Class 3 License Application

The ACHP shall consider requests for reclassification of the license within 60 calendar days of receipt of the Operator's written request. A Class III license requires a separate application, to be completed by the Operator and the Resident Manager (if any) and both must:

1. Have operated or managed a Class II Adult Foster Home for at least a twelve (12) month period or, holds a current license as a health care professional in Oregon.
2. Have at least thirty-six (36) months of verifiable full time, hands-on experience providing care to elderly or disabled persons who are dependent in at least four ADL's.
3. Provide current satisfactory references from at least two medical professionals, such as a physician or Registered Nurse, who have direct knowledge of the applicant's ability and experience as a caregiver with persons who are dependent in at least 4 ADL's; and
4. Have no substantiated complaints of abuse/neglect within the past thirty-six (36) months.
5. Be able to demonstrate to the ACHP the ability to provide appropriate care to persons who are dependent four or more ADL's.

This is an application for a Class 3 license. Also attached are two medical reference forms that must be completed by at least two medical professionals. (The references may be sent in separately to the ACHP by the person completing them.)

NAME OF APPLICANT ____

Current Address ____

Phone ____________________________ Email address ____________________________

Adult Care Home operated or managed for at least 12 months:

Name of Operator ____

Address of home ____

Dates: From ________________ To______________ License Number: __________________

Experience: List where you worked and provided care to persons dependent in four or more ADL's. (Attach additional sheets if necessary)

1. Name of facility (if ACH, name of operator)___________________________________
Address____

Dates: From__________________________ To_________________________________

Supervisors Name (who can provide verification)___________________________________

Telephone_________________________________

2. Name of facility (if ACH, name of operator)___________________________________
Address____

Dates: From__________________________ To_________________________________

Supervisors Name (who can provide verification)___________________________________

Telephone_________________________________

3. Name of facility (if ACH, name of operator)___________________________________
Address____

Dates: From__________________________ To_________________________________

Supervisors Name (who can provide verification)___________________________________

Telephone_________________________________

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:

Substantiated abuse/neglect complaints within past 3 years: Yes________ No_________

Compliance history supports ability to provide care to Class III persons in all areas, including resident care, resident record keeping and fire safety:
Yes_________No_________

Approved________Denied_________Licenser____

CLASS 3 REFERENCE
MEDICAL PROFESSIONAL REFERENCE FOR OPERATOR/RESIDENT MANAGER

Operator/Resident Manager ____________________ Adult Care Home Address ____________________

The above named individual has requested a Level 3 Adult Care Home license classification. This requires that the Operator/Resident Manager have at least three (3) years experience providing direct care to persons dependent in at least four (4) of the following six Activities of Daily Living (ADLs):

1). Eating/Nutrition
2). Dressing/Grooming
3). Personal Hygiene/Bathing
4). Mobility/Transferring
5). Bowel/Bladder Control
6). Behavior Management

The Operator/Resident Manager must furnish satisfactory references from at least two medical professionals (physicians, nurse practitioners, physician assistants or registered nurses) who have direct knowledge of the applicant's ability and past experience as a caregivers. You are being asked to provide a reference, which allows us to evaluate the applicant's abilities. This may include a personal interview.

Recommendation/Reference: Please describe how you are acquainted with the applicant and how long you have known them. Describe your direct knowledge of this applicant's experience providing direct care to persons dependent in four or more ADL's, and your assessment of their ability to provide care to persons with complex medical conditions and/or persons who require full assistance with 4 or more ADL's. If necessary, please describe the knowledge or skills you believe this applicant needs to develop in order to provide this proposed level of care. Attach additional pages as needed.

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Print Name & Title ____________________ Signature & Date ____________________

Address ____________________

Email Address ____________________ Telephone ____________________

CLASS 3 REFERENCE
MEDICAL PROFESSIONAL REFERENCE FOR OPERATOR/RESIDENT MANAGER

Operator/Resident Manager ______________________ Adult Care Home Address ______________________

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Print Name & Title ______________________ Signature & Date ______________________

Address ______________________

Email Address ______________________ Telephone ______________________