ADULT FAMILY HOME INITIAL LICENSE APPLICATION

- Completion of this form is required by Chapter 50.033(2m), Wis. Stats., and DHS 88.03(2)(a), (b) and (4)(b), Wis. Admin. Code. Failure to complete this form accurately may result in licensure denial and/or delay in processing.
- Send the completed form with attachments listed below to the Division of Quality Assurance (DQA) regional office assigned to the county in which the facility is located. Contact the appropriate regional office if you have questions about completion of this form. Regional office locations can be found at: **http://dhs.wisconsin.gov/bqaconsumer/AssistedLiving/ALSreglmap.htm**
- **The following items must be submitted with this application:**
  - Program statement
  - Floor plan (w/ room dimensions, exits, usage)
  - Verification of completion - AFH webcast, if a new provider
  - Fire evacuation plan
  - Proof of vehicle and home owners / renters insurance
  - Admission / Service agreement
  - House rules and responsibilities
  - Resident grievance procedure
  - Background check
  - *Assisted Living Facility Model Balance Sheet* (F-62674A)
  - Resident rights policy
  - Documentation of 60-day operating funds
  - License fee **(Non-refundable)**; Check payable to: **DQA**

NOTE: The licensee is responsible for notifying the Division of Quality Assurance in writing of any change in the information provided on this application.

☐ YES ☐ NO Did you submit form F-82064 (BID) and form F-82069 (BID Appendix) to the Office of Caregiver Quality at the address listed below?

DHS / Division of Quality Assurance
Office of Caregiver Quality
P.O. Box 2969
Madison, WI 53701-2969

☐ YES ☐ NO Does the licensee currently hold another type of license or certification?

FACILITY INFORMATION

Name – Facility				FEIN
Street Address - Facility	City	State	Zip Code	County
Telephone Number - Facility	Fax Number - Facility	E-mail Address - Facility		

Facility Administrator Information

Name - Administrator			Birth Date - Administrator
Mailing Address - Administrator	City	State	Zip Code
Telephone Number - Administrator	E-mail Address - Administrator		

Designated Mail Recipient *(Provide contact information for the individual to whom mail from DHS/DQA is to be sent.)*

Name – Designated Mail Recipient	Telephone Number	E-mail Address	
Mailing Address	City	State	Zip Code

RESIDENT INFORMATION

Total Resident Capacity			
☐ Three ☐ Four	☐ All Female ☐ All Male ☐ Both	☐ Ambulatory ☐ Non-Ambulatory	Does the Adult Family Home have a contract with a county agency or managed care organization to serve publicly funded individuals? ☐ Yes ☐ No

Check the box indicating the **primary client group(s)** you are requesting to serve.

- ☐ AA - Advanced aged
- ☐ ALZ - Irreversible dementia/Alzheimer's
- ☐ DD - Developmentally disabled
- ☐ MH - Emotionally disturbed / mental illness
- ☐ ADA - Alcohol / drug dependent
- ☐ PD - Physically disabled
- ☐ PWC - Pregnant women who need counseling
- ☐ CC - Correctional clients
- ☐ TI - Terminally ill
- ☐ TBI - Traumatic brain injury

List the **days** when residents are **NOT** in the facility.	List the **hours** when residents are **NOT** in the facility.

LICENSEE INFORMATION *(Check only one box.)*

Governmental	Proprietary	Voluntary Non-Profit
☐ City	☐ Individual	☐ Corporation
☐ County	☐ Partnership	☐ Church
☐ State	☐ Corporation	☐ Limited Liability Co.
☐ Tribal	☐ Limited Liability Co.	

Name - Licensee [Individual or Corporation (legal entity)]	Birth Date – Licensee	Name - Owner or President

Mailing Address - Licensee	City	State	Zip Code

Telephone Number - Licensee	E-mail Address - Licensee

If the licensee currently holds another type of license or certification, identify the type of license or certification from the following list.

License Type	Certification Type	Registration Type
☐ Foster Home (children) ☐ Group Foster Home (children) ☐ Residential Care Center for Children and Youth ☐ Shelter Care (children) ☐ Adult Family Home ☐ Nursing Home ☐ Hospital ☐ Community Based Residential Facility ☐ Day Care Center (family or group) ☐ Other *(Specify.)* _____	☐ Alcohol and Other Drug Abuse Program ☐ Mental Health Program ☐ Adult Day Care ☐ Certified Residential Care Apartment Complex ☐ Other *(Specify.)* _____	☐ Residential Care Apartment Complex

FIT AND QUALIFIED

The following information will be used to determine if the applicant meets the fit and qualified requirements under Chapter 50, Wis. Stats.

1. Has the licensee ever operated a residential facility, health care facility, or a day care program for adults or children in Wisconsin or in any other state?
   ☐ Yes ☐ No If "yes," provide the name, address, and telephone number of the facility / program.

2. Was the facility / program licensed, certified, or otherwise regulated by any government or private agency?
   ☐ Yes ☐ No If "yes," provide the name, address, and telephone number of that agency.

3. Has the licensee ever had a license, certification or governmental approval to operate a facility / program denied, revoked, suspended or not renewed?
   ☐ Yes ☐ No If "yes," specify the type of license, certification, or approval affected; in which state the action occurred; which agency took the enforcement action; and the name, address, telephone number, and type of facility / program that was affected.

Date of Action:

MONTHLY FEES

Enter the minimum and maximum **monthly fees** charged for resident care in the space below. Include fees paid from all sources including government, private agencies, residents, and / or resident's family.

Minimum $ _____ per month	**Maximum** $ _____ per month

MONTHLY OPERATING EXPENSES

- **A current balance sheet must be submitted with this application.** (See DQA form F-62674A, *Assisted Living Facility Model Balance Sheet.)*
- **Submit copies of financial documents verifying your ability to operate the facility for 60 days. This amount must be equal to or more than 2 times your monthly operating expenses.**

All Salaries (i.e., licensee, caregivers, contract providers, etc.)	$
Lease or Mortgage	$
All Other (food, supplies, utilities, insurance, taxes, etc.)	$
TOTAL Monthly Expenses	$

If income from residents would not be adequate to pay your monthly operating expenses, you must have other sources of funds or income that may be used to continue the operation of the facility for at least a 60-day period.

Check all other sources of income.

- ☐ Savings or other financial reserves
- ☐ Purchase contract (county department or managed care organization)
- ☐ Outside employment
- ☐ Line of credit
- ☐ Loan
- ☐ Other *(Specify.)* _____

LICENSEE OWNERSHIP

The licensee owns the: ☐ Building ☐ Land ☐ Operation

NON RESIDENT INFORMATION

List below the names of all persons, age 10 and older, who live in the facility and are not a resident.

Name			Relationship to Licensee	Date of Birth
Last Name	First Name	MI		
Last Name	First Name	MI		
Last Name	First Name	MI		
Last Name	First Name	MI		
Last Name	First Name	MI		

FIRE DEPARTMENT INFORMATION

Local fire departments have requested knowing where licensed facilities exist. The Division of Quality Assurance will send a copy of the license to the local fire department. Enter the fire department's name, address, and telephone number below.

Name - Local Fire Department	Telephone Number **(Do not enter 911.)**

Address (Street or PO Box)	City	State	Zip Code

Provide specific directions to the facility from the closest major STATE highway.

The licensee is responsible for notifying the Division of Quality Assurance, in writing, of any changes in the information provided on this application.

I understand, under penalty of law, that the information provided above is truthful and accurate to the best of my knowledge and that knowingly providing false information or omitting information may result in a fine of up to $10,000 or imprisonment not to exceed 6 years, or both (Chapter 946.32, Wis. Stats.).

SIGNATURE (FULL) **–** Licensee or Designee	Date Signed

Name – Licensee or Designee (Print or type.)	Title