

ADULT FAMILY HOME INITIAL LICENSE APPLICATION

Completion of this form is required by s. 50.033(2m), Wis Stats., and ss. HFS 88.03(2)(a), (b) and (4)(b), Wis. Adm. 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 Office of Quality Assurance (OQA) regional office assigned to the county in which the facility is located. OQA regional office locations are found at <http://www.dhfs.wisconsin.gov/bqaconsumer/AssistedLiving/ALSreglmap.htm> Contact the appropriate regional office if you have questions about completion of this form.

THE FOLLOWING ITEMS MUST BE SUBMITTED

- Vehicle insurance coverage HFS 88.04(4)(a)
- Documentation of home owners or renters insurance HFS 88.04(4)(b)
- Program Statement HFS 88.03(2)(b)1.
- Evidence of 60 day operating funds
- License Fee s. 50.033(2), Wis. Stats. (NON-REFUNDABLE)
- Check payable to: Office of Quality Assurance
- Floor plan with room dimensions, exits and usage
- Balance Sheet, OQA-2674 (model form)

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

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

IDENTIFY THE INDIVIDUAL TO WHOM MAIL IS TO BE SENT

Name	Telephone Number	
Mailing Address		
City	State	Zip Code

Total Resident Capacity	<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"/> Three <input type="checkbox"/> Four			<input type="checkbox"/> Yes <input type="checkbox"/> No

CHECK THE BOX(ES) THAT BEST DESCRIBE YOUR RESIDENTS

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

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"/> Married Couple	<input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited Liability Corp.	<input type="checkbox"/> Corporation <input type="checkbox"/> Church <input type="checkbox"/> Limited Liability Corp. <input type="checkbox"/> Other	<input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other
Licensee Name – Individual or Corporation (legal entity)		Birthdate – Licensee	Name - Owner or President
Mailing Address			Telephone Number
City		State	Zip Code

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	<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	<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:

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

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.	
TOTAL Monthly Expenses	

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. [HFS 88.04(3)]

Check all other sources of income.

- | | |
|----------------------------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Savings or other financial reserves | <input type="checkbox"/> Line of credit |
| <input type="checkbox"/> Purchase contract (County Department) | <input type="checkbox"/> Loan |
| <input type="checkbox"/> Outside employment | <input type="checkbox"/> 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.

The licensee owns the: Building Land Operation

List below the names of all persons, age 10 and older, who live in the facility and are not a resident. HFS 88.03(3)(b)

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

Local fire departments have requested knowing where licensed facilities exist. The Office 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 / PO Box, City, State and Zip Code)	

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

The licensee is responsible for notifying the Office 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 (946.32 Wis. Stats.).

SIGNATURE IN FULL –Licensee or Designee	Title	Date Signed
------------------------------------------------	-------	-------------