Reclassification Request

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_____