and Safety Code sections 11361.5 and 11361.7.

**Have you ever been convicted of a crime from another state, federal court, military or jurisdiction outside of U.S.?** .....  YES  NO

Criminal convictions from another State or Federal court are considered the same as criminal convictions in California.

If you answer YES, give details on the back of this page indicating the nature and circumstances of each crime and the date and the location in which each crime occurred.

You must disclose convictions, including reckless and drunk driving convictions even if:

1. It happened a long time ago;
2. It was only a misdemeanor;
3. You didn't have to go to court (your attorney went for you);
4. You had no jail time or the sentence was only a fine or probation;
5. You received a certificate of rehabilitation;
6. The conviction was later dismissed, set aside or the sentence was suspended.

**NOTE:** IF THE CRIMINAL BACKGROUND CHECK REVEALS ANY CONVICTION(S) THAT YOU DID NOT DISCLOSE ON THIS FORM, YOUR FAILURE TO DISCLOSE THE CONVICTION(S) WILL RESULT IN AN EXEMPTION DENIAL, LICENSE APPLICATION DENIAL, LICENSE REVOCATION, OR EXCLUSION FROM A LICENSED FACILITY.

<b>I declare under penalty of perjury under the laws of the State of California that I have read and understand the information contained in this affidavit and that my responses and any accompanying attachments are true and correct.</b>			
FACILITY NAME		FACILITY NUMBER	
YOUR NAME (PRINT CLEARLY)	YOUR ADDRESS	CITY	ZIP
SOCIAL SECURITY NUMBER (SEE PRIVACY STATEMENT ON REVERSE SIDE)	DATE OF BIRTH	DMV LICENSE NUMBER	
SIGNATURE		DATE	

**I. Instructions to Respondents:**

If you have been convicted of a crime in California, another state or in federal court, provide the following information:

*(You need not disclose any marijuana-related offenses covered by the marijuana reform legislation codified at Health and Safety Code sections 11361.5 and 11361.7.)*

What was the offense? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

In which state and city did you commit the offense? \_\_\_\_\_

\_\_\_\_\_

When did this occur? \_\_\_\_\_

\_\_\_\_\_

Tell us what happened. (Use additional sheets of paper if needed) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I certify under penalty of perjury that the above information is true and correct to the best of my knowledge.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**II. Instructions to Licensees:**

If the person discloses a criminal conviction, review the person's statement and discuss it with your Licensing Program Analyst (LPA). Maintain this form in your facility personnel file and send a copy to your LPA.

**PRIVACY STATEMENT**

Pursuant to the Federal Privacy Act (P.L. 93-579) and the Information Practices Act of 1977 (Civil Code section 1798 et seq.), notice is given for the request of the Social Security Number (SSN) on this form. The California Department of Justice uses a person's SSN as an identifying number. The requested SSN is voluntary. Failure to provide the SSN may delay the processing of this form and the criminal record check.

In order to be licensed, work at, or be present at, a licensed facility, the law requires that you complete a criminal background check. (Health and Safety Code sections 1522, 1568.09, 1569.17 and 1596.871) The Department will create a file concerning your criminal background check that will contain certain documents, including information that you provide. You have the right to access certain records containing your personal information maintained by the Department (Civil Code section 1798 et seq.). Under the California Public Records Act, the Department may have to provide copies of some of the records in the file to members of the public who ask for them, including newspaper and television reporters.

**NOTE: IMPORTANT INFORMATION**

The Department is required to tell people who ask, including the press, if someone in a licensed facility has a criminal record exemption. The Department must also tell people who ask, the name of a licensed facility that has a licensee, employee, resident, or other person with a criminal record exemption.

If you have any questions about this form, please contact your local licensing regional office.

**APPLICATION FOR ADMINISTRATOR CERTIFICATION**  
**ADMINISTRATOR CERTIFICATION PROGRAM**

<b>For Office Use Only:</b>	
PRINTS TO DOJ:	_____
DOJ CLEARED:	_____
FBI CLEARED:	_____
CACI:	_____
FACILITY #:	_____
D.O. #:	_____
LIS #:	_____

**Instructions:** See page 2 for complete instructions.

**(1) Type of Application:**

(Check one box only. If renewing, provide certificate number and expiration date.)

**New**    **Renewal**   Certificate # \_\_\_\_\_  
Expires: \_\_\_\_\_

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

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

**(3) Applicant Information:** (Please print.)    Check here if any information has changed since last submittal.

Name (First, MI, Last): \_\_\_\_\_

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

Telephone Number: \_\_\_\_\_ Cell: \_\_\_\_\_ E-mail: \_\_\_\_\_

Social Security Number:\* \_\_\_\_\_ Date of Birth: (MM/DD/YY) \_\_\_\_\_

(a) 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). (Include any Administrator Certificates.)  YES    NO

(b) 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). (Include any community care facility licenses.)  YES    NO

(c) 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). (Place an \* by those where currently employed.)  YES    NO

(d) Have you been the subject of any legal, administrative, or other action involving licensure, certification or other approvals as specified in (a), (b), and (c) above? If yes, please explain and provide the date(s). (Include any Administrative Actions. Attach additional pages if more space is needed.)  YES    NO

**(4) For INITIAL APPLICANTS ONLY**, indicate when you would like your **certificate to expire**. (Select one box only. If you do not select one, two years from issuance will be used.)

Two years from date of certificate issuance.  
 Your birthdate of the second calendar year from certificate issuance. (This irrevocable selection means your initial certificate term may be for more or less than two full years.)

**(5) Applicant Certification:** I declare that the foregoing information is true and correct to the best of my knowledge.

Applicant 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.

## Instructions:

**FOR ALL APPLICANTS:** Use the applicable following checklist to ensure your application is complete (including all supporting forms and fees) and submit it to: CDSS, Administrator Certification Section (ACS), 744 "P" Street, MS 9-14-47, Sacramento, CA 95814. Keep a complete copy of your package for your records. If you have any questions about the application process, please call the ACS at (916) 653-9300.

## FOR INITIAL APPLICANTS:

To receive your Administrator Certificate, applicant shall be at least 21 years of age, have a high school diploma or equivalent, such as a General Education Development (GED) certificate, have the required criminal record clearance (or exemption) on file with the Department of Justice (including, for GH administrators, a Child Abuse Central Index check clearance), and must submit the following within 30 days of receiving your congratulatory letter:

- A copy of the Department's **congratulatory letter** verifying a passing exam score. (Keep original for your files.)
- A copy of the Department's application deadline **extension approval letter**, if applicable. (Keep original for your files.)
- A completed **Application for Administrator Certification** (form LIC 9214 (01/16))
- A **check or money order** for \$100 payable to the Department of Social Services. Please include your administrator certificate number on your check. Paper clip your check to your documents; do not staple or glue.
- A copy of your **high school diploma or equivalent** (e.g., GED certificate) or college diploma. (Keep original for your files.)
- A copy of your **Certificate of Completion** of the Initial Certification Training Program (ICTP, provided by ICTP vendor).
- A completed **Criminal Record Statement** (form LIC 508 (03/11))
- If you have already been fingerprinted by Live Scan, a copy of the completed **Request for Live Scan Service** (form LIC 9163 03/11), signed by the Live Scan operator. (Note: You do not need to wait for your Live Scan results before submitting your application.)
- If applicable, for RCFE applicants only, a copy of your current **Nursing Home Administrator** license.

## FOR RENEWAL APPLICANTS:

In order to maintain compliance with the provisions of the Administrator Certification Program, you are required to maintain the criminal record clearance (or exemption), and submit the following information **prior** to the certificate expiration date. *Note that certificates cannot be renewed if they have been expired for more than four (4) years.*

- A completed **Application for Administrator Certification** (form LIC 9214 (01/16))
- A **check or money order** for \$100 payable to the Department of Social Services (**OR** for \$300 if you're renewing after your certificate expired). Please include your administrator certificate number on your check. Paper clip your check to your documents; do not staple or glue.
- Proof of completion** (e.g., copies of completion certificates from course vendors) of forty (40) hours of continuing education (OR twenty (20) hours for RCFE/NHA certificate holders) sufficiently related by subject matter and logic to the Core of Knowledge for your certificate type (e.g., ARF, GH, RCFE) and provided by approved vendors per program regulations. The total units must include: \*
  - At least four (4) hours of instruction in laws, regulations, policies and procedural standards that impact your type of care facility (e.g., ARF, GH, RCFE);
  - If not included in your ICTP, at least one (1) hour of instruction in cultural competency and sensitivity in issues related to the lesbian, gay, bisexual, and transgender community.
  - For RCFE (and RCFE/NHA) certificate holders, at least eight (8) hours in subjects related to serving residents with Alzheimer's Disease or other dementias
- If applicable, for RCFE applicants only, a copy of your current **Nursing Home Administrator** license.
- For applicants renewing more than two (2) years but less than four (4) years after certificate expired, **proof of completion** of an **additional** forty (40) hours of continuing education (or 20 for RCFE/NHA certificate holders), including an additional four (4) hours in laws, etc., and eight (8) hours in dementia subjects as detailed above.

# Residential Care Facility for the Elderly (RCFE) 40-Hour Initial Certification \*Core of Knowledge Guideline

8-Hours	3-Hours	3-Hours	5-Hours	2-Hours	5-Hours	5-Hours	5-Hours	4-Hours
<b>LAW &amp; REGULATIONS</b> Health and Safety Code 1569 Regulations Title 22, Div. 6, Chapter 8 • Administrative responsibility/accountability • Mandated reporting • Confidentiality • Personal rights • Complaint procedures State Fire Code Regulations • R2 Occupancies Conservatorship • Full • Limited Physical Plant	<b>BUSINESS OPERATIONS</b> Liability issues Budgeting and fiscal documentation Monitoring of ongoing operations Funding sources Overview of labor laws Marketing a facility Rate setting/record keeping Other agencies • IRS • EDD • INS Audits: • Program • Financial Accounting & tax filing requirements Fund raising: • What's legal? • Audits • How to mix with other funds	<b>MANAGEMENT/SUPERVISION OF STAFF</b> Staffing requirements/ratio Hiring practices: • Criminal background requirements • Use of volunteers/interns • EEO requirements • General requirements • Other issues • Job descriptions • Federal/state requirements Employee performance evaluations Personnel policy manual Admin/staff training requirements • First Aid • CPR • HIV/TB • Water safety • OSHA • Illness/injury and violence prevention plan • Duties/responsibility of staff • Employer responsibility • Staffing patterns	<b>PSYCH/SOCIAL NEEDS</b> Identifying characteristics and special needs of client population Mental health issues Family involvement/participation and dynamics Bereavement/stress issues Activities Dementia care	<b>COMMUNITY &amp; SUPPORT SERVICES</b> Responsibilities & expectations of referral agencies Mental health resources Ombudsman Adult Protective Services Other resources	<b>PHYSICAL NEEDS</b> Understanding the client needs • Nutrition • Assisting with ADLs • Health conditions • Aging process Individual health care needs • Dental • Vision • Podiatry • Hearing • Physical limitations • Hospice care/end of life issues Sexuality in the aging adult Nutritional support	<b>MEDICATION</b> Administration of medication • Technical aspects Regulatory requirements: • Storage • Documentation • Disposal Role of medications in treatment plan, including typical interactions & staff's role Communication with pharmacists, MDs Drug interaction/pharmacodynamics Common medications: • Infection control • Seizure disorder • Psychotropic Client advocacy related to medication use Medi-Cal Medical/dental funding	<b>ADMISSION &amp; ASSESSMENT RETENTION</b> Program Statement Allowable vs. prohibited conditions/IMS Appraisals: • Pre-admission • Physician's report • Functional • Social • Ongoing Needs and services plan: • Development • Review Charting and documentation Admission agreements Adult Protective Services/emergency placement Incidental medical services • Allowable • Restricted • Prohibited Client satisfaction Contract compliance Age exceptions Relocation/eviction	<b>ALZHEIMER'S &amp; DEMENTIA TRAINING</b> Overview of Alzheimer's Disease and dementia Understanding dementia-related behaviors Communications Personal care Medications Environment/physical plant Individualized Service Plan (ISP)

\*Topics within the basic curriculum may include, but not be limited to, topics as specified in the Department's Core of Knowledge Guideline.



# Residential Care Facilities for the Elderly (RCFE) Administrator 80-Hour Initial Certification Core of Knowledge Training Standard\*

New Form

8-Hours	6-Hours	6-Hours	7-Hours	8-Hours	2-Hours	8-Hours	10-Hours	8-Hours	1-Hour	4-Hours	4-Hours	8-Hours
<p><b>LAWS, REGULATIONS, POLICIES, AND PROCEDURAL STANDARDS IMPACTING RCFE</b></p> <p>Health and Safety Code 1569</p> <p>Overview of Title 22, CCR, Div 6, Chapter 8, RCFE, Articles 1-15</p> <ul style="list-style-type: none"> <li>• Licensing Process</li> <li>• Non-transferability of License</li> <li>• Certification process</li> <li>• New Laws and Regulations</li> <li>• Administrative responsibility/accountability</li> <li>• Mandated reporting</li> <li>• Confidentiality</li> <li>• Personal rights</li> <li>• Complaint procedures</li> <li>• Forms</li> <li>• Navigation of CCID website</li> <li>• Agencies</li> </ul> <p>State Fire Code Regulations</p> <ul style="list-style-type: none"> <li>• R2 Occupancies</li> <li>• R3.1 Occupancies</li> </ul> <p>State/Federal Laws</p> <p>Program Flexibility</p> <p>Exceptions</p> <p>Waivers</p>	<p><b>BUSINESS OPERATIONS</b></p> <p>Title 22, CCR, Div 6, Chapter 8, RCFE, Article 4 – Operating Requirements</p> <p>Wage Order 5</p> <p>Liability issues</p> <p>Insurance types</p> <p>Budgeting and fiscal documentation</p> <p>Monitoring of ongoing operations</p> <p>Overview of labor laws/Federal Requirements</p> <p>Personnel/Wages</p> <p>Classification of employees</p> <p>Employments</p> <p>status</p> <ul style="list-style-type: none"> <li>• Live-in</li> <li>• Salary vs hourly</li> <li>• Contract vs employee</li> <li>• FMLA</li> </ul> <p>Marketing a facility</p> <ul style="list-style-type: none"> <li>• General requirements</li> <li>• Type of facility</li> </ul> <p>Rate setting/ record keeping</p>	<p><b>MANAGEMENT/ SUPERVISION OF STAFF</b></p> <p>Title 22, CCR, Div 6, Chapter 8, RCFE, Article 6 – Background Check &amp; Article 7 - Personnel</p> <p>Staffing requirements/ Day/Night supervision</p> <p>Hiring practices:</p> <ul style="list-style-type: none"> <li>• Criminal background requirements</li> <li>• Use of volunteers and interns</li> <li>• EEO requirements</li> <li>• Federal/ State requirements</li> <li>• Wages</li> <li>• Interviewing</li> <li>• Termination</li> <li>• Fact sheet 33</li> </ul> <p>Performance evaluations</p> <p>Personnel policy manual</p> <p>Personnel records requirements</p> <p>Admin/ staff training requirements</p> <ul style="list-style-type: none"> <li>• First Aid/CPR</li> <li>• Immunizations and health</li> <li>• Water safety</li> <li>• Cal-OSHA</li> <li>• Illness/injury prevention plan</li> </ul>	<p><b>PSYCHOSOCIAL NEEDS OF THE ELDERLY</b></p> <p>Title 22, CCR, Div 6, Chapter 8, RCFE, Article 8 – Resident Assessments, Fundamental Services, and Rights</p> <p>Identifying characteristics and special needs of client population</p> <p>Evaluation and Observation</p> <ul style="list-style-type: none"> <li>• Initial</li> <li>• ongoing</li> </ul> <p>Mental health issues</p> <p>Family involvement/ participation and dynamics</p> <p>Bereavement/ stress issues</p> <p>Activities</p> <ul style="list-style-type: none"> <li>• Interests</li> <li>• Resident councils</li> </ul> <p>Basic services</p>	<p><b>PHYSICAL NEEDS FOR ELDERLY PERSONS</b></p> <p>Title 22, CCR, Div 6, Chapter 8, RCFE, Article 8 &amp; Article 11 – Health Background Check &amp; Article 7 - Personnel</p> <p>Hydration</p> <p>Understanding the client needs</p> <ul style="list-style-type: none"> <li>• Nutrition</li> <li>• Assisting with ADLs</li> <li>• Health conditions</li> <li>• Aging process</li> </ul> <p>Individual health care needs</p> <ul style="list-style-type: none"> <li>• Dental</li> <li>• Vision</li> <li>• Podiatry</li> <li>• Hearing</li> <li>• Physical limitations</li> </ul> <p>Sexuality in the aging adult</p> <p>Nutritional support/food service</p> <ul style="list-style-type: none"> <li>• Quality</li> <li>• Quantity</li> </ul>	<p><b>COMMUNITY &amp; SUPPORT SERVICES</b></p> <p>Responsibility &amp; expectations of referral agencies</p> <p>Mental health resources</p> <p>Ombudsman</p> <p>Adult Protective Services</p> <p>Resident and support services</p> <p>Suicide prevention</p> <p>Funding sources</p> <p>Other resources</p> <ul style="list-style-type: none"> <li>• Local area agencies on aging</li> <li>• Assisted living waiver program</li> <li>• DDS Regional centers</li> <li>• Free legal eye care</li> <li>• Dental</li> <li>• Trans- portation</li> <li>• PACE</li> </ul>	<p><b>MEDICATION MANAGEMENT</b></p> <p>Title 22, CCR, Div 6, Chapter 8, RCFE, Article 8 – Resident Assessments, Fundamental Services, and Rights</p> <p>Health &amp; Safety Code</p> <p>AB 1570</p> <p>Administration of medication</p> <ul style="list-style-type: none"> <li>• Technical aspects</li> </ul> <p>Regulatory requirements:</p> <ul style="list-style-type: none"> <li>• Storage</li> <li>• Documentation</li> <li>• Disposal</li> </ul> <p>Role of medications in treatment plan, including typical interactions &amp; staff's role</p> <p>Misuse and adverse effects of medication with Communication pharmacists &amp; MDs</p>	<p><b>RESIDENT ADMISSION, RETENTION &amp; ASSESSMENT PROCEDURES</b></p> <p>Title 22, CCR, Div 6, Chapter 8, RCFE, Article 12 – Dementia Program Statement</p> <p>Allowable vs. prohibited conditions/ IMS</p> <p>Appraisals:</p> <ul style="list-style-type: none"> <li>• Pre-admission</li> <li>• Physician's report</li> <li>• Functional</li> <li>• Social</li> <li>• Ongoing</li> </ul> <p>Needs and services plan:</p> <ul style="list-style-type: none"> <li>• Development</li> <li>• Review</li> </ul> <p>Charting and documentation</p> <p>Admission agreements</p> <p>Adult Protective Services / emergency placement</p> <p>Incidental medical services</p> <ul style="list-style-type: none"> <li>• Allowable</li> <li>• Restricted</li> <li>• Prohibited</li> </ul>	<p><b>MANAGING ALZHEIMER'S DISEASE AND RELATED DEMENTIAS</b></p> <p>Title 22, CCR, Div 6, Chapter 8, RCFE, Article 8 – Resident Assessments, Fundamental Services, and Rights</p> <p>Non-pharmacologic person-centered approaches to dementia care</p> <p>Overview of Alzheimer's Disease and dementia</p> <p>Understanding dementia-related behaviors</p> <p>How the patient communicates</p> <p>Personal care</p> <p>Medications</p> <p>Environment &amp; physical plant</p> <ul style="list-style-type: none"> <li>• Egress</li> </ul>	<p><b>CULTURAL COMPETENCY AND SENSITIVITY TO AGING LGBT COMMUNITY</b></p> <p>AB 663</p> <p>Issues related to the underserved again lesbian, gay, bisexual, and transgender community</p> <p>LGBT</p> <ul style="list-style-type: none"> <li>• Ethics &amp; values</li> <li>• Self-awareness</li> <li>• Education/ Skills/ Resources/ Advocacy</li> <li>• Staff Training</li> <li>• Requirements</li> </ul> <p>Care – Equality</p>	<p><b>MANAGING THE PHYSICAL ENVIRONMENT</b></p> <p>Title 22, CCR, Div 6, Chapter 8, RCFE, Article 5 – Physical Environment and Accommodations</p> <p>Maintenance Requirements</p> <p>Housekeeping Requirements</p> <p>Health and Safety Considerations</p> <ul style="list-style-type: none"> <li>• air/water temperature</li> <li>• lighting</li> <li>• grab bars</li> <li>• non-skid strips</li> <li>• signal system</li> </ul> <p>Disaster plan</p> <p>Capacity</p> <p>Use of space and storage</p> <ul style="list-style-type: none"> <li>• Poisons and pesticides</li> <li>• Firearms</li> <li>• Clear passageways</li> </ul> <p>Physical Plant</p>	<p><b>RESIDENTS' RIGHTS</b></p> <p>Title 22, CCR, Div 6, Chapter 8, RCFE, Article 8 – Resident Assessments, Fundamental Services, and Rights</p> <p>Statutory Personal Rights Afforded by AB 2171</p> <p>Initial and ongoing staff training to ensure residents' rights are fully respected and implemented</p> <p>Resident and Family Councils</p> <p>Basic services</p> <ul style="list-style-type: none"> <li>• Transportation</li> <li>• Handling of money</li> <li>• Protection from other residents</li> </ul>	<p><b>POSTURAL SUPPORTS, RESTRICTED HEALTH CONDITIONS &amp; HOSPICE CARE</b></p> <p>Postural Supports</p> <p>Restricted Health Conditions or Health Services</p> <p>Hospice Care</p> <ul style="list-style-type: none"> <li>• waiver</li> </ul> <p>Bedridden resident</p> <p>Exception Requests and Conditions for Them</p> <p>Total Care Waiver</p> <p>Home Health and other allied professional relationships</p>

\*Subtopics within the basic curriculum must include, but are not limited to, the topics specified in this RCFE Core of Knowledge Standard.

## Residential Care Facilities for the Elderly (RCFE) Administrator 80-Hour Initial Certification Core of Knowledge Training Standard \*

<ul style="list-style-type: none"> <li>Accounting &amp; tax filing requirements</li> <li>Bonding</li> <li>IRS</li> <li>Commingling</li> <li>Theft/Loss</li> <li>Plan of Operation</li> </ul>	<ul style="list-style-type: none"> <li>Other agencies</li> <li>IRS</li> <li>EDD</li> <li>INS</li> <li>Contract compliance</li> <li>Audits: <ul style="list-style-type: none"> <li>Program</li> <li>Financial</li> </ul> </li> <li>Legal fund raising: <ul style="list-style-type: none"> <li>Audits</li> <li>Co-mingling of funds</li> </ul> </li> <li>Phones/Vehicles</li> </ul>	<ul style="list-style-type: none"> <li>Staff Duties and responsibilities</li> <li>Employer responsibilities</li> <li>Staffing patterns</li> <li>General personnel requirements</li> <li>Training</li> <li>Types &amp; Frequency</li> </ul>	<ul style="list-style-type: none"> <li>Training</li> <li>Types</li> <li>Frequency</li> <li>Advanced Health Care Directives</li> <li>DNR Orders</li> <li>End of life planning</li> </ul>	<ul style="list-style-type: none"> <li>Storage</li> <li>Basic services</li> <li>Annual Physical 602</li> <li>Ongoing assessment &amp; observation</li> <li>Areas of neglect in direct client care <ul style="list-style-type: none"> <li>-Dehydration</li> <li>-Skin Breakdown</li> <li>-Malnutrition</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Medicare</li> <li>Medi-Cal</li> <li>211</li> <li>VA</li> <li>Adult day care center</li> <li>SSI</li> </ul>	<ul style="list-style-type: none"> <li>Written instructions</li> <li>Drug interaction/pharmacodynamics</li> <li>Common medications: <ul style="list-style-type: none"> <li>Infection control</li> <li>Seizure disorder</li> <li>Psychotropic</li> </ul> </li> <li>Client advocacy related to medication use</li> <li>Medi-Cal</li> <li>Medical/dental funding</li> <li>Required Training</li> <li>Common Medication Errors</li> <li>Address toxic medication precautions</li> <li>Hospice</li> </ul>	<ul style="list-style-type: none"> <li>Client satisfaction</li> <li>Contract compliance</li> <li>Age exceptions</li> <li>Relocation / eviction</li> <li>Evaluation and Observation <ul style="list-style-type: none"> <li>Initial</li> <li>ongoing</li> </ul> </li> <li>Assessment tools</li> <li>Home Health and other allied professional relationships</li> </ul>	<ul style="list-style-type: none"> <li>Storage of dangerous items</li> <li>Individualized Service Plan (ISP)</li> <li>Marketing and advertising</li> <li>Dementia Care</li> <li>Dementia Plan of Operation</li> </ul>	<ul style="list-style-type: none"> <li>Changes to Plan of Operation</li> <li>Building and Safety Code</li> <li>State Fire Code Regulations</li> <li>R2 Occupancies</li> <li>R3.1 Occupancies</li> </ul>	<ul style="list-style-type: none"> <li>Safeguard resident's cash, etc.</li> <li>Accommodations</li> <li>Observations</li> <li>Advance Health Care Directives</li> <li>DNR</li> <li>dignity</li> <li>Conservatorship</li> <li>Full</li> <li>Limited</li> <li>Abuse Prevention</li> <li>Polst</li> </ul>
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