

ADULT DAY CARE INITIAL CERTIFICATION APPLICATION

- In accordance with 42 CFR 441.352(a)(1) and (2), adult day care centers serving Medicaid waiver clients (COP-W, CIP-I, or CIP II), must meet State certification requirements in order to receive funds for the cost of care for these participants.
- Completion of this form is required to become certified as an adult day care center. Failure to accurately complete and submit this form will result in denial of certification.
- Send the completed form, with the attachments listed below, to the Division of Quality Assurance (DQA) regional office assigned to the county in which the facility is located.
- DQA regional office locations are found at http://dhfs.wisconsin.gov/ri_DSL/Contacts/ALSreglmap.htm. Contact the appropriate regional office if you have questions about completion of this form.
- **ATTACH THE FOLLOWING TO THIS APPLICATION.**
 - Diagram of floor plan of TOTAL space to be used by the center. Indicate dimensions, exits, and room usage.
 - Certification Fees (non-refundable)

Check one of the following.

- Currently Serving Medicaid Waiver Clients (*Identify the county agency providing funding.*) _____
- Anticipate Serving Medicaid Waiver Clients Within the Next 90 Days

Name- Facility			Total Number of Clients Served	
Facility Street Address			Telephone Number	
Facility Mailing Address (if different from street address, e.g., PO Box)			Fax Number	
City	State	Zip Code	County	
Name – Owner / Applicant			Telephone Number	
Address		City	State	Zip Code
Name – Administrator			Telephone Number	
Address		City	State	Zip Code
Name – Center Director	Days of Operation	Hours of Operation		

Identify client groups to be served [*e.g., advanced age, developmentally disabled, Alzheimers / dementia, physically disabled, mentally ill / emotionally disturbed, terminally ill, traumatic brain injury (TBI)*].

Is the adult day care located in:		
The Provider's Home? <input type="checkbox"/> Yes <input type="checkbox"/> No	A Nursing Home? <input type="checkbox"/> Yes <input type="checkbox"/> No	A Community Based Residential Facility (CBRF)? <input type="checkbox"/> Yes <input type="checkbox"/> No
Will meals be provided? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are any clients non-ambulatory? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Provide directions to the facility from the closest STATE highway.

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 – Owner / Applicant	Title	Date Signed
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