

## 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. DQA Regional office locations can be found at <http://dhs.wisconsin.gov/bqaconsumer/AssistedLiving/ALSreglmap.htm>.
- **The following items must be submitted:**
  - Vehicle insurance coverage [DHS 88.04(4)(a)]
  - Documentation of home owners or renters insurance [DHS 88.04(4)(b)]
  - Program Statement [DHS 88.03(2)(b)1.]
  - Evidence of 60 day operating funds
  - License Fee (NON-REFUNDABLE) [Chapter 50.033(2), Wis. Stats.]
  - Check payable to: **Division of Quality Assurance**
  - Floor plan with room dimensions, exits, and usage
  - Assisted Living Facility Model Balance Sheet, F-62674A
- **The licensee is responsible for notifying the Division of Quality Assurance, in writing, of any change in the information provided on this application.**

Name – Adult Family Home		Name - Manager / Administrator	
Street Address		City	State    Zip Code
County	Fire Number	Telephone Number	Fax Number

**Identify the individual to whom mail is to be sent.**

Name		Telephone Number
Mailing Address		City    State    Zip Code

**RESIDENT INFORMATION**

Total Resident Capacity <input type="checkbox"/> Three <input type="checkbox"/> Four	<input type="checkbox"/> All Female <input type="checkbox"/> All Male <input type="checkbox"/> Both	<input type="checkbox"/> Ambulatory <input type="checkbox"/> Non-Ambulatory	Does the Adult Family Home have a contract with a county human services or social services department to serve Medicaid waiver eligible residents? <input type="checkbox"/> Yes <input type="checkbox"/> No
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**Check the box(es) that best describe your residents.**

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| <input type="checkbox"/> AA Advanced aged (60+ years)              | <input type="checkbox"/> PWC Pregnant women who need counseling                      |
| <input type="checkbox"/> ALZ Irreversible dementia/Alzheimer's     | <input type="checkbox"/> CC Correctional clients                                     |
| <input type="checkbox"/> DD Developmentally disabled (DD)          | <input type="checkbox"/> TI Terminally ill   |
| <input type="checkbox"/> MH Emotionally disturbed / mental illness | <input type="checkbox"/> TBI Traumatic brain injury                                  |
| <input type="checkbox"/> ADA Alcohol / drug dependent              | <input type="checkbox"/> AIDS Persons with acquired immunodeficiency syndrome (AIDS) |
| <input type="checkbox"/> PD Physically disabled                    |  |

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

**LICENSEE INFORMATION**

	For Profit Organization	Non-Profit	Government
<input type="checkbox"/> Individual	<input type="checkbox"/> Corporation <input type="checkbox"/> Partnership	<input type="checkbox"/> Corporation <input type="checkbox"/> Church <input type="checkbox"/> Limited Liability Corp. <input type="checkbox"/> Other (Specify.)	<input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other (Specify.)
<input type="checkbox"/> Married Couple	<input type="checkbox"/> Limited Liability Corp.		
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	

Does the licensee currently hold another type of license or certification?  Yes  No

If "yes," identify the type of license or certification from the following list.

License Type	Certification Type	Registration Type
<input type="checkbox"/> Foster Home (children) <input type="checkbox"/> Group Foster Home (children) <input type="checkbox"/> Residential Care Center for Children and Youth <input type="checkbox"/> Shelter Care (children) <input type="checkbox"/> Adult Family Home <input type="checkbox"/> Nursing Home <input type="checkbox"/> Hospital <input type="checkbox"/> Community Based Residential Facility <input type="checkbox"/> Day Care Center (family or group) <input type="checkbox"/> Other (Specify.)	<input type="checkbox"/> Alcohol and Other Drug Abuse Program <input type="checkbox"/> Mental Health Program <input type="checkbox"/> Adult Day Care <input type="checkbox"/> Certified Residential Care Apartment Complex <input type="checkbox"/> Other (Specify.)	<input type="checkbox"/> Residential Care Apartment Complex

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.

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.

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.

<b>Minimum</b> \$	per month	<b>Maximum</b> \$	per month
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**MONTHLY OPERATING EXPENSES**

All Salary Expenses (i.e., licensee, caregivers, contract providers, etc.)	
Lease or Mortgage Expense	
All Other Expenses (i.e., food, supplies, utilities, insurance, taxes, etc.)	
<b>TOTAL Monthly Expenses</b>	

If income from residents would not be adequate to pay the 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. *[DHS 88.04(3)]*

Check all other sources of income.

- Savings or other financial reserves
- Purchase contract (County Department)
- Outside employment
- Line of credit
- Loan
- Other (Specify.)

**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.**

**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. *[DHS 88.03(3)(b)]*

Name			Relationship to Licensee	Date of Birth
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 <b>(Do not enter "911.")</b>
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
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Name – Licensee or Designee (Print or type.)	Title
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