# RENEWAL RESIDENT MANAGER
## Application Check list

Multnomah County Adult Care Home Program
421 SW Oak St., Suite 650, Portland, Oregon 97204
Email: advsd.adult.carehomeprogram@multco.us

ACHP OFFICE USE ONLY

$_____ #_____

INT_____

**BEFORE YOU MAIL YOUR APPLICATION, REFER TO THE CHECKLIST BELOW AND <u>PLEASE</u> DO NOT RETURN THE APPLICATION UNTIL YOU:**

- ❒ Submit a check or money order for correct amount ($25 or $40)
  $15.00 pays for your Background Check Request (BCR), if needed, & $25.00 pays to process your Resident Manager application. *If you have a current background check approval from the ACHP, a second background check is <u>not</u> necessary, unless you are applying for a new role or a different adult care home.)*
- ❒ Complete every question, and have signed and dated the application.
- ❒ Complete and submit a Background Check Request Form with a copy of your current photo identification, if a current one does not already exist. ***<u>ALL NEW AND EXPIRED</u>*** *applicants must bring their BCR and photo ID in person.*
- ❒ Attach a completed Physician's Report Form, *<u>signed and dated by a physician</u>*
  *EVERY TWO YEARS.
- ❒ Attach copies of current annual Continuing Education Hour Certificates to verify completion.
  *(12 hours annually required for Class I, 14 hours for Class II and 16 hours for Class III).*
- ❒ Attach a copy of current First Aid Certificate and CPR Certificate.

**IF ANY PART OF THE APPLICATION OR REQUIREMENTS ARE NOT COMPLETED CORRECTLY, THE APPLICATION WILL BE RETURNED TO YOU. DO NOT REMOVE THIS PAGE FROM APPLICATION AND <u>ALWAYS KEEP A COPY OF YOUR COMPLETED APPLICATION FOR YOUR FILES.</u>**

## ***<u>The Multnomah County Administrative Rules (MCAR's) State:</u>***

- The Adult Care Home Program (ACHP) will not process license applications until a complete application packet is received by the ACHP. (MCAR 023-040-225)
- The ACHP shall grant or deny a license to an applicant within 60 days of the date the ACHP receives a complete application packet. (MCAR 023-040-240)
- Application packets are void 30 days from the date any portion of the application packet and/or fees are received by the ACHP if the application packet is not complete. (MCAR 023-040-245)
- Failure to provide accurate and complete information may result in denial of the application. (MCAR 023-040-250)

**Adult Care Home Program**
421 SW OAK ST., SUITE 650
PORTLAND OR 97204
(503) 988-3000
Email: advsd.adult.carehomeprogram@multco.us

Multnomah County

# RENEWAL RESIDENT MANAGER APPLICATION

Complete the application *in full* and return to the above address. ***A renewal application must be completed every year.***.

**PLEASE PRINT USING A BALLPOINT PEN OR TYPE. AN INCOMPLETE APPLICATION WILL NOT BE PROCESSED**

Resident Manager Information (NOT OWNER/OPERATOR)

1. Name:_____ Telephone:_____

   Address:_____

   City/State:_____ Zip:_____

   E-Mail:_____ Cell Phone:_____

2. Persons to contact in case of an emergency:_____

   Address:_____ Telephone: _____

3. Special Qualifications

   ❑ Registered Nurse: State & #:_____

   ❑ Licensed Practical Nurse: State & #:_____

   ❑ Certified Nurses Aid ❑ Certified Med-Aid (Enclose certification copy)

   ❑ Sign Language ❑ Other Language(s) Spoken_____

   ❑ Other_____

4. Date CPR expires:___/___/_____ Date First Aid Training expires:_____/___/_____

Operator Name:_____

Facility Address:_____ Zip:_____

Telephone:_____ Cell Phone:_____

* A resident manager is any employee of the operator who lives and/or works in the home and has sole or primary responsibility for the facility and its residents on a regular and continuing basis, working multiple 24 hour periods during a month or any period that exceeds 48 hours (MCAR 023-070-105). List Continuing Education received in the last licensing year. (12 hours for Class I, 14 hours for Class II and 16 hours for Class III. CPR and First Aid do not count towards Continuing Education hours.

5. **Title of Training** **Trainer** **Date** **# of Hours**

6. Do you currently attend school or have a job or business outside of the adult care home?

❑ No ❑ Yes Explain: _____

**7. Have you ever had a substantiated abuse or neglect complaint? ☐ Yes ☐ No**

I declare under penalties of perjury that I have examined this application and to the best of my knowledge and belief it is true, correct and complete. I hereby authorize the department to conduct an investigation of my background. If approved as Resident Manager, I understand that I am required by law to comply with all applicable laws and rules, to comply with the standards for adult care home, and to comply with the residents' Bill of Rights. I agree to cooperate with the department in all future inspections, interviews and other investigations conducted in order to approve a license and to monitor continuing compliance with the MCAR's.

Signature of Resident Manager:_____ Date:_____

**Enclosures which must be returned with this application:**

- ❑ Background Check Request Form **$15.00 fee, if needed**
- ❑ $25.00 Application **Processing fee (required for all applications)**
- ❑ Copy of CPR Certificate / First Aid Certificate
- ❑ Physician evaluation every two years

# Health History and Physician/Nurse Practitioner's Statement

**Applicant's name:**_____ **Birth date:** _____

**Part 1** ***(*Pages 1-2) To be completed by the operator and given to physician or nurse practitioner for review.***

**Part 2** ***(Pages 3-4)*** **To be completed by physician or nurse practitioner and return directly to ACHP.**

**Current physician or nurse practitioner's name:**

**Date of exam by this medical provider** **/** **/**

## Review of symptoms (check all that apply)

| Do you have any of the following? | | Do you have any of the following? | | Have you ever had? | |
|---|---|---|---|---|---|
| Weight loss/weight gain | | Tiredness or significant fatigue | | A car accident | |
| Fevers/headaches | | Unable to tolerate heat or cold | | Loss of consciousness | |
| Difficulty with vision | | Short of breath with or without | | Loss of vision | |
| Dizziness/vertigo | | Palpitation or skipped beats | | Abnormal heart rhythm | |
| Seasonal allergies | | Chest pain or tightness | | Seizure | |
| Sinus problems | | Indigestion/heartburn | | Panic attacks | |
| Wheezing | | Abdominal pain | | Head injury | |
| Cough | | Diarrhea/constipation | | Stroke | |
| Back pain | | Irregular periods | | Paralysis | |
| Joint pain or swelling | | Frequent urinary tract infections | | Back injury | |
| History of broken bones | | Kidney stones | | Psychiatric treatment | |
| | | Skin problems (rash, psoriasis) | | | |

## Vaccination history/communicable diseases* *(Have you had?)*

| | Yes | No | Unsure |
|---|---|---|---|
| The standard series of childhood vaccinations? | | | |
| The disease "chicken pox" or the chicken pox vaccine *(Varicella)*? | | | |
| A tetanus/diphtheria booster shot within the last 10 years? | | | |
| Hepatitis B vaccination *(this is a series of 3 injections spaced several months apart)*? | | | |
| The disease "Tuberculosis"? | | | |
| A positive tuberculosis test *(also called PPD or Tine Test)* | | | |
| Vaccination against tuberculosis with BCG *(this is uncommon in the United States)*? | | | |

http://www.cdc.gov/vaccines/spec-grps/hcw.htm - Healthcare Personnel Vaccination Recommendations

## *Current* medical or psychiatric conditions *(Those that you are currently experiencing and receiving treatment for)*

| | *Please list* N/A | Date of onset | | *Please list* | Date of onset |
|---|---|---|---|---|---|
| 1 | | | 2 | | |
| 3 | | | 4 | | |
| 5 | | | 6 | | |

**Note**: Check N/A (not applicable) if you are not experiencing or receiving treatment for any Medical or Psychiatric condition.

## Medications/treatments ☐ N/A (Please include prescription medications, non-prescription medications, vitamins, herbal supplements, medical marijuana and treatments)

| | | | |
|---|---|---|---|
| 1 | | 2 | |
| 3 | | 4 | |
| 5 | | 6 | |
| 7 | | 8 | |

***Question:*** *Do you have any allergies to medications or other substances? If yes, please list.*

**Note**: Check N/A *(not applicable)* if you are not on any medication prescription, non-prescription medications, vitamins, herbal supplements or Medical Marijuana or do not have any medication allergies.

## Occupational assessment

| | Yes | No | Unsure |
|---|---|---|---|
| *1.* Do you have any physical limitations *(such as lifting or mobility restrictions)* that may limit the type of resident/client you can care for? *(If yes explain)* | | | |
| 2. Do you currently use illicit/illegal drugs? *(If yes explain)* | | | |
| 3. How many alcoholic drinks do you consume per day? Per Week? | | | |
| 4. Have you ever had an occupational injury/illness before (back strain, chemical exposure, or infection due to human blood and body fluid exposure)? *(If yes explain)*. | | | |
| 5. Do you have any condition (physical, medical or psychological) that would require special accommodations in order for you to perform your job? *(If yes explain)* | | | |

I declare under penalty of perjury that all statements made in this Health History are true and complete. I authorize the Multnomah County, Adult Care Home Program and my physician, nurse practitioner or clinic to exchange any medical information that is pertinent to my ability to provide care to the frail, elderly or disabled adults and operate my adult foster home(s). I understand that my failure to provide accurate and complete information may result in the denial of my application or other administrative sanctions against my adult foster home license.

*Applicant's signature* *Date*

**PART 2 - THIS FORM IS TO BE COMPLETED AND RETURNED TO THE ADULT CARE HOME PROGRAM BY THE HEALTH CARE PROVIDER. Return completed form to:** Adult Care Home Program, 421 SW Oak St, suite 650 Portland Or 97204

**Applicant's name:** _____ **Exam date:** / /
Please print applicant's name

**INSTRUCTIONS TO THE HEALTH CARE PROVIDER:**

The individual named above is under consideration for a care provider position in an adult care home. A completed Physician/Nurse Practitioner's Statement is required every two years or more frequently if needed, as a means of documenting that the applicant is in satisfactory health to provide care and services to older adults and adults with disabilities.

**ALL CAREGIVERS, must be physically, mentally and emotionally able to care for individuals who may require varying levels of assistance with their Activities of Daily Living.**

The job requires physical, mental and emotional health sufficient to perform the following duties safely. This list is not all inclusive but provided to give you a sense of the care requirements the above individual will be required to provide.

Physical activities include, changing bedding, mattresses and/or moving furniture in resident rooms; lifting, rotating and assisting residents who are partially or totally incapacitated; providing personal care in eating, dressing, hair and body care, communication, toileting, bathing, oral care, etc.; operating equipment such as wheelchairs, lifting devices, mechanized beds and other related medical device; medication administration and medical treatments per physician order and under nursing delegation supervision.

Emotional/mental activities being able to patiently listen and provide non-judgmental support and empathy, quick clear thinking and can remain calm in an emergency, able to be assertive and act as a resident advocate, able to follow rules and procedures directing them on the resident care and safety and able to deal in a supportive and empathetic manner to difficult situations.

## Physician/nurse practitioner questions

1. How long have you known this person?
   ☐ Just met today ☐ Months Years ☐ Other *(describe below)*
   _____ - _____

2. What information did you review to complete this Health History Assessment? *(Check all that apply)*
   ☐ Interview – date occurred
   ☐ Physical exam – date occurred
   ☐ Medical record review – please be specific
   ☐ Diagnostic testing and studies – please be specific

3. In your assessment have you identified any physical conditions or impairments that would limit this person's ability to care for, lift or physically support the movement of heavy, frail, elderly or disabled adults?
   ☐ No ☐ Yes **If yes, please explain below and include what information and/or documentation you relied on.**

Please rate the applicants' ability to:

| | UNKNOWN | POOR | AVERAGE | GOOD |
|---|---|---|---|---|
| Lift over 50lbs on a regular/daily basis: | ☐ | ☐ | ☐ | ☐ |
| Cope with high levels of stress on a daily basis: | ☐ | ☐ | ☐ | ☐ |
| Stand for long periods of time: | ☐ | ☐ | ☐ | ☐ |
| Communicate Verbally with Medical Personnel: | ☐ | ☐ | ☐ | ☐ |
| Follow instructions: | ☐ | ☐ | ☐ | ☐ |

4. This person listed their current medication(s)/treatment(s) on page 2 of this document. After your review of that medication/treatment list have you identified any issues that might reduce this individual's capacity to safely care for frail, elderly or disabled adults?

☐ No ☐ Yes **If yes, please explain below.**

5. Based on your health assessment and review of the applicant's health inventory, does this person have any mental or emotional problems that might hinder his/her ability to care for frail, elderly or disabled adults?

☐ No ☐ Yes **If yes, please explain below.**

6. Based on your health assessment and review of the applicant's health inventory, does this person have any cognitive problems that might hinder his/her ability to care for frail, elderly or disabled adults?

☐ No ☐ Yes **If yes, please explain below.**

7. Are there any indications this person ever abused drugs or alcohol?

☐ No ☐ Yes

**If yes, please explain below and include treatment received if any.**

8. In your opinion, would this applicant benefit from any evaluation and/or monitoring in either of the following areas:

Physical health concerns ☐ No ☐ Yes Mental/emotional health concern ☐ No ☐ Yes

**If yes, please explain below.**

9 Do you have any concerns that have not been addressed in this form?

☐ No ☐ Yes **If yes, please explain below.**

Thank you for completing this form. Your assessment and statement are used to ensure resident and caregiver safety in the Adult Foster Home setting.

**Physician Attestation and Signature**

I do hereby attest that this information is true, accurate and complete to the best of my knowledge. I understand that any falsification, omissions, or concealment of material fact may subject me to administrative, civil or criminal liability.

Signature stamps are not accepted

Signature and credentials of physician or nurse practitioner Date Phone number

# BACKGROUND CHECK REQUEST

Adult Care Home Program
Aging, Disability & Veterans Services Division

☐ **Background Check Request ($15.00 included)** ☐ **New (must be seen in person)**

☐ **Background Check Approval Verification Attached (no fee)** ☐ **Renewal**

**APPLICANT INFORMATION:** *Please attach a copy of your current government-issued photo ID.*

| | |
|---|---|
| 1. Last Name | 6. Government ID Type *(Driver's License, Passport, etc.)* |
| 2. First Name | 7. Government ID Number |
| 3. Middle Name | 8. Government ID State or Country of Issue |
| 4. Other Names Used *(last, middle, first)* | 9. Social Security Number *(optional; used to confirmed identity during criminal records check process)* |
| 5. Date of Birth | 10. Gender ☐Male ☐Female |

**CONTACT INFORMATION:** *Do not use the Operator's address unless you will live in the Adult Care Home.*

| | | | | | |
|---|---|---|---|---|---|
| 11. Home Phone | 12. Cell Phone | | 13. Email Address | | |
| 14. Physical Street Address & Apt. Unit | | | 15. Mailing Address *(if different from physical address)* | | |
| City | State | Zip Code | City | State | Zip Code |

**ROLE AND POPULATION**

16. Check one box for your role. *Note: a separate background check is required for each role.*
*Care Provider (ACHP Application required):* ☐ Caregiver ☐ Resident Manager ☐ Operator
*Noncaregiver (background check only):* ☐ Household Member ☐ Occupant
☐ Volunteer ☐ Housekeeper ☐ Property Maintenance ☐ Other:

17. Check the box for the population you intend to provide care for or have contact with:
☐ APD (Aging & People with Disablities) ☐ DD (Developmental Disabilities) ☐ AMH (Addictions & Mental Health)

18. Will you have direct contact with any of the following? ☐ Adults ☐ Seniors (age 65 or older)
☐ Confidential information ☐ Secure Facilities ☐ Finances or financial records ☐ Information Technology Systems

| | |
|---|---|
| 19. Will you be providing transportation services to residents in the adult care home? *If yes, please attach a copy of your valid driver's license.* | ☐Yes ☐No |

**APPROVED BACKGROUND CHECK OR LONG-TERM CARE REGISTRY**

| | |
|---|---|
| 20. Do you have a current approved background check (final fitness determination) from the state Background Check Unit for this role and this population, or are you on the Long-Term Care Registry (LTCR)? | ☐Yes ☐No |
| • *If yes, attach a copy of the approval letter from the state Background Check Unit or Long-Term Care Registry. List approval dates and complete #26 through #28.*<br>• *If no, complete #21 (New Background Check Request) through #28 on next page.* | LTCR Expiration Date: |

**21. NEW BACKGROUND CHECK REQUEST ($15 fee required)**
Only complete this section if you do not have a current approved background check (final fitness determination), or if you are not on Long-Term Care Registry, for this role and population.

| | |
|---|---|
| 22. Are you requesting preliminary approval pending final background check approval? | ☐Yes ☐No |
| 23. During the last 5 years, have you been outside of Oregon for 60 days in a row or more? If yes, complete the following for each residence in the past five years. | ☐Yes ☐No |

| Start Date | End Date | City | State | Country | Names Used at this residence |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

| | |
|---|---|
| 24. Have you **ever** been arrested, charged or convicted of a crime? If yes, list all arrests, charges and/or convictions (adult and juvenile) and the outcome, regardless of how long ago. For each arrest, charge or conviction you list, provide as much information as possible regarding the incident. *Attach additional pages as needed.* | ☐Yes ☐No |

| Date | Charge, arrest or conviction | Outcome (e.g., conviction, dismissal) | City | County | State |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

25. If you have potentially disqualifying conditions or convictions, the Background Check Unit must consider several factors to determine the risk of vulnerable individuals and your fitness to hold the position. Please provide any information about the details of your criminal history, yourself, your training, education, work history, treatment and circumstances since your criminal history. *Attach additional pages as needed.*

| | |
|---|---|
| 26. I understand that criminal record and abuse checks will be completed on me. My signature authorizes the ACHP and Background Check Unit to request and receive any juvenile, police, court or investigation reports needed to complete this background check. If I fail to list any part of my history, I understand my application may be closed or denied due to false statement. In the event that potentially disqualifying abuse is discovered, I will be notified at the address listed above and asked to provide additional information. | ***Initials:*** _____ |
| 27. If you have out-of-state identification, lived outside of Oregon in the past 5 years or have ever been arrested or convicted of a crime in Oregon or elsewhere, or if you are requested to submit fingerprints for any other reason, you are responsible for submitting electronic fingerprints within 10 days of the state Background Check Unit's request, which ACHP will email or mail to you. If you do not provide electronic fingerprints within the specified time, this application may be closed. By initialing here, you acknowledge that once this application is closed, a new application and fees must be submitted. | ***Initials:*** _____ |
| 28. I certify the information I have provided is correct and complete. I understand that if I provide false or incomplete information, my application may be closed or I may be denied the position. I understand the background check may be repeated while I hold this position. | ***Initials:*** _____ |

Signature:_____ Date: _____

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