



South Carolina Department of Labor, Licensing and Regulation
**South Carolina Board of
Long Term Health Care Administrators**
110 Centerview Dr. • Columbia • SC • 29210
P.O. Box 11329 • Columbia • SC 29211-1329
Phone: 803-896-4544 • Contact.LTHCA@llr.sc.gov • Fax: 803-704-6775
www.llr.sc.gov/lthc

**COMMUNITY RESIDENTIAL CARE FACILITY ADMINISTRATOR
ADMINISTRATOR-IN-RESIDENCY (AIR) PROGRAM
REQUIREMENTS AND APPLICATION OVERVIEW**

***AIR Program is an alternative option to the work experience requirements
outlined in S.C. Code of Law §40-35-40(B).***

Administrator-In-Residency (AIR) Requirements

A person is qualified to participate in the Community Residential Care Facility Administrator AIR program if the following requirements are met:

- Submission of a completed application and payment of application fee.
- Graduate from an accredited college or university or be enrolled in a course of study that will award such a degree on completion, plus completion of AIR program:
 - For participants with a baccalaureate or higher degree, the duration of the program shall be for three (3) months;
 - For participants with a health-related associate's degree, the duration of the program shall be for six (6) months;
 - For participants with a non-health related associate's degree or who is a licensed practical nurse, the duration of the program shall be for nine (9) months;
- Secure a Board approved Preceptor.

Application Process

Your application is good for one (1) year from the date of receipt. If all required information is not received within this one (1) year period; you must begin the application process from the beginning. This includes, but is not limited to, the application fee, transcripts, agreement forms, etc.

1. **Application** – In addition to the completed application, the following must also be sent:
 - a. Check or money order only, in the amount of \$25 made payable to Long Term Health Care Administrators Board (Fees are non-refundable). A returned check fee of up to \$30, or an amount specified by law, may be assessed on all returned funds. NO CASH IS ACCEPTED
 - b. Copy of your valid Driver's License, State Issued ID, or Passport
 - c. Copy of your Social Security Card
 - d. Legal documentation for name change (marriage certificate, divorce decree, etc.)
 - e. Notarized [Verification of Lawful Presence Form](#)
 - f. Signed [CRCFA AIR Participant/Preceptor Agreement Form](#)

2. Documents to be sent directly to the Board from issuing agency/institution:
 - a. Education Verification: Contact your college/university to request an official copy of your transcript be sent directly to the Board office. Transcripts may be accepted via email at contact.lthca@llr.sc.gov. Unsealed transcripts submitted with applications will not be accepted.
 - b. License Verification: Contact the state board(s) where you are currently and/or have been previously licensed and have the license verification emailed or mailed directly to the Board's office. We will accept a state board issued form. Email directly to contact.lthca@llr.sc.gov.
3. Once a completed application has been approved, AIR applicants will be notified of the required program length and start date. Programs begin the first of the month. Completed applications must be received no later than the 15th of the month preceding the planned starting month. Applications received after the 15th will not be eligible to begin until the beginning of the following month. (Example: Agreement received on August 20th, if approved, will result in the AIR program starting on October 1). For information on Program Guidelines, click [here](#).

Following the successful completion of the AIR Program, applicants may apply for licensure as specified in S. C. Code of Law §40-35-40(B). Per statutes, the completion of an AIR Program allows for the exemption from work experience requirements in S.C. Code of Law §40-35-40(B).



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COMMUNITY RESIDENTIAL CARE FACILITY ADMINISTRATOR ADMINISTRATOR-IN-RESIDENCY PERMIT APPLICATION

Submit the following with your application:

- Check or money order, in the amount of \$25 made payable to Long Term Health Care Administrators Board. (Fees are non-refundable and non-transferrable). A returned check fee of up to \$30, or an amount specified by law, may be assessed on all returned funds. NO CASH IS ACCEPTED.
- Copy of your valid driver's license, state issued ID, passport or military ID
- Copy of your Social Security card
- Notarized [Verification of Lawful Presence Form](#)
- Signed [CRCFA AIR Participant/Preceptor Agreement Form](#)
- Legal documentation for name change (marriage cert., divorce decree, court order, etc.), if applicable

Have submitted directly to the Board office address above from the issuing agency:

Documentation may be sent from the issuing agency via email to Contact.LTCHA@llr.sc.gov or mailed to the address above:

- College transcripts
- License verification(s)

APPLICANT INFORMATION

Last Name: _____ First: _____ Middle: _____ Suffix: _____

Have you ever legally changed your name? ☐ Yes ☐ No Prior Name/Alias: _____

If yes, you are required to enclose a copy of the legal document indicating the official change.

Home Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____
(If different than above)

Phone: _____ Email Address: _____

Date of Birth: _____ Social Security No.: _____

For statistical purposes only: Race: _____ Gender: ☐ Female ☐ Male

PRECEPTOR INFORMATION

Preceptor Name: _____ Preceptor License No.: _____

Facility Name: _____ Facility License No.: _____

EDUCATION

Transcripts may be sent from the issuing agency via email to Contact.LTCHA@lrr.sc.gov. Transcripts must contain the school seal.

College/Technical School:

School: _____ Degree: _____

Date of Attendance/ Date Degree Awarded: _____

College/Technical School:

School: _____ Degree: _____

Date of Attendance/ Date Degree Awarded: _____

EMPLOYMENT HISTORY

List employment in chronological order (most recent listed first).

Company Name: _____ Dates of Employment: _____

Supervisor: _____ Supervisor Title: _____

Business Address: _____

Email: _____ Phone: _____

Company Name: _____ Dates of Employment: _____

Supervisor: _____ Supervisor Title: _____

Business Address: _____

Email: _____ Phone: _____

Company Name: _____ Dates of Employment: _____

Supervisor: _____ Supervisor Title: _____

Business Address: _____

Email: _____ Phone: _____

Company Name: _____ Dates of Employment: _____

Supervisor: _____ Supervisor Title: _____

Business Address: _____

Email: _____ Phone: _____

PRIOR LICENSURE

List **any** types of professional licensure you have held in this or any other state. License verification must be submitted for each license listed.

License Type: _____ State: _____ License No.: _____

License Type: _____ State: _____ License No.: _____

PERSONAL HISTORY QUESTIONS

You are required to include a [written statement](#) with your application for any questions marked “Yes”. If you answer “Yes” to a conviction; you will need to attach a criminal background check from your state of residence (i.e., SLED, etc.) and from the state where the conviction occurred.

1. Has any licensing agency revoked, suspended, or restricted any occupational or professional license you currently hold or have held in the past, or otherwise disciplined you? ☐ Yes ☐ No
2. Have you ever been convicted of, pled guilty, or pled nolo contendere (no contest) to a felony, or a crime involving the safety, health, or welfare of a patient or financial misconduct relevant to the practice of long term health administration, or a crime involving drugs, physical violence, fraud or forgery? ☐ Yes ☐ No
3. Do you have any physical or mental disease or condition, including an addiction to drugs or alcohol, that currently interferes with your ability to competently and safely perform the essential functions of practice? (If you have a physical or mental disease or condition that is appropriately being treated and does not currently impair your judgment or otherwise adversely affect your ability to practice, you may answer ‘No.’) ☐ Yes ☐ No

ATTESTATION

I, _____, am the person described and identified, in all documents presented in support of this application. I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind and I declare that all statements made by me herein are true and correct. Should I furnish any false or incomplete information in this application I hereby agree that such act shall constitute the cause for denial or revocation of my license to practice community residential care facility administration in South Carolina.

Applicant’s Signature: _____ Date: _____

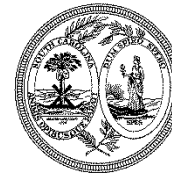
PRIVACY DISCLOSURE

South Carolina Law requires that every individual who applies for an occupational or professional license provide a social security number for use in the establishment, enforcement and collection of child support obligations and for reporting to certain databanks established by law. Failure to provide your social security number for these mandatory purposes will result in the denial of your licensure application. Social security numbers may also be disclosed to other governmental regulatory agencies and for identification purposes to testing providers and organizations involved in professional regulation. Your social security number will not be released for any other purpose not provided for by law.

Other personal information collected by the Department for the licensing boards it administers is limited to such personal information as is necessary to fulfill a legitimate public purpose. The South Carolina Freedom of Information Act ensures that the public has a right to access appropriate records and information possessed by a government agency. Therefore, some personal information on the application may be subject to public scrutiny or release. The Department collects and disseminates personal information in compliance with The South Carolina Freedom of Information Act, the South Carolina Family Privacy Protection Act, and other applicable privacy laws and regulations. Additionally, the Department shares certain information on the application with other governmental agencies for various governmental purposes, including research and statistical services.



STATE OF SOUTH CAROLINA
DEPARTMENT OF LABOR, LICENSING AND REGULATION
VERIFICATION OF LAWFUL PRESENCE IN THE UNITED STATES
AFFIDAVIT OF ELIGIBILITY



Pursuant to Section 8-29-10, *et seq.* of the South Carolina Code of Laws (1976, as amended), the Department of Labor, Licensing and Regulation must verify that any person who applies for a South Carolina license is lawfully present in the United States. Complete and sign this affidavit of eligibility. The information provided is subject to verification.

Section A: LAWFUL PRESENCE in the United States.

The undersigned _____, of _____
(Print clearly First, Middle, and Last name) (Home Address, City, State, and Zip Code)
being first duly sworn deposes and states as follows:

Check only one box:

1. ☐ I am a United States citizen; or
2. ☐ I am a Legal Permanent Resident of the United States eighteen years of age or older; or
3. ☐ I am a Qualified Alien or non-immigrant under the Federal Immigration and Nationality Act, Public Law 82-414, eighteen years of age or older, and lawfully present in the United States.
4. ☐ Other: _____ Please submit any documentation that supports this status.

Date of Birth: _____

Alien Number: _____ I-94 Number: _____

(If you checked number 2, 3, or 4 you must attach a copy of your immigration documents. See instruction sheet for a list of accepted immigration documents.)

Section B: ATTESTATION.

I understand that in accordance with section 8-29-10 of the South Carolina Code of Laws, a person who knowingly and willfully makes a false, fictitious, or fraudulent statement or representation in an affidavit shall, in addition to other sanctions imposed by this State or the United States, be guilty of a felony, and upon conviction must be fined and/or imprisoned for not more than 5 years (or both).

I understand that the representations made in this Affidavit shall apply through any license(s) or renewals issued, and that I shall have an affirmative duty to immediately advise the Department of Labor, Licensing and Regulation of any change of my immigration or citizenship status.

I swear and attest the information contained herein is true and correct to the best of my knowledge. I understand that under South Carolina law, providing false information is grounds for denial, suspension, or revocation of a license, certificate, registration or permit.

Signature of Affiant

SWORN to before me this _____ day of _____, 20____

Notary Signature

Print Name

Notary Public for _____

My Commission Expires: _____

INSTRUCTION SHEET FOR COMPLETING AFFIDAVIT OF ELIGIBILITY

CHECK box 1:

If you are a United States Citizen by birth or naturalization

CHECK box 2:

If you are a Legal Permanent Resident and you are not a U.S. Citizen, but are residing in the U.S. under legally recognized and lawfully recorded permanent residence as an immigrant.

PROVIDE A COPY OF ALL IMMIGRATION DOCUMENTS.

CHECK box 3:

If you are a Qualified Alien. You are a Qualified Alien if you are:

An alien who is lawfully admitted for residence under the INA.

An alien who is granted asylum under Section 208 of the INA.

A refugee who is admitted to the United States under Section 207 of the INA.

An alien who is paroled into the United States under Section 212(d)(5) of the INA for a period of at least 1 year.

An alien whose deportation is being withheld under Section 243(h) of the INA (as in effect prior to April 1, 1997) or whose removal has been withheld under Section 241(b)(3).

An alien who is granted conditional entry pursuant to Section 203(a)(7) of the INA as in effect prior to April 1, 1980.

An alien who is a Cuban/Haitian Entrant as defined by Section 501(e) of the Refugee Education Assistance Act of 1980.

An alien who has been battered or subjected to extreme cruelty, or whose child or parent has been battered or subject to extreme cruelty.

PROVIDE A COPY OF ALL IMMIGRATION DOCUMENTS.

ACCEPTED IMMIGRATION DOCUMENTS:

Unexpired Reentry Permit (I-327)

Permanent Resident Card or Alien Registration Receipt Card With Photograph (I-551)

Unexpired Refugee Travel Document (I-571)

Unexpired Employment Authorization Card Which Contains a Photograph (I-766)

Machine Readable Immigrant Visa (with Temporary I-551 Language)

Temporary I-551 Stamp (on passport or I-94)

I-94 (Arrival/Departure Record) in Unexpired Foreign Passport

I-20 (Certificate of Eligibility for Nonimmigrant, F-1, Student Status)

DS2019 (Certificate of Eligibility for Exchange Visitor, J-1, Status)



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**COMMUNITY RESIDENTIAL CARE FACILITY ADMINISTRATOR
ADMINISTRATOR-IN-RESIDENCY (AIR) PROGRAM
PARTICIPANT/ PRECEPTOR AGREEMENT**

FACILITY INFORMATION

Facility Name: _____ Facility License No.: _____

Preceptor Name: _____ License No.: _____

AIR PARTICIPANT INFORMATION

Full Name _____ AIR Permit No.: _____

License Type: ☐ Community Residential Care Facility Administrator ☐ Dual License

The above listed AIR participant and AIR preceptor have agreed to participate in an AIR Program approved by the Board of Long Term Health Care Administrators (LTHCA). The program will be conducted at the SC DPH licensed facility listed above, commencing on _____ and will last a period of _____ months.

PROGRAM PROPOSAL

Listed below are the suggested hours to be spent in each area of practice. Complete the following section in accordance with the program structure most appropriate for the AIR. All programs require Board approval prior to implementation.

DEPARTMENT	3-MONTH PROGRAM Bachelor's Degree	6-MONTH PROGRAM Health-related Associate Degree	9-MONTH PROGRAM Associate degree in a non- health-related field or licensed LPN
ADMINISTRATION	100	200	300
HUMAN RESOURCES	35	75	100
HEALTH CARE SERVICES	70	150	200
REHABILITATION	15	30	50
MEDICAL/RESIDENT RECORDS	15	35	50
ACTIVITIES	10	20	40
SOCIAL SERVICES/ADMISSIONS	15	30	50
BUSINESS OFFICE	50	100	150
DIETARY	15	30	50
HOUSEKEEPING/LAUNDRY	15	25	40
MAINTENANCE/ENVIRONMENTAL	20	25	50
OTHER – detail in section below			
TOTAL HOURS	360	720	1080

SPECIAL PROJECTS OR ACTIVITIES:

All special projects or activities to be completed during the course of the AIR Program must be detailed below. There are several suggested activities in the NAB AIR Manual: AIR Model Standards Covering the Domains of Practice.

Additionally, AIR preceptors and participants may wish to develop a special project that does not appear in the NAB Manual.

- Activity/Project:

Estimated Time Required: _____ NAB Domain of Practice: _____

- Activity/Project:

Estimated Time Required: _____ NAB Domain of Practice: _____

- Activity/Project:

Estimated Time Required: _____ NAB Domain of Practice: _____

- Activity/Project:

Estimated Time Required: _____ NAB Domain of Practice: _____

- Activity/Project:

Estimated Time Required: _____ NAB Domain of Practice: _____

- Activity/Project:

Estimated Time Required: _____ NAB Domain of Practice: _____

- Activity/Project:

Estimated Time Required: _____ NAB Domain of Practice: _____

- Activity/Project:

Estimated Time Required: _____ NAB Domain of Practice: _____

- Activity/Project:

Estimated Time Required: _____ NAB Domain of Practice: _____

ATTESTATION

By signing the affidavit below, the two parties acknowledge and agree to the following:

- That no AIR program may begin until Board approval is received.
- To follow the standards and guidelines set forth by the Board and to submit the required reports along with any special reports that may be requested.
- That enrollment in an AIR program and successful completion thereof does not guarantee approval to take the South Carolina or NAB Community Residential Care Facility Administrator License Examination.
- That a Preceptor shall not train an employer or supervisor.
- That the Preceptor's final report and evaluation will become part of the AIR participant's permanent record with the Board of LTHCA.

PRECEPTOR'S ATTESTATION:

I, _____, am the person described and identified in all documents presented in support of this application. I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind and I declare that all statements made by me herein are true and correct. Should I furnish any false or incomplete information in this application I hereby agree that such act shall constitute the cause for denial or revocation of my license to practice nursing home administration and/or community residential care facility administration in South Carolina.

Signature: _____

Date: _____

AIR PARTICIPANT ATTESTATION:

I, _____, am the person described and identified in all documents presented in support of this application. I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind and I declare that all statements made by me herein are true and correct. Should I furnish any false or incomplete information in this application I hereby agree that such act shall constitute the cause for denial or revocation of my license to practice nursing home administration and/or community residential care facility administration in South Carolina.

Signature: _____

Date: _____



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EXPLANATION OF “YES” ANSWERS

Name: _____ Phone No.: _____

Email: _____

Explanation of “Yes” answer to Personal History Question no.:

☐ 1 ☐ 2 ☐ 3

Jurisdiction in which the action/event occurred (City, County & State): _____

Any case, file or credential number: _____

Attach all supporting documentation, such as court documentation and disposition, if applicable.

Explanation:

AFFIRMATION

I certify that that all statements, answers and representations made in this form, including all supplementary documents submitted with the form, are true and correct to the best of my knowledge after undertaking due diligence to determine their accuracy. I understand that providing any false, incomplete or misleading information herein is grounds for the denial or revocation of my license or registration in South Carolina.

Signature

Date