

This form may be completed online, printed and mailed to the address listed below.

**APPLICATION FOR APPROVAL OF INITIAL
ASSISTED-LIVING FACILITY ADMINISTRATOR TRAINING**

STATE OF NEBRASKA

Department of Health and Human Services
Division of Public Health
Licensure Unit
PO Box 94986
Lincoln, NE 68509-4986

Name: <input type="checkbox"/> Mr. <input type="checkbox"/> Ms.			
Home Address:	Street/PO/Route		
	City:	State:	Zip:
Home Telephone Number:		FAX Number (if applicable):	
Facility Name:			
Facility Address: <small>(if applicable)</small>	Street/PO/Route:		
	City:	State:	Zip:
Facility Telephone Number:		FAX Number (if applicable):	
Social Security Number:		Birth Date:	
<p>After January 1, 2005, an Assisted- Living Facility Administrator must have successfully completed initial training consisting of a total of at least 30 hours. (175 NAC 4-006.02A) Verification of initial training completed must be submitted to the Department for approval. Please check one of the following and submit documentation for verification: (175 NAC 4-006.02B)</p>			
1	<input type="checkbox"/>	Evidence of completion of training (certificate or letter) including documentation of date of training, number of hours, description of training, and trainer qualifications;	
2	<input type="checkbox"/>	Evidence of successful completion of college courses and/or degrees which includes topics in 175 NAC 4-006.02A listed below;	
		Resident Care and Services Social Services Financial Management Administration Gerontology Rules, regulations, and standards relating to the operation of an Assisted-Living Facility	
3	<input type="checkbox"/>	Evidence of completion of a Department approved training program; or	
If an Assisted-Living Facility Administrator is currently licensed as a nursing home administrator or is a hospital administrator, the following must be submitted:			
1	<input type="checkbox"/>	Evidence of current licensure as a nursing home administrator in NE or other jurisdiction	
2	<input type="checkbox"/>	Evidence of a statement from the governing authority of hospital or other authorizing entity that can verify administrator status.	

Applicant Signature _____ Date _____

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Lawful Presence in the United States Attestation: For the purpose of complying with Neb. Rev. Stat. §§38-129 and 4-108 through 4-114, I attest as follows:

Please check the appropriate box(s) below:

- I am a citizen of the United States
- I am an alien lawfully admitted into the United State who is eligible for a credential under the Uniform Credentialing Act
- I am a non immigrant whose visa for entry, or application for visa for entry, is related to such employment in the United States
- I am a qualified alien under the Federal Immigration and Nationality Act

I hereby attest that my response and the information provided on this form and any related application for public benefits are true, complete and accurate and I understand that this information may be used to verify my lawful presence in the United States. ____

Application Attestation: I further attest that:

1. I have read the application or have had the application read to me;
2. All statements on the application are true and complete;
3. I am of good character; and
4. I have not committed any act that would be grounds for denial under 38-178 and/or 38-179. If you have committed an act(s), you must provide an explanation of all such act(s).

Print Name: _____

Signature: _____

Date: _____

For Department Use

If Applicable – Date of Request for More Information _____

Information Requested

Date Additional Information Received _____

Approval/Denial Notification Date _____

Department Staff Signature _____

Registry # _____

Date Registered _____