ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Provider Services and Quality Assurance

Application for Psychiatric Residential Treatment Facility (PRTF) Administrators

The information contained herein, together with all attached documents will be regarded as property of the Department. Release of this information is governed by the Freedom of Information Act.

Please indicate application type: ☐ New Applicant ☐ Reciprocity Applicant ☐ Previous Applicant

SECTION 1: PERSONAL INFORMATION							
Last Name		First Name			Middle Initial		
Mailing Address							
City			State		Zip Code		
Primary Telephone		☐ Cell ☐ Home ☐ Work			Date of Birth		
Email Address					Place of Birth (City, State)		

Based on the Workforce Freedom Act of 2021, an occupational or professional licensing entity shall grant an occupational or professional license to an individual who fulfills the requirements of the occupation or profession in this state and is a person who holds a Federal Form I-766 United States Citizenship and Immigration Services-issued Employment Authorization Document, known as a "work permit." Reference A.C.A. §17-1-110

Are you a U.S. Citizen?	☐ Yes	☐ No	☐ I hold a Federal Form I-766 (please attach to application)

The Arkansas Occupational Licensing of Uniformed Service Members, Veterans, and Spouses Act of 2021 removes occupational licensure barriers that may impede the launch and sustainability of civilian occupational careers and employment faced by uniformed service members, uniformed service veterans, and their spouses due to frequent uniformed service assignments. Reference A.C.A. §17-4-106

Are you qualified to receive a military exemption? ☐ Yes ☐ No ☐ N/A

Select military status, if applicable (please attach supporting documentation to application)

☐ I am a uniformed service member stationed in the State of Arkansas.

☐ I am a service veteran who resides in or establishes residency in the State of Arkansas and makes an application within one (1) year of discharge from uniformed service.

☐ I am the spouse of:

- ☐ a uniformed service member stationed in the State of Arkansas
- ☐ a service veteran who resides in or establishes residency in the State of Arkansas
- ☐ a uniformed service member who is assigned a tour of duty that excludes the uniformed service member's spouse from accompanying the uniformed service member and the spouse relocates to the State of Arkansas; or
- ☐ a uniformed service member who is killed or succumbs to injuries or illnesses in the line of dutyif the spouse establishes residency in the State of Arkansas

SECTION 2: RECIPROCITY STATUS

Per A.C.A. §17-7-104, applicants currently licensed as a Psychiatric Residential Treatment Facility Administrator in good standing within another state shall be granted an automatic license if the applicant does not have a disqualifying criminal offense and does not have a complaint, allegation, or investigation pending for his or her occupational activity.

Have you ever applied for a Psychiatric Residential Treatment Facility Administrator (PRTF) license in another state? YES ☐ NO ☐

Do you currently hold a PRTF Administrator license, in good standing, in another state? ☐ YES ☐ NO

Please indicate which states and license number as applicable (please attach supporting documentation to application)

STATE OF LICENSURE	LICENSE NUMBER

Has your license, in any state listed above, ever been subject to discipline? ☐ YES ☐ NO

If yes, please explain and attach a copy of any settlement agreement, contract, etc. that you entered at the time of the discipline, if applicable:

Have you ever been denied licensure in another state? ☐ YES ☐ NO

If yes, please explain:

SECTION 3: PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY EXPERIENCE	
Are you currently working in a Psychiatric Residential Treatment Facility? ☐ YES ☐ NO	Name of Facility: Position/Title:
List Specific Job Duties:	
Have you previously worked in a Psychiatric Residential Treatment Facility facility? ☐ YES ☐ NO	
Please enter information on facilities you have previously worked. Print additional pages if necessary.	
Name of Facility:	
Facility Address:	City/State/Zip:
Position/Title:	Employment Dates:
List Specific Job Duties:	
Name of Facility:	
Facility Address:	City/State/Zip:
Position/Title:	Employment Dates:
List Specific Job Duties:	
Name of Facility:	
Facility Address:	City/State/Zip:
Position/Title:	Employment Dates:
List Specific Job Duties:	
Name of Facility:	
Facility Address:	City/State/Zip:
Position/Title:	Employment Dates:
List Specific Job Duties:	
Name of Facility:	
Facility Address:	City/State/Zip:
Position/Title:	Employment Dates:
List Specific Job Duties:	

SECTION 4: EMPLOYMENT HISTORY	
Please provide your experience for the ten (10) year period prior to this application. Do not duplicate the information in Section 3 above. Print additional pages if necessary.	
Name of Organization:	
Address:	City/State/Zip
Position/Title:	Name/Title of Supervisor:
Employment Dates:	Reason for Leaving:
List Specific Job Duties:	
Name of Organization:	
Address:	City/State/Zip
Position/Title:	Name/Title of Supervisor:
Employment Dates:	Reason for Leaving:
List Specific Job Duties:	
Name of Organization:	
Address:	City/State/Zip
Position/Title:	Name/Title of Supervisor:
Employment Dates:	Reason for Leaving:
List Specific Job Duties:	
Name of Organization:	
Address:	City/State/Zip
Position/Title:	Name/Title of Supervisor:
Employment Dates:	Reason for Leaving:
List Specific Job Duties:	
Name of Organization:	
Address:	City/State/Zip
Position/Title:	Name/Title of Supervisor:
Employment Dates:	Reason for Leaving:
List Specific Job Duties:	

SECTION 5: EDUCATIONAL RECORD
Per A.C.A. §20-10-403, successful applicants must present satisfactory evidence of sufficient education, training, or experience; or satisfactorily completed a course of instruction and training prescribed by the Department.
Please select the appropriate educational experience and attach supporting documentation and official transcripts to the application.
Bachelor’s Degree (BS or BA) or higher in child development, psychology, sociology, social work, guidance and counseling, education, administration, business, or a related field with: ☐ At least two (2) years of experience in a health-related field within the past five (5) years, or ☐ An employee with at least fifteen (15) years of executive level PRTF experience.

Please complete the following educational record as applicable to your selection				
	HIGH SCHOOL	COLLEGE	GRADUATE SCHOOL	OTHER
Name				
Location				
Dates of Attendance				
Grades,Years, or Hours Completed				
Type of Degree, Diploma, Certificate and Year Received				
Field of Study				

Please include any additional licenses or certifications relevant to your application, if applicable

SECTION 6: REFERENCES

Applicants must provide at least three (3) professional references, non-relatives, who have first-hand knowledge of the applicant's character, work experience, conduct and abilities. Applicant must attach a Letter of Reference from each to the application.

NAME	ADDRESS	HOW LONG HAVE THEY KNOWN YOU	PHONE NUMBER

SECTION 7: BACKGROUND

Have you ever been convicted for any violation of any law other than minor traffic violation?	☐ YES	☐ NO
Do you have any substantiated history of exclusion from Medicare or Medicaid programs?	☐ YES	☐ NO

Per A.C.A. §17-3-102, an individual is not eligible to receive or hold a license issued by the licensing entity if that individual has plead guilty or nolo contendere to or been found guilty of offense noted within the statute by any court in the State of Arkansas or of any similar offense by a court in another state or of any similar offense by a federal court, unless the conviction was lawfully sealed under the Comprehensive Criminal Record Sealing Act of 2013.

Have you been plead guilty, nolo contendere or been found guilty of any offense noted below? ☐ YES ☐ NO

(1) Capital murder;
(2) Murder in the first degree and second degree;
(3) Manslaughter;
(4) Negligent homicide;
(5) Kidnapping;
(6) False imprisonment in the first degree;
(7) Permanent detention or restraint;
(8) Robbery;
(9) Aggravated robbery;
(10) Battery in the first degree;
(11) Aggravated assault;
(12) Introduction of a controlled substance into the body of another person;
(13) Aggravated assault upon a law enforcement officer or an employee of a correctional facility, if a Class Y felony;
(14) Terroristic threatening in the first degree;
(15) Rape;
(16) Sexual indecency with a child;
(17) Sexual extortion;
(18) Sexual assault in the first degree, second degree, third degree, and fourth degree;
(19) Incest;
(20) Offenses against the family;
(21) Endangering the welfare of an incompetent person in the first degree;
(22) Endangering the welfare of a minor in the first degree;
(23) Permitting the abuse of a minor;
(24) Engaging children in sexually explicit conduct for use in visual or print media, transportation of minors for prohibited sexual conduct, pandering, or possessing visual or print media depicting sexually explicit conduct involving a child, or use of a child or consent to use of a child in a sexual performance by producing, directing, or promoting a sexual performance by a child;
(25) Computer child pornography;
(26) Computer exploitation of a child in the first degree;
(27) Felony adult abuse;
(28) Theft of property;
(29) Theft by receiving;
(30) Arson;
(31) Burglary;
(32) Felony violation of the Uniform Controlled Substances Act, § 5-64-101 et seq;
(33) Promotion of prostitution in the first degree;
(34) Stalking;
(35) Criminal attempt, criminal complicity, criminal solicitation, or criminal conspiracy

CONSENT AND ACKNOWLEDGEMENTS

By initialing next to each, you consent or attest to the statement

☐ I agree to have and pay for a criminal background check as part of my application review.

☐ I have read Arkansas Code Ann. § 20-10-401 *et. seq.* and the Rules and Regulations promulgated thereunder entitled "Psychiatric Residential Treatment Facilities Licensure Manual."

The following documents are attached to this application:

☐ Criminal Background Check
☐ Adult Maltreatment Registry Check
☐ Child Maltreatment Registry Check
☐ Sex Offender Registry Check

☐ This application and all attached documents contain no willful misrepresentation of falsification, and the information given by me is true and complete to the best of my knowledge and belief. I am aware that should investigation by the Department disclose any such misrepresentations or falsifications, it may prevent me from becoming licensed or, if I am already licensed, cause my license as a long-term care home administrator to be revoked.

☐ If this application is approved, I have nine (9) months from the date of approval to become licensed including obtaining a passing score on a written examination administered by the Department.

APPLICANT SIGNATURE AND NOTARIZATION

Signature of Applicant (ink or indelible pencil)	**Signature Date**

Sworn to and subscribed before me by the above this _____ day of _____, 20_____ **Notary Public**		
Signature	**County**	**State**
	Date My Commission Expires	

The Americans with Disabilities Act ensures that any person with disabilities will be afforded reasonable accommodations for testing and/or examination purposes. If you have a disability and may require some accommodations in taking examinations, you must request a "Request for Accommodation" form to be filed with this application. If accommodations are not requested forty-five (45) days in advance, we cannot guarantee the availability of accommodation on site. Contact the Office of Long-Term Care for the "Request for Accommodation" form.

If you are requesting consideration of your application for reciprocity under Section 1 of this application based upon military status, please submit the following documentation:

- Form DD214-DD 214/Separation Documents
- Interstate Transfer Form/Reciprocity Request
- Image/copy of individuals social security card
- Image/copy of valid US government issued photo identification; and
- Proof of service education, training, experience, and service-issued credentials by means of a Joint Service Transcript (JST).

The Department may require evidence of the completion of continuing education before granting a subsequent Administrator licensure or authorizing the renewal of an Administrator licensure to allow full or partial exemption from continuing education requirements.

OFFICE USE ONLY

Approved ☐ Denied ☐

Based on

Date Reviewed By