Oregon Department of Human Services
AGING & PEOPLE WITH DISABILITIES
Safety, Oversight and Quality Unit

Request to Amend Classification of APD Adult Foster Home License

The licensed provider may request a different adult foster home license classification on their application during the license renewal period, or at any other time using this form. All the home's providers *(Licensee, Co-Licensees, Administrator, Resident Manager, Floating Resident Manager and Shift Caregivers, as applicable)* must meet the standards for the requested classification of the home. Ensure you and your caregivers meet the required standards for your requested classification before submitting your request. Refer to OAR 411-049-0105(9), Classification of adult foster homes.

Instructions: Submit this completed form together with all other APD 0748 and APD 0748A forms *(as indicated in Part A, number 3 below)* to your local licensing authority.

Part A: General information

1. Name: ______________________ Phone: ______________
Licensee

Phone: ______________________ Cell phone: ______________

2. AFH's legal business name: ______________________

AFH address: ______________________
Street City State ZIP

AFH mailing address: ______________________
(if different)
Street City State ZIP

3. Classification requested: ☐ Class 1 ☐ Class 2 ☐ Class 3

Additional providers. Indicate by checking the appropriate box if your AFH has other providers or check this box ☐ if not applicable.

- ☐ Co-licensee *The Co-Licensee must complete a separate APD 0748 form.*
- ☐ Administrator *Include APD 0748A completed by the Administrator.*
- ☐ Resident manager *Include APD 0748A completed by the Resident Manager.*
- ☐ Floating resident manager *Include APD 0748A completed by the Floating Resident Manager.*
- ☐ Shift caregiver If you have sift caregivers, how many? _________
  Include APD 0748A completed by each shift caregiver.

All additional provider forms *(APD 0748 and APD 0748A as applicable)*, must be submitted together with this request.

Part B: Work experience

1. Work experience: Provide current contact information for work references who may help to verify your experience providing direct care to adults who are older, or adults with physical disabilities. Note – when there is a potential conflict of interest between the work reference and you, additional verification may be required.

For a class 2 license, your verifiable experience must be equivalent to at least two years of full-time work.

For a class 3 license, your verifiable experience* must be equivalent to at least three years of full-time work where you provided care to adults who required full assistance in four or more of their ADLs.

*For a class 3 license, verification of this work experience is not required if you possess a valid Oregon license as a health care professional.

Work references: Attach information on an additional sheet of paper if needed.

a. Name: ________________________________ Phone:______________

Relationship to licensee: ________________________________

Mailing address: ________________________________

Email address: ________________________________

Job title: ____________________ Employment dates:__________ to __________
Start *End*

Describe duties: ________________________________

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b. Name: ________________________________ Phone:______________

Relationship to licensee: ________________________________

Mailing address: ________________________________

Email address: ________________________________

Job title: ____________________ Employment dates:__________ to __________
Start *End*

Describe duties: ________________________________

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c. Name: ______________________________ Phone: ______________

Relationship to licensee: ______________________________

Mailing address: ______________________________

Email address: ______________________________

Job title: ____________________ Employment dates: __________ to __________
Start *End*

Describe duties: ______________________________

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2. If you are requesting a class 3 license, select one of the following options:

☐ **Option 1:** Attach verification you are a health care professional with a current Oregon license. (Refer to OAR 411-049-0102 for the definition of "Licensed health care professional.")

☐ **Option 2:** Provide current contact information for two licensed health care professionals with a valid Oregon license. These individuals must have **direct knowledge** of your ability and past experience as a caregiver.

a. ______________________________ ______________
Name of licensed health care professional *Type of license*

____
Mailing address

______________ ______________________________
Phone *Email address*

b. ______________________________ ______________
Name of licensed health care professional *Type of license*

____
Mailing address

______________ ______________________________
Phone *Email address*

Part C: Affirmation and signature

I declare, under penalties of perjury, this information is true, correct and complete to the best of my knowledge. I understand that:

- Failure to provide accurate information may result in sanctions, including the denial of my request.
- This request to amend my license classification is not complete until all required items have been submitted.
- An incomplete request to amend my license classification will result in the denial of my request.

I authorize the Department to verify the information provided with this request to amend my license classification.

I agree to abide by the Oregon Administrative Rules 411-049-0100 through 411-052-0045.

I understand if the Department denies this request, I will have the right to request an administrative hearing on that denial.

____ ____________________

Licensee's signature *Date*