License Classification and/or Level Change Request

A change in classification license requires a separate application to be completed by the Operator and must:

1. Have verifiable full time, hands-on experience and the ability to provide appropriate care to the population the Operator intends to serve (e.g. aging or disabled persons who are dependent in at least four ADLs, developmentally disabled adults, etc.).

2. Have completed training and testing necessary to serve the intended population (see below). For DD homes, the Operator, Resident Manager, and **all Caregivers** must complete the training and testing.

   APD: Basic Training (Ensuring Quality Care) and Qualifying Test
   DD: DD Basic Training and Qualifying Test plus OIS for Level 2B homes
   MH: MH Basic training and Qualifying Test

3. Have no substantiated complaints of abuse/neglect within the past thirty-six (36) months.

4. For a Level 3 license, please include two (2) medical references.

Please provide the information below, then email this request to the ACHP at advsd.adult.carehomeprogram@multco.us or fax to 503-988-5722.

Operator: _____ License #: _____

How many years have you been licensed in your current classification/level: _____

Address of ACH: _____

Phone: _____

Email: _____

New classification requested: ☐ APD ☐ DD ☐ MH

New level requested: ☐ APD or MH Level 2 ☐ APD Level 3
☐ DD Level 2B ☐ DD Level 2M

Background Check Request submitted for new population: ☐ Yes ☐ No

WORK EXPERIENCE

List where you have worked and provided care to persons who are representative of the population you intend to serve. (Attach additional sheets if necessary.)

1. Name of facility (if ACH, name of operator):_____

Address: _____

Dates: From _____ To _____

Typical number of hours worked per week: _____

Supervisor's Name (who can provide verification):_____

Phone: _____

2. Name of facility (if ACH, name of operator):_____

Address: _____

Dates: From _____ To _____

Typical number of hours worked per week: _____

Supervisor's Name (who can provide verification):_____

Phone: _____

My signature below indicates that I declare under penalties of perjury that the information provided by me is true and correct to the best of my knowledge.

Signature:_____ Date:_____

For ACHP Use Only

Compliance history supports ability to provide resident care in all areas, including basic care, recordkeeping, and fire safety:

☐ Yes ☐ No
☐ Approved ☐ Denied If denied, explanation: _____

_____

ACHP Staff Member's Name: _____ Signature: _____

If you disagree with this decision, you may request an administrative conference by emailing advsd.adult.carehomeprogram@multco.us or by calling the ACHP at 503-988-3000.

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