

**NOTICE OF FORM CHANGE NO. 04-084**

DATE

03/05/2004

**TO:**  
County Welfare Director  
Supply Clerk / Forms Coordinator

**FROM:**  
Forms Management Unit  
(916) 657-1907

Community Care Licensing District Offices  
 Private and Public Adoption Agencies

District Attorney  
 Other

Listed below is information regarding a form change. Only applicable information is shown.

This notice updates your Department of Social Services County Forms Catalog.

FORM NUMBER AND TITLE LIC 9140 (1/04) - Request For Course Approval

ORDER UNIT <b>MASTER ONLY</b>	<input checked="" type="checkbox"/> Free <input type="checkbox"/> Sold	ESTIMATED PRICE	INITIAL SUPPLY SENT <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<input type="checkbox"/> New <input checked="" type="checkbox"/> Revised	DATE OF FORM 1/04	REPLACES 6/01	<input type="checkbox"/> Obsolete
REQUIRED FORM- <input checked="" type="checkbox"/> No Change Permitted	REQUIRED FORM- <input type="checkbox"/> Substitute Permitted With Prior DSS Approval	<input type="checkbox"/> Recommended Form	
UNLESS OTHERWISE SPECIFIED STOCK MAINTAINED AT: <b>Department of Social Services Warehouse</b> <b>P.O. Box 980788</b> <b>West Sacramento, CA 95798-0788</b>		<input type="checkbox"/> Other:	

**FORMS DISPOSITION AND SPECIAL INSTRUCTIONS**

DISPOSITION OF OLD SUPPLY

Use until exhausted  Destroy

USE NEW FORM

When supply available in DSS Warehouse  Use new form effective 1/04

USE FORM IN ACCORDANCE WITH

All County Letter No.  
 Other (specify)

ADDITIONAL INFORMATION REGARDING FORM CHANGE

Form is a Master Only

Attached is a Reproducible Copy

Check on the internet to see if forms are available at [www.dss.cahwnet.gov](http://www.dss.cahwnet.gov)

For camera-ready copies of English and Spanish forms, please call the Forms Management Unit (FMU) at (916) 657-1907, or by electronic mail at: [fmudss@dss.ca.gov](mailto:fmudss@dss.ca.gov).

# REQUEST FOR COURSE APPROVAL

## ADMINISTRATOR CERTIFICATION PROGRAM

**INSTRUCTIONS:**

Mail the request for approval to CDSS, ACS, 744 "P" Street, M.S. 19-47, Sacramento, CA 95814. Submit this request 60 days in advance of the date the class is offered. Submit a separate request and package for each course/program type.

(1) Program/Type (Check  One Box)

<input type="checkbox"/> RCFE 40-Hour (740-1)	<input type="checkbox"/> ARF 35-Hour (735-1)	<input type="checkbox"/> GH 40-Hour (730-1)	<input type="checkbox"/> RCFE CEU (740-2)	<input type="checkbox"/> ARF CEU (735-2)	<input type="checkbox"/> GH CEU (730-2)
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(2) Will this course be co-located with any other course program/type(s)  YES  NO  
 (Co-locate means that the exact same CEU course ARF/RCFE/GH is to be taught in the same location at the same time.)  
 If Yes, please provide program/type and course number(s) if available: \_\_\_\_\_

(3) Vendor Name (listed on LIC 9141)	Vendor Approval Number	Business Phone Number
(4) Vendor Mailing Address (Street Address, City, State, Zip Code)		Business E-mail Address
(5) Course Title		
(6) Dates Offered (If known)	Total Classroom Hours	Fee

- I. **Instructor(s) Qualifications:** Include a current resume and complete the back side of this form for each instructor. Instructors must have knowledge and/or experience in the subject area to be taught and must meet at least one of the following criteria:
  - a. Possession of a 4-year college degree and 2 years experience relevant to the course to be taught, or
  - b. Four years experience relevant to the course to be taught, or
  - c. Be a professional, in a related field, with a valid license to practice in California, or
  - d. Have at least 4 years experience in California as an administrator of a facility, within the last 8 years in substantial compliance.
- II. **Description of Course:** Show how course directly relates to either the business operations or the care of residents in the facility.
- III. **Objective of Course:** What is the student expected to know upon completion of this course?
- IV. **Teaching Methods:** Explain the types of teaching methods to be used.
- V. **Course Content:** Hour-by-hour detail of course outline, including instructor for each segment.
- VI. **Method of Course Evaluation by Participants:** Explain how participants will evaluate the course.
- VII. **Method of Evaluating Participants:** Explain how you will evaluate the participants.
- VIII. **Types of Records to be Maintained and Address Where Records are Maintained.**
- IX. **Address and/or Geographic Area Where the Course Will Be Presented.**
- X. **Make Up Policy for 40-Hour/35-Hour Initial Certification Courses Only.**

(7) I declare under penalty of perjury that the foregoing information is true.

(8) Print Name of Vendor/Authorized Representative	Signature of Vendor/Authorized Representative
(9) Title	Date

**DO NOT WRITE BELOW THIS LINE**

40/35 Hour Course Approval Number			-	-	-	-	Date Approved
CEU Course Approval Number			-	-	-	-	Date Approved
Approved by							Expiration Date

NAME OF INSTRUCTOR		SOCIAL SECURITY NUMBER *	
(10) Does the instructor currently possess or has previously held a license, certification or other approval as a professional in a specified field? If yes, please indicate the type of license(s) or certificate(s) and number(s).		<input type="checkbox"/> YES	<input type="checkbox"/> NO
(11) Has the instructor held or currently holds a government-issued facility license to operate and provide services to individuals? If yes, please indicate the type of license(s) and license number(s).		<input type="checkbox"/> YES	<input type="checkbox"/> NO
(12) Is the instructor currently employed or was previously employed by a community care facility? If yes, please indicate the facility name(s) and license number(s).		<input type="checkbox"/> YES	<input type="checkbox"/> NO
(13) Has the instructor been the subject of any administrative, legal or other action involving licensure, certification, or other approvals as specified in (10), (11), and (12) above? If yes, please explain and provide dates. If additional space is needed, please attach to this application.		<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>I declare under penalty of perjury that the foregoing information is true.</b>			
SIGNATURE		DATE	

NAME OF INSTRUCTOR		SOCIAL SECURITY NUMBER *	
(10) Does the instructor currently possess or has previously held a license, certification or other approval as a professional in a specified field? If yes, please indicate the type of license(s) or certificate(s) and number(s).		<input type="checkbox"/> YES	<input type="checkbox"/> NO
(11) Has the instructor held or currently holds a government-issued facility license to operate and provide services to individuals? If yes, please indicate the type of license(s) and license number(s).		<input type="checkbox"/> YES	<input type="checkbox"/> NO
(12) Is the instructor currently employed or was previously employed by a community care facility? If yes, please indicate the facility name(s) and license number(s).		<input type="checkbox"/> YES	<input type="checkbox"/> NO
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<b>I declare under penalty of perjury that the foregoing information is true.</b>			
SIGNATURE		DATE	

\* 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.

\* Disclosure of Social Security Number(s) is optional.