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: 803-896-4515
llr.sc.gov/lthc

COMMUNITY RESIDENTIAL CARE FACILITY (CRCFA) AIT INTERNSHIP PROGRAM REQUIREMENTS FOR PROGRAM AND APPLICATION PROCESS OVERVIEW

AIT Internship Program is not a required program. The program is an alternative option to the work experience requirements outlined in S.C. Code of Law §40-35-40(B).

Administrator-In-Training (AIT) Requirements

A person is qualified to participate in the Community Residential Care Facility AIT 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 AIT internship:
  - For candidates with a baccalaureate or higher degree, the duration of the internship shall be for three (3) months;
  - For candidates with a health related Associate's degree, the duration of the internship shall be for six (6) months;
  - For candidates with a non-health related Associate's degree or who is a licensed practical nurse, the duration of the internship shall be for nine (9) months;
- Secure a Board approved Preceptor

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

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, Passport, or Military ID
   c. Copy of your Social Security Card
   d. Legal documentation for name change (marriage certificate, divorce decree, etc.)
   e. Notarized Verification of Lawful Presence
   f. Signed AIT Participant/Preceptor Agreement

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 or mail. Unsealed transcripts submitted with applications will not be accepted.

3. Once a completed application has been approved, AIT applicant 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 AIT program starting on October 1)

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COMMUNITY RESIDENTIAL CARE FACILITY ADMINISTRATOR-IN-TRAINING APPLICATION

Submit the following with your application to the above address:

- 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.
- Copy of your valid Driver's License, State Issued ID, Passport
- Copy of your Social Security Card
- Signed AIT Participant/Preceptor Agreement Form

Have sent to the Board by issuing agency:

- College Transcripts

APPLICANT INFORMATION

Last Name:____________________First:______________________Middle:_________________Suffix:________

Home Address: ___________________________________City:_____________State:______Zip: ___________

Mailing Address: ______________________________________City:___________State:_____Zip:__________
(If different than above)

Phone: _________________________________ Email Address: _______________________________________

Date of Birth: ____________________________ Social Security No.: __________________________________

Gender (for statistical purposes): ☐ Female ☐ Male

Have you ever been known by any other surname? ☐ Yes ☐ No

If yes, list names: ____

PRECEPTOR INFORMATION

Preceptor Name: ________________________________ Facility Name:___________________________

Preceptor License Number: ________________ License Type: ☐ Community Residential Care ☐ Dual License

EDUCATION

Transcripts must contain the School seal and registrar's signature.

College/Technical School:

School: ____________________________ Location (city/state or country): ____________________________

Degree: ____________________________ Date of Attendance/ Date Degree Awarded: _________________

College/Technical School:

College/School: ____________________ Location (city/state or country): ____________________________

Year Graduated: ____________________ Year 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: ______________________________________

CERTIFICATION

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

License Type: ____________________________ State: ______________ License No.: ______________________

Date licensed: ____________________________ Status: ____
(active, lapsed, disciplined, etc.)

License Type: ____________________________ State: ______________ License No.: ______________________

Date licensed: ____________________________ Status: ____
(active, lapsed, disciplined, etc.)

PERSONAL HISTORY QUESTIONS

Please respond to all questions. If you answer "Yes" to any question, you must attach a written explanation. In addition, 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 your occupational or professional license or otherwise disciplined you? ☐ Yes ☐ No

2. Have you ever been convicted of or pled guilty or nolo contendere to a felony of any kind or to a non-felony crime involving drugs or moral turpitude? (*You may exclude juvenile or expunged crimes*.) ☐ Yes ☐ No

3. Do you have a mental or physical impairment or addiction that would prohibit you from safely practicing as a nursing home administrator? ☐ 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 nursing home administration and/or community residential care facility administration in South Carolina.

Applicant 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: ______________________________

Rev: 02-02-2015

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 FACILITY ADMINISTRATOR-IN-TRAINING/PRECEPTOR AGREEMENT

AIT Participant Name:____________________________ AIT Participant No.: _______________________

Preceptor Name: _________________________________ Facility Name:____________________________

Preceptor License Number: _________________ License Type: ☐ Community Residential ☐ Dual License

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

PROGRAM PROPOSAL

Listed below is the standard of time to be spent in each area of practice based upon the percentages recommended in the *NAB AIT Program Manual – Hours Conversion*. An AIT with significant experience in one or more areas may request Board approval for an altered program. Complete the following section in accordance with the program structure most appropriate for the AIT. All programs require Board approval prior to implementation.

DEPARTMENT	% OF TIME	3 MONTH PROGRAM	6 MONTH PROGRAM	9 MONTH PROGRAM	PROPOSED PROGRAM
ADMINISTRATION	27%	3 wks	6 wks	9 wks	wk(s)
HUMAN RESOURCES	10%	2 wks	3 wks	4 wks	wk(s)
MEDICAL/RESIDENT RECORDS	4%	1 wk	1 wk	2 wks	wk(s)
ACTIVITIES	3%	½ wk	1 wks	3 wks	wk(s)
SOCIAL SERVICES/ADMISSIONS	4%	1 wk	2 wks	2 wks	wk(s)
BUSINESS OFFICE	14%	2 wks	3 wks	5 wks	wk(s)
DIETARY	4%	1 wk	1 wk	2 wks	wk(s)
HOUSEKEEPING/LAUNDRY	4%	1 wk	1 wk	1 wk	wk(s)
MAINTENANCE/ENVIRONMENTAL	5%	1 wk	2 wks	2 wks	wk(s)
OTHER – *detail in section below*	2%	½ wk	1 wk	1 wk	wk(s)
		13 wks	26 wks	39 wks	wk(s)

SPECIAL PROJECTS OR ACTIVITIES

All special projects or activities to be completed during the course of the AIT Program must be detailed below. There are several suggested activities in the NAB AIT Manual: AIT Model Standards Covering the Domains of Practice. Additionally, preceptors and AITs 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: ___________________________

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

- That no AIT 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 AIT program and successful completion thereof does not guarantee approval to take the South Carolina or NAB Nursing Home 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 AIT'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: ______________________

AIT 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: ______________________

PRIVACY DISCLOSURE

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