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| ***FOR OFFICE USE ONLY*** |
| Application Approved: |
| License Number: |
| Issue Date: |
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| |
| ID#: |
| Receipt #: |

***Instructions and Application For
License As An
Assisted Living Residence
Administrator***

- By Examination By Endorsement
- By Rhode Island Nursing
Home Administrator License

Applicant - Print Name

| | | |
|----------------------|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <i>LAST NAME</i> | <i>FIRST NAME</i> | <i>MI</i> |

GENERAL INFORMATION

Enclosures

The following information is enclosed:

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 - By RI Nursing Home Administrator License
 - By Endorsement
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Statute

Chapter 23-17.4 entitled “Assisted Living Residence Licensing Act” can be downloaded at the following website:

<http://www.rilin.state.ri.us/statutes/title23/23-17-21.2>

Rules and Regulations

To obtain the Rules and Regulations for your profession visit the A-Z list on the Topics & Programs page at the following web site. From the list click on the letter for your profession.

<http://www.health.ri.gov/atoz/>

APPLICATION PROCESS OVERVIEW

The licensure process in the State of Rhode Island is conducted by the Rhode Island Department of Health (HEALTH), Office of Health Professions Regulation, 3 Capitol Hill, Room 105, Providence, RI 02908.

Application Process

You must submit the application and additional information. All items listed on the following applicable checklist must be submitted for an application to be considered complete. **APPLICATIONS ARE ONLY VALID FOR A ONE (1) YEAR PERIOD.**

You are responsible for notifying HEALTH, in writing, when your address changes.

Once completed, the application will be reviewed and you will be contacted in writing. NOTE: You may ***not*** practice as an Assisted Living Residence Administrator in Rhode Island until you have an active license.

To obtain your licensure status and license number, please refer to the HEALTH Licensee Lookup website:

<https://healthri.mylicense.com/Verification/>

If you have any questions about the application process, please contact this office at (401) 222-5888.

Licenses will be issued within 7-10 working days following approval of the license. Wallet-sized license cards are mailed within 4 weeks from the date of issuance, and are mailed to the address furnished in the application.

INSTRUCTIONS FOR COMPLETING THE APPLICATION

Read the following instructions carefully before you complete the application. **Only completed applications will be accepted.** Failure to submit all required information, appropriate documentation and required fee will result in processing delays.

General Instructions

1. Make a copy of the application and forms before you begin in case you make a mistake.
2. Type your information or print in blue or black ball-point pen. Illegible information will not be accepted.
3. Provide a response to each section or question; otherwise, mark "N/A" for Not Applicable.
4. Make a copy of your completed application before you submit it to HEALTH.
5. It is your responsibility to check on the status of your application.

Completing your Application

1. Complete the application. You must respond to all sections of the application as instructed. If you attach separate pages as a continuation of the application, please clearly indicate the section for which such information is being reported.
2. Make a check or money order payable to the **General Treasurer, State of Rhode Island** and staple it to the upper left-hand corner of the first page of the application. The application fee is NON-REFUNDABLE.
3. Do not submit the application without all applicable information, documentation and fee. Mail the application to:

| |
|--|
| <p style="text-align: center;">Rhode Island Department of Health 3 Capitol Hill, Room 105 Providence, RI 02908-5097</p> |
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APPLICATION CHECKLISTS

Please review the following checklists, **choose which one applies to you**, and include all of the required information to complete your Assisted Living Residence Administrator application.

All applicants must include the following:

By Examination

1. Two original letters of good moral character on company letterhead;
2. **Original** BCI check from the RI Attorney General's Office; if positive BCI, a detailed explanation is required.
3. Completion of a Department approved training program, which includes:
 - RIALA's Certificate,
 - RIALA's letter with examination results, and
 - AIT Certification Form, for 80 hours field experience within a 12 month period in a RI licensed ALR facility; **OR**

Completion of Degree in health care-related field, which includes:

- Official school transcript(s), with registrar's signature and school seal
- Examination results, and
- AIT Certification Form, for 80 hours field experience within a 12 month period in a RI licensed ALR facility; **OR**

Active Rhode Island Nursing Home Administrator license in good standing.

NHA Number _____

4. An original or notarized copy of birth certificate for US born applicants OR
Notarized proof of citizenship and eligibility for employment for foreign-born applicants;
5. A passport-type 2 x 3 inch photograph, taken within 1 year;
6. Notarized application; and
7. \$220.00 non-refundable check or money order made payable to the RI General Treasurer

By Endorsement

1. Two original letters of good moral character on company letterhead;
2. **Original** BCI check from the RI Attorney General's Office; if positive BCI, a detailed explanation is required.
3. Official school or training transcript(s), with registrar's signature and school seal;
4. An original or notarized copy of birth certificate for US born applicants OR
Notarized proof of citizenship and eligibility for employment for foreign-born applicants;
5. A passport-type 2 x 3 inch photograph, taken within 1 year;
6. A brief history of prior experience in Assisted Living or related industry.
7. Notarized application;
8. \$220.00 non-refundable check or money order made payable to the RI General Treasurer
9. Evidence of a current license in good standing as an ALRA in all alternate jurisdictions
 - Completed Interstate Verification form(s).



State of Rhode Island

Application for License as an Assisted Living Residence Administrator

Refer to the Application Instructions when completing these forms. Type or block print only. Do not use felt-tip pens.

1. Name(s)

This is the name that will be printed on your License/Certificate.

Title (i.e., Mr., Mrs., Ms., etc.)

First Name

Middle Name

Surname, (Last Name)

Suffix (i.e., Jr., Sr., II, III)

Maiden, if applicable

Name(s) under which originally licensed in another state, if different from above (First, Middle, Last).

2. Social Security Number

U.S. Social Security Number

"Pursuant to Title 5, Chapter 76, of the Rhode Island General Laws, as amended, I attest that I have filed all applicable tax returns and paid all taxes owed to the State of Rhode Island, and I understand that my Social Security Number (SSN) will be transmitted to the Division of Taxation to verify that no taxes are owed to the State."

3. Gender

 Male Female

4. Date of Birth

Month

Day

Year

5. Home Address

It is your responsibility to notify HEALTH of all address changes.

1st Line Address (Apartment/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City

Country, If NOT U.S.

Home Phone

State

Zip Code

Postal Code, If NOT U.S.

Home Fax

Email Address

6. Business Address (ONLY if it is RELATED to your license.)

It is your responsibility to notify HEALTH of all address changes.

This address will appear on the Health web site.

Name of Business/Work Location

1st Line Address (Department/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City

Country, If NOT U.S.

Business Phone

Extension

Business Fax

State

Zip Code

Postal Code, If NOT U.S.

13. Affidavit of Applicant

Complete this section and sign in the presence of a notary public.

I, _____, being first duly sworn, depose and say that I the person referred to in the foregoing application and supporting documents.

I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice as an Assisted Living Residence Administrator in the State of Rhode Island.

I understand that this is a continuing application and that I have an affirmative duty to inform HEALTH of any change in the answers to these questions after this application and this affidavit is signed.

Signature of Applicant

Date of Signature (MM/DD/YY)

The foregoing instrument was acknowledged before me this _____ day of _____, 20_____, by _____, who is personally known to me or has produced _____ as documentation and did / did not take an oath.

Name of Notary (Print, Type or Stamp)

Signature of Notary

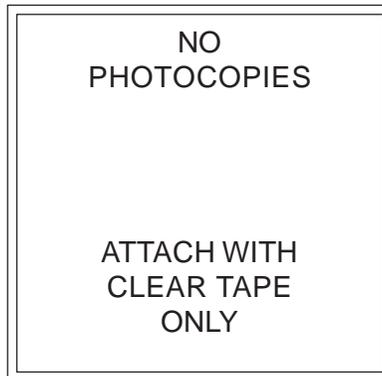
Notary No./Commission No.

Commission Expiration Date (MM/DD/YY)

Notary Seal

14. Recent Photograph

Securely tape a current 2" x 3" photograph.



Provide the date that the photograph was taken.

Date of Photograph



Rhode Island Department of Health

Room 105, 3 Capitol Hill
Providence, RI 02908-5097
(401) 222-5888

Documentation of Eighty (80) Hours of Field Experience (AIT Certification Form)

Print/Type Applicant's Full Name _____ Social Security Number _____ Date of Birth _____

*R23-17.4-ALA "Rules and Regulations for the Certification of Administrators of Assisted Living Residences" - Section 3.0, "Qualifications for Licensure" - requires successful completion of a degree in a health-care related field from an accredited College or University **and** requires satisfactory completion of a field experience of at least eighty (80) hours, within a twelve (12) month period, in a training capacity in a licensed assisted living/nursing facility that shall include training in the following areas: Administration, Nursing, Activities Department, Admissions, Human Resources, Business Office, Dietary Department, Environment/Maintenance and Housekeeping/Laundry. At the conclusion of the field experience, the administrator of the licensed assisted living/nursing facility where the field experience was performed must attest that the training included each area.*

I hereby attest that _____ has satisfactorily completed eighty (80) hours of Field Experience in the following areas:

- | | | | | | |
|--------------------------|---|--------------------------|----------------------------------|--------------------|--|
| Number of Hours | <input type="checkbox"/> Administration | Number of Hours | <input type="checkbox"/> Nursing | Number of Hours | <input type="checkbox"/> Human Resources |
| <input type="checkbox"/> | Activities Department | <input type="checkbox"/> | Admissions | | |
| <input type="checkbox"/> | Dietary Department | <input type="checkbox"/> | Environment/Maintenance | | |
| <input type="checkbox"/> | Housekeeping/Laundry | <input type="checkbox"/> | Business Office | | |
| <input type="checkbox"/> | Other, Explain: _____ | | | | |
| <input type="checkbox"/> | Total number of hours in AIT Training Program (if hours are obtained at more than one facility, please make photocopies of this form) | | | | |

Name of Rhode Island Assisted Living Residence Facility

Signature of Rhode Island Assisted Living Residence Administrator

Print or Type Name of ALRA

Date of Signature

RI ALRA License Number

The foregoing instrument was acknowledged before me this _____ day of _____, 20____, by _____, who is personally known to me or has produced _____ as documentation and did / did not take an oath.

Name of Notary (Print, Type or Stamp)

Signature of Notary

Notary Seal

Notary No/Commission No.

Commission Expiration Date (MM/DD/YY)



Substitute forms are not acceptable, copy this form as needed.

Rhode Island Department of Health

Room 105, 3 Capitol Hill
Providence, RI 02908-5097
(401) 222-5888

INTERSTATE VERIFICATION FORM - OTHER STATE LICENSE(S)

I am applying for a license to practice as an Assisted Living Residence Administrator in the State of Rhode Island. The Rhode Island Board of Assisted Living Residence Administrator Certification requires that the following form be completed by the jurisdiction(s) in which I hold or have held a license. This constitutes authority for you to release all information in your files, favorable or otherwise, directly to the Rhode Island Board of Assisted Living Residence Administrator Certification at the above address.

Print/Type Full Name _____ Signature _____ Date _____

Previous Names Used _____ Social Security Number _____ Date of Birth _____

License Number _____ Date Issued _____

THIS SECTION TO BE COMPLETED BY THE ASSISTED LIVING RESIDENCE BOARD

| | | |
|--|---|------------------|
| Assisted Living Residence Administrator Program Completed: | Location: | Graduation Date: |
| Licensed by Examination? <input type="checkbox"/> Yes <input type="checkbox"/> No | Applicant has completed and passed the National Certification Exam: <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| License Status: <input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Lapsed | Original Date Issued: | Expiration Date: |

Questions:

- Has this licensee ever been investigated by your Board? Yes No
- Has this licensee incurred any disciplinary proceedings in your state, or is any action pending? Yes No
- Has the applicant's license ever been denied, surrendered, reprimanded, suspended, revoked or placed on probation? Yes No
- Do you know of any information that may discredit this person? Yes No

If you answer "Yes" to questions 1-4, please provide a written explanation below, and attach a copy of all supporting documentation (e.g., Board order, complaint, etc.).

Certification:

Signature _____ Date _____

Type or Print Name _____

Please Affix
Board Seal Here

Title _____

Full Name and State of Licensing Board _____

Please return directly to HEALTH at the above address. Thank you for your prompt cooperation.