

DD License 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 you complete this form and submit it with the requested verification. Remember if there is a Resident Manager in home being reclassified that 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. You have successfully operated or managed an Adult Care Home for at least twelve (12) month period.
2. Have at least 24 months months of verifiable full time experience successfully providing care to residents in the classification you are applying for
 - An Operator with a Class DD 2B license provides care to residents with developmental disabilities who exhibit behavior that poses a significant danger to themselves or others. Examples of behaviors that may pose a significant danger to the resident or others include but are not limited to: (a) Acts or a history of acts that have caused injury to self or others requiring medical treatment. (b) Use of fire or items to threaten injury to others or damage to property. (c) Acts that cause significant damage to homes, vehicles, or other properties. (d) Actively searching for opportunities to act out thoughts that involve harm to others.
 - An Operator with a DD Class 2M license provides care to residents with developmental disabilities who have a medical condition that is serious and may be life-threatening. Examples of medical conditions that are serious or may be life-threatening include but are not limited to: (a) Brittle diabetes or diabetes not controlled through medical or physical interventions. (b) Significant risk of choking or aspiration. (c) Physical, intellectual, or mental limitations that render the individual totally dependent on others for access to food or fluids. (d) Mental health or alcohol or drug problems that are not responsive to treatment interventions. (e) A terminal illness that requires hospice care.
3. Submit 2 two professionals reference from a Case Manager, Behavioral Specialist, Service Coordinator, or Medical Professional who have direct knowledge of the applicant's ability and experience in managing the complex needs associated with this request.
4. Have no substantiated complaints of abuse/neglect within the past thirty-six (36) months.
5. Have completed all required training and certification for new license classification, including recent completion of at least 6 CEUs for population you wish to serve.

Applicant name: _____ License# _____

Current Address: _____

Phone _____

Email address _____

Please attached verification of required continuing education credits

Experience: List where you worked and provided care to persons dependent in four or more ADL's. Please 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 _____

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 2B or 2M persons in all areas, including resident care, resident record keeping and fire safety:
Yes _____ No _____

Approved _____ Denied _____ Licensor _____ Date: _____