

VENDOR APPLICATION/RENEWAL
ADMINISTRATOR CERTIFICATION PROGRAM

Instructions: To apply to become (or to renew as) a course vendor for this Program, submit this completed application and a check or money order for the applicable processing fee to CDSS, ACS, 744 "P" Street, MS 9-14-47, Sacramento, CA 95814. Submit a separate vendor application and check or money order for each type of program (ARF, GH, RCFE) and vendorship (ICTP or CEU).

(1) **Type of Application:** (Check one box only. If renewing, provide vendor number and expiration date, and attach LIC 9139 if renewing courses.)

New **Renewal** Vendor # _____ Expires: _____ LIC 9139 attached? YES NO

(2) **Type of Program:** (Check one box only; if applying for more than one, submit separate application for each.)

ARF (Adult Residential Facility) GH (Group Home) RCFE (Residential Care Facility for the Elderly)
 STRTP (Short-Term Residential Therapeutic Program)

(3) **Type of Vendor:** (Check one box only; if applying for both types, submit separate applications.)

ICTP (Initial Certification Training Program) Vendor (\$150 Fee) **CEU** (Continuing Education) Vendor (\$100 Fee)

(4) **Applicant Information:** (Please print.)

Organization/Vendor Business Name: _____

Address (Street Address, City, State, Zip): _____

Authorized Representative/Contact Person (Name): _____

Business Phone Number: _____ Fax: _____ E-mail: _____

Company Website: _____

Company Type: (Check one box. Provide documentation of authority to conduct business in California (e.g., certificate of status from CA Secretary of State).

Individual University, College or School Provider Association
 Partnership Non-Profit Organization Corporation
 Government Agency Other: _____

List each individual authorized representative/contact person (e.g., partner, Executive Director, and/or board members) and their titles. Each person listed in this section must complete and sign Sections 6-10 on page 2 of this form. (Copy page 2 as needed)

| Name | Title/Position | Sec's 6-10 Completed ? |
|------|----------------|------------------------|
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(5) **Applicant Certification:** I declare that the foregoing information is true and correct to the best of my knowledge.

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|---|--|
| Signature of Vendor/Authorized Representative | Printed Name of Vendor/Authorized Representative |
| Title | Date |

DO NOT WRITE BELOW THIS LINE

| | |
|--|------------------|
| Application/Renewal has been <input type="checkbox"/> approved OR <input type="checkbox"/> disapproved by: | Date: |
| Approved Vendor Number | Expiration Date: |

| | |
|--|--------------------------|
| Printed Name: | Social Security Number:* |
| <p>(6) Do you currently hold or have you previously held a license, certification or other approval as a professional in a specified field (e.g., RN, NHA)? If yes, please list the type(s) of license(s) or certificate(s) and their number(s). (Include any Administrator Certificates.) <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>(7) Do you currently hold or have you previously held a State-issued care facility license? If yes, please list the type of license(s) and license number(s). (Include any community care facility licenses.) <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>(8) Are you currently employed or were you previously employed by a State-licensed care facility? If yes, please list the facility name(s) and license number(s). (Place an * by those where currently employed.) <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>(9) Have you been the subject of any legal, administrative, or other action involving licensure, certification or other approvals as specified in (6), (7), and (8) above? If yes, please explain and provide the date(s). (Include any Administrative Actions. Attach additional pages if more space is needed.) <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>(10) I declare that the foregoing information is true and correct to the best of my knowledge.</p> | |
| Signature | Date |

| | |
|--|--------------------------|
| Printed Name: | Social Security Number:* |
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| Signature | Date |

* Optional but requested for CDSS use only to assist in verifying identity and licensing affiliations. Federal law (at Title 5 United States Code Section 552a Note) states that: Any federal, state, or local government agency which requests an individual to disclose his social security account number shall inform that individual whether that disclosure is mandatory or voluntary, by what statutory or other authority such number is solicited, and what uses will be made of it.