APD or MHA Class 2 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 reclassification of a license requires that you complete this form and submit it with the requested verification. Remember if there is a Resident Manager in the home being reclassified, the Resident Manager must also qualify for the new classification. **To be approved, you must demonstrate to the ACHP that you have the ability to provide appropriate care and services. Please see the following criteria.**

1. Have operated or managed an Adult Care Home for at least a twelve (12) month period.

2. Have at least twenty-four (24) months of verifiable full time, hands-on experience providing care to residents in the classification you are applying for. An Operator with an APD or MHA Class 2 license may provide care for residents who require assistance in all ADL, but do not require full assistance in more than three ADL, and for individuals with severe and persistent mental illness who may also have limited medical conditions.

3. Submit two (2) current satisfactory references from professionals who have direct knowledge of the applicant's ability and experience as managing the needs of residents within the requested classification; and

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

5. Have completed all required training and certifications for the new license classification.

Requested Classification: ☐ APD Class 2 ☐ MHA Class 2

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 who require assistance in all 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 Level 2 persons in all areas, including resident care, resident record keeping and fire safety: Yes_____No_____

Approved_____Denied_____ Licenser_____ Date_____