

FOR DQA OFFICE USE ONLY
COA Number
COA Fee
Caregiver Background Fee
Effective Date

## HOSPITAL CERTIFICATE OF APPROVAL APPLICATION

TYPE OF APPLICATION
<input type="checkbox"/> Initial <input type="checkbox"/> Change of Ownership

- Hospitals are required to complete this form per Chapter 50.35, Wis. Stats. Failure to complete this form may result in non-issuance of a hospital certificate of approval.
- The personally identifiable information collected on this form will be used to determine licensure eligibility and for statistical information and for no other purpose.
- Collection of the applicant's social security number (SSN) or federal employer identification number (FEIN) is required by Chapter 50.498, Wis. Stats. Failure to supply the number may result in denial of the application. The number will be disclosed only to the Department of Revenue for use in collection of tax delinquencies.
- Return the completed application to:** Division of Quality Assurance  
 Bureau of Technology, Licensing and Education  
 PO Box 2969  
 Madison WI 53701-2969

Questions about completion of this application may be directed to the Bureau of Technology, Licensing and Education at **608-266-7297**.

### I. GENERAL INFORMATION

#### A. HOSPITAL LOCATION

Name –Facility		Initial Begin Date (at present location)	
Previous Hospital Name (if applicable)			
Street (physical) Address			
Mailing Address			
City	County	State	Zip Code
Telephone Number	Fax Number	E-mail Address	

#### B. CHANGE OF OWNERSHIP

List the previous owner's name, Certificate of Approval (COA) number, and Medicare and Medicaid numbers.

Name – Previous Owner		
Previous COA Number	Medicare Number - Previous Owner	Medicaid Number - Previous Owner

**C. TYPE OF HOSPITAL**

- |  |   |
|--|---|
| <input type="checkbox"/> General                       | <input type="checkbox"/> Critical Access Hospital (CAH)           |
| <input type="checkbox"/> Special                       | <input type="checkbox"/> Long Term Acute Care                     |
| <input type="checkbox"/> Chemical Dependency / Alcohol | <input type="checkbox"/> Hospital Located Within Another Hospital |
| <input type="checkbox"/> Children's                    | <input type="checkbox"/> Maternity                                |
| <input type="checkbox"/> Rehabilitation                | <input type="checkbox"/> Psychiatric                              |
| <input type="checkbox"/> Orthopedic                    | <input type="checkbox"/> Other (Specify.) _____                   |
| <input type="checkbox"/> Surgical                      |   |

Name - Fiscal Intermediary

Fiscal Year End Date

**D. TYPE OF CERTIFICATION**

**Applying for:**

- |   |   |
|---|---|
| <input type="checkbox"/> Medicare (Title XVIII) | <input type="checkbox"/> Medicare and Medicaid                                |
| <input type="checkbox"/> Medicaid (Title XIX)   | <input type="checkbox"/> State Licensed Only (no TXIX / TXVIII certification) |

**E. ACCREDITATION STATUS**

- Non Accredited
- Applying for Accreditation with:  JCAHO  AOA  Program JCAHO  Other \_\_\_\_\_

Complete the following for CHANGE OF OWNERSHIP applications only.

<input type="checkbox"/> Currently Accredited	Accredited by <input type="checkbox"/> JCAHO <input type="checkbox"/> AOA <input type="checkbox"/> Other _____	Accreditation Begin Date	Accreditation End Date
<input type="checkbox"/> Deemed		Deemed Begin Date	Deemed End Date

**F. BED CAPACITY**

Indicate the total number of beds requested for those categories that apply.

General Acute Beds	Breakdown	
TOTAL Psychiatric Beds	Psychiatric Beds	*PPS Psychiatric Beds
TOTAL Rehabilitation Beds	Rehabilitation Beds	*PPS Rehabilitation Beds
Chemical Dependency / Alcohol Beds	* PPS (Prospective Payment System) excluded psychiatric beds and PPS excluded rehabilitation beds must have prior approval from the Centers for Medicare and Medicaid Services (CMS). If you are adding new PPS excluded psychiatric or rehabilitation beds, you must include a copy of the CMS approval letter with this application.	
<b>TOTAL BEDS</b>		
<b>If Critical Access Hospital (CAH):</b>	Total Number of Acute Care Beds	Are swing bed services provided? <input type="checkbox"/> Yes <input type="checkbox"/> No

**G. OFFSITE LOCATIONS**

- Yes  No Attach additional pages, if necessary.

Name of Off-Site	Type of Provider		
Street (Physical) Address	Telephone Number		
City	State	Zip Code	Number of Beds

Services Provided

Name of Off-Site			Type of Provider
Street (Physical) Address			Telephone Number
City	State	Zip Code	Number of Beds
Services Provided			

Name of Off-Site			Type of Provider
Physical Address			Telephone Number
City	State	Zip Code	Number of Beds
Services Provided			

**Check here**  if a change of ownership or more offsite locations are being applied for or have been approved by the Centers for Medicare and Medicaid Services (CMS), and attach a separate listing.

The listing should include all required information for each component that is not located on the hospital's premises and that will be billed under the hospital's Medicare provider number. Also, describe the services that will be provided and the number of beds if overnight inpatient services will be provided. Provide a copy of CMS' approval letter for each offsite location. Off-site locations that meet the definition of a hospital as described at Chapter 50.33(2), Wis. Stats., and HFS 124.02(6), Wis. Admin. Code, must be licensed separately.

**SERVICES PROVIDED BY THE HOSPITAL**

Check the type of services that will be provided. Attach additional pages if necessary. Place a "1" if service will be provided directly by hospital staff and a "2" if the service will be provided by contracting with another provider of service. If services will be provided both directly and by contract, insert a "3."

Check if Provided	Enter 1, 2, or 3	Service
<input type="checkbox"/>		Acute renal dialysis
<input type="checkbox"/>		Alcohol and/or drug services
<input type="checkbox"/>		Anesthesia services
<input type="checkbox"/>		Blood bank
<input type="checkbox"/>		Burn care unit
<input type="checkbox"/>		Chiropractic services
<input type="checkbox"/>		Coronary care unit
<input type="checkbox"/>		Dental services
<input type="checkbox"/>		Dietetic services

Check if Provided	Enter 1, 2, or 3	Service
<input type="checkbox"/>		Open heart surgery facilities
<input type="checkbox"/>		Operating rooms
<input type="checkbox"/>		Optometric services
<input type="checkbox"/>		Organ bank
<input type="checkbox"/>		Organ transplant services
<input type="checkbox"/>		Outpatient services
<input type="checkbox"/>		Outpatient surgery unit
<input type="checkbox"/>		Pediatric services
<input type="checkbox"/>		Pharmacy

<input type="checkbox"/>	Emergency services (organized)
<input type="checkbox"/>	Home care program
<input type="checkbox"/>	Hospice
<input type="checkbox"/>	Inpatient surgical services
<input type="checkbox"/>	Intensive care unit
<input type="checkbox"/>	Laboratory services (clinical)
<input type="checkbox"/>	Laboratory services (anatomical)
<input type="checkbox"/>	Long term care unit
<input type="checkbox"/>	Neonatal nursery
<input type="checkbox"/>	Nuclear medicine services
<input type="checkbox"/>	Obstetrics
<input type="checkbox"/>	Occupational therapy services

<input type="checkbox"/>	Physical therapy services
<input type="checkbox"/>	Post-operative recovery rooms
<input type="checkbox"/>	Psychiatric services
<input type="checkbox"/>	Radiology services (diagnostic)
<input type="checkbox"/>	Radiology services (therapeutic)
<input type="checkbox"/>	Rehabilitation services
<input type="checkbox"/>	Respiratory care services
<input type="checkbox"/>	Self care unit
<input type="checkbox"/>	Shock trauma
<input type="checkbox"/>	Social services
<input type="checkbox"/>	Speech pathology services
<input type="checkbox"/>	Other (Specify.): _____

**I. STAFFING**

Indicate number of full-time (FT) and part-time (PT) employees. Attach additional pages, if necessary.

	FT	PT		FT	PT
1. Chief Executive Officer			8. Pharmacy		
*2. Nurse Administrator, RN			9. Dietary		
*3. Nurse Supervisor			10. Laboratory		
*4. Registered Staff Nurses			11. Housekeeping		
*5. LPN Staff Nurses			12. Maintenance Personnel		
6. Nurse Aides			13. Laundry Personnel		
7. Medical Records			14. Other (Specify.) _____		

\* Under 2, 3, 4, and 5, report only those registered or licensed nurses with a current registration or license number. Report all other nurses under number 6.

**II. PLANT DESCRIPTION AND SPACE USE**

Not required for facilities that already have departmentally approved plans.

**A. DESCRIPTION OF FACILITY [HFS 124.27, 42 CFR 485.623(a)]**

**Attach** plans or drawings for each floor of the building occupied by the existing hospital and **identify**:

1. Life Safety Code Plans

- (a) Exiting
- (b) Fire barriers
- (c) Smoke barriers
- (d) Horizontal exits
- (e) Exit passage ways
- (f) Vertical shafts
- (g) Linen and trash chutes, and
- (h) Additional relevant information.

2. Building Information

- (a) Construction type
- (b) Age of existing building segments
- (c) Additional relevant information
- (d) Local zoning compliance statement

3. Existing Space Description

- (a) Current room/space use
- (b) Identification of hazardous areas protected by rated fire resistive partitions
- (c) Other relevant information.

4. Proposed Use of Rooms / Space within the Hospital
5. ADA (Americans with Disabilities Act) Accessibility Plan
  - (a) Parking
  - (b) Access routes
  - (c) Toilet rooms for public, staff, and patients indicating if ADA accessible
  - (d) Additional relevant information

Answer each of the following questions by checking the “Yes” or “No” boxes.

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>1-a.</b> Are building alterations and remodeling proposed? <b>1-b.</b> If <b>YES</b> , attach plans or drawings indicating the areas of remodeling. <b>SEE item B.2.</b>
<input type="checkbox"/>	<input type="checkbox"/>	<b>2-a.</b> Will the building have a mixed occupancy? <b>2-b.</b> If <b>YES</b> , identify all classifications and locations on the drawings or plans requested above.
<input type="checkbox"/>	<input type="checkbox"/>	<b>3-a.</b> Has the JCAHO (Joint Commission on the Accreditation of Healthcare Organizations), or the State approved any Life Safety Code variances or waivers? <b>3-b.</b> If <b>YES</b> , attach a copy of the award letter and waivers that have been approved.
<input type="checkbox"/>	<input type="checkbox"/>	<b>4-a.</b> Are all patients/clients/residents capable of leaving the building on their own?
<input type="checkbox"/>	<input type="checkbox"/>	<b>4-b.</b> If <b>NO</b> , are there instances when four (4) or more staff dependent patient/clients/residents are present in the building at the same time?
<input type="checkbox"/>	<input type="checkbox"/>	<b>5.</b> Is the building equipped with a fire alarm system?
<input type="checkbox"/>	<input type="checkbox"/>	<b>6-a.</b> Is there an interconnected smoke detection system? <b>6-b.</b> If <b>YES</b> , is the smoke detection system <ul style="list-style-type: none"> <li><input type="checkbox"/> throughout the building, i.e., in all areas, common areas and work spaces, whether occupied or not.</li> <li><input type="checkbox"/> in limited areas. (Identify locations on drawings.)</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	<b>7-a.</b> Is there an approved and supervised automatic sprinkler system? <b>7-b.</b> If <b>YES</b> , is the automatic sprinkler system <ul style="list-style-type: none"> <li><input type="checkbox"/> throughout the building, i.e., in <u>all</u> areas throughout the building.</li> <li><input type="checkbox"/> in limited areas. (Identify locations on drawings.)</li> </ul>
<b>ENTER NUMBER BELOW.</b>		<b>8.</b> Indicate the number of building stories.
		<b>8-a.</b> Above ground, including the exit level.
		<b>8-b.</b> Below the ground level of the exit.

## B. PROPOSED USE OF IDLE SPACE

**Use of idle space requires considerable study to determine how the facility can be sectioned-off for new services, renters, or types of uses, etc. The direction and scope of renovations must be in compliance with LIFE SAFETY CODES. Applicant is strongly urged to seek expert advice, e.g., an engineering consultant, to determine which space to declare idle. Renovation cost may be a factor to consider before applying for hospital licensure status.**

1. Explain how you will utilize the idle space, e.g., rental to outside groups, expansion of outpatient services, integration of existing or new health care services. Attach narrative.

2. If applicable, provide a description of construction considerations and time frame for the renovations described in the table above. Attach **only one** narrative covering all proposed building changes. **NOTE:** You must contact the Division of Quality Assurance prior to initiating all physical plant and environment renovations.

Plan Approval Applications (form OQA-2333) can be obtained at <http://dhfs.wisconsin.gov/forms/DDES/OQA2333.pdf> or by calling (608) 264-9838.

### III. ADMINISTRATION

#### A. HOSPITAL ADMINISTRATOR / CHIEF EXECUTIVE OFFICER (CEO)

Name - Administrator / CEO	<input type="checkbox"/> Male <input type="checkbox"/> Female	Begin Date
Title	Status <input type="checkbox"/> Interim <input type="checkbox"/> Acting <input type="checkbox"/> Permanent	
Is the Administrator / CEO in charge of more than one facility? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, Name of Facility and City	Type of Provider	

#### Education

Name of School / College / University	Years Attended
Address	Diploma / Degree / Year
Name of School / College / University	Years Attended
Address	Diploma / Degree / Year

#### Work Experience

Employer	Position
Address	Dates

**Attach a resume and a copy of the professional license, if applicable, for the administrator, managing employee, and medical director which includes their educational and work experience.**

#### B. PERSON IN CHARGE IN ABSENCE OF ADMINISTRATOR / CEO (SUBSTITUTE ADMINISTRATOR)

Name	Begin Date
Title	
<b>Education</b>	
Name of School / College / University	Years Attended
Address	Diploma / Degree / Year
Name of School / College / University	Years Attended
Address	Diploma / Degree / Year

### Work Experience

Employer	Position
Address	Dates

### C. MEDICAL DIRECTOR

Name – Medical Director	<input type="checkbox"/> Male <input type="checkbox"/> Female	Begin Date
Title	Status <input type="checkbox"/> Interim <input type="checkbox"/> Acting <input type="checkbox"/> Permanent	
Is the Medical Director in charge of more than one facility? <input type="checkbox"/> Yes <input type="checkbox"/> No		

### Education

Name of School / College / University	Years Attended
Address	Diploma / Degree / Year
Name of School / College / University	Years Attended
Address	Diploma / Degree / Year

### Work Experience

Employer	Position
Address	Dates

### D. NURSE ADMINISTRATOR (DIRECTOR OF NURSING)

Name	Begin Date
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### E. NAME OF PERSON IN CHARGE OF EACH DEPARTMENT

Dietary Service	Medical Records
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## IV. OWNERSHIP

### A. APPLICANT (OWNER)

Identify person(s) or business entity having the authority to direct the management or policies of the facility.

Name – Applicant (owner)	FEIN or SSN		
Street (Physical) Address			
Mailing Address (if different from physical address)			
City	State	Zip Code	County
Fax Number	Telephone Number	E-mail Address	
Contact Person			Telephone Number
Title – Contact Person			

Holding (i.e., what the owner owns):  Operations  Building  Land

**B. TYPE OF ORGANIZATION**

Check type of ownership.

Governmental	Proprietary	Voluntary Non-Profit
<input type="checkbox"/> City <input type="checkbox"/> County <input type="checkbox"/> State <input type="checkbox"/> Federal <input type="checkbox"/> City / County <input type="checkbox"/> Tribal	<input type="checkbox"/> Sole Proprietary <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Limited Liability Company <input type="checkbox"/> Limited Liability Partnership <input type="checkbox"/> Trust	<input type="checkbox"/> Corporation <input type="checkbox"/> Church <input type="checkbox"/> Association <input type="checkbox"/> Church / Corporation <input type="checkbox"/> Private Non-Profit <input type="checkbox"/> Limited Liability Company <input type="checkbox"/> Limited Liability Partnership <input type="checkbox"/> Trust
If Incorporated, Date Incorporated		

**C. INTERESTED PARTIES**

List all names, principal business addresses and the percentage of ownership interest of all officers, directors, stockholders owning 5% or more of stock, and members, partners, and all other persons having authority or responsibility for the operation of the organization. For non-profit organizations or governmental organizations, list the names and principal business address of all officers, directors, and board members. Attach additional pages if necessary.

Name		Title	
Address			Begin Date
City	State	Zip Code	Ownership Percentage
Name		Title	
Address			Begin Date
City	State	Zip Code	Ownership Percentage
Name		Title	
Address			Begin Date
City	State	Zip Code	Ownership Percentage
Name		Title	
Address			Begin Date
City	State	Zip Code	Ownership Percentage
Name		Title	
Address			Begin Date
City	State	Zip Code	Ownership Percentage

**D. OTHER PROVIDERS**

Identify other providers that are licensed and / or Medicare certified, located in Wisconsin, and are owned or operated by the applicant / owner under the exact same owner name.

If more than two, check here  and attach additional pages.

Name – Provider

City	State	Zip Code
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Relationship Type (nursing home, home health agency, community based residential facility, hospital)

Name – Provider

City	State	Zip Code
------	-------	----------

Relationship Type (nursing home, home health agency, community based residential facility, hospital)

**E. SUBSIDIARY / PARENT INFORMATION**

1. Is the applicant a subsidiary company, either wholly or partially owned by another organization or business?

Yes     No

If "Yes," provide the following information:

Legal Business Name – Parent Company

DBA (Doing Business As)

Type of Ownership

Mailing Address

City	State	Zip Code
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Contact Person	Telephone Number
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2. Is the applicant affiliated with any subsidiaries in the health care field in this state or any other state?

Yes     No

If Yes, provide one of the following:

- Names and addresses of all subsidiaries owned by the parent company, in this state or any other state, (relationship type: nursing homes, home health agencies, hospices, hospitals, rehabilitation facilities, etc.)
- Organizational chart exhibiting the legal business names and, if applicable, the DBA name of all the subsidiaries currently owned by the parent company in the health care field in this state or any other state, (relationship type: nursing homes, home health agencies, hospices, hospitals, rehabilitation facilities, etc.)
- Complete annual report to shareholders.

**F. CHAIN ORGANIZATION**

Is the applicant under the control of a chain organization?  Yes  No

Chain organization is defined as multiple providers, and/or suppliers owned, leased, or through any other devices, **controlled** by a **single business entity** (defined as chain home office). Each entity in the chain may have a different owner but the “home office” maintains **uniform procedures** in each facility for handling utilization review, reimbursement, handling admissions, also maintains and controls centrally, provider/suppliers cost reports, etc.

In addition, a chain facility would not necessarily be a subsidiary of the parent corporation but the chain facility or facilities could be owned by different subsidiaries of the same corporate parent.

Name – Chain Organization

**G. 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 applicant been affiliated in the past five years with a hospice (HSP), a home health agency (HHA), a residential care facility, e.g., Community Based Residential Facility (CBRF), Adult Family Home (AFH), or a health care facility (HCF), e.g., hospital, nursing home, or facility for the developmentally disabled in the State of Wisconsin or in any other state?

Yes  No

**IF THE ANSWER IS “YES,”** complete all information in the section below. Use the facility abbreviations (in parenthesis) from above to identify the type of facility.

**IF THE ANSWER IS “NO,”** complete only questions 4 –14 of this section.

Facility Name and Address	City and State	Type of Health Care Provider	Owner / Operator / Mgr. Vendor / Provider No.	Dates of Affiliation

2. Has any adverse action initiated by any state licensing agency resulted in the denial (D), suspension (S), or revocation (R) of a license or approval?

Yes  No

If “yes,” please complete the following table. Use abbreviations to describe the type of adverse action and refer to G.1. (above) for abbreviations for type of health care provider.

Facility Name and Address	City and State	Type of Health Care Provider	Type of Adverse Action	Effective Dates of Adverse Action


3. Has any adverse action initiated by a state or federal agency based on non compliance resulted in civil money penalties (CMP), termination of provider agreement (TPA), suspension of payments (SOP), or the appointment of temporary management of the facility (TMF)?

Yes       No

If "yes," please complete the following table. Use abbreviations to describe the type of adverse action and refer to G.1. (above) for abbreviations for type of health care provider.

Facility Name and Address	City and State	Federal or State	Type of Health Care Provider	Type of Adverse Action	Effective Dates of Adverse Action

4. Has the applicant ever had a denial, suspension, enjoining, or revocation of a health care provider license, in this state or any other state, as defined in Chapter 146.81, Wis. Stats., or any conviction for providing health care without a license?

Yes       No

If "yes," explain.

5. Has the applicant ever been convicted of a crime involving neglect or abuse of patients, or involved in assaultive behavior, wanton disregard for the health and safety of others, or any act of elder abuse under Chapter 46.90, Wis. Stats.?

Yes       No

If "yes," explain.

6. Has the applicant ever been convicted of a crime related to the delivery of health care services or items?

Yes  No

If "yes," explain.

7. Has the applicant ever been convicted of a crime involving controlled substances under Chapter 161, Wis. Stats.?

Yes  No

If "yes," explain.

8. Has the applicant had any prior financial failure that resulted in bankruptcy or in the closing of a hospice, home health agency or an inpatient health care facility, e.g., nursing home or hospital, or the relocation of its patients or residents?

Yes  No

If "yes," explain.

9. Has the applicant/owner been adjudicated bankrupt?

Yes  No

If "yes," explain on a separate page. Provide the dates, court, and disposition of each action.

10. Are there any unsatisfied judgements against the applicant/owner?

Yes  No

If "yes," explain on a separate page. Provide the names and addresses of creditors, amounts, and the reasons for non-payment.

11. Does the applicant / owner owe any debts that are 90 days past due?

Yes  No

If "yes," explain on a separate page. Provide the names and addresses of creditors, amounts, and reasons for non-payment.

12. Does the applicant / owner plan to provide care to patients who are unable to pay for service?

Yes  No

13. Attach proof of sufficient resources as may be necessary to operate the facility for at least 90 days. Proof of sufficient financial resources should include income / expense statements.

14. Financial References

This question is to be completed by the **applicant**. Include at least one bank. Attach additional pages, if necessary

Name	Telephone Number
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Address		
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City	State	Zip Code
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Name	Telephone Number
------	------------------

Address		
---------	--	--

City	State	Zip Code
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**H. OWNER OF BUILDING / LAND**

If the building, land, or building and land, is owned by an entity (i.e., corporation, partnership, individual, etc.) other than the applicant / owner, complete this section. If the owner of the land is another entity, also complete Section I.

Holding:     Building         Land

Name	Telephone Number
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Mailing Address	Fax Number
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City	County	State	Zip Code
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**Type Of Organization**

Check type of ownership.

Governmental	Proprietary	Voluntary Non-Profit
<input type="checkbox"/> City <input type="checkbox"/> County <input type="checkbox"/> State <input type="checkbox"/> Federal <input type="checkbox"/> City / County <input type="checkbox"/> Tribal	<input type="checkbox"/> Sole Proprietary <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Limited Liability Company <input type="checkbox"/> Limited Liability Partnership <input type="checkbox"/> Trust	<input type="checkbox"/> Corporation <input type="checkbox"/> Church <input type="checkbox"/> Association <input type="checkbox"/> Church / Corporation <input type="checkbox"/> Private Non-Profit <input type="checkbox"/> Limited Liability Company <input type="checkbox"/> Limited Liability Partnership <input type="checkbox"/> Trust

**Interested Parties**

**Definition:** Interested parties are (1) persons or business entities having ownership interest of 5% or more, (2) partners if the entity is a partnership, (3) officers and directors if the entity is a corporation, and (4) if the entity is either governmental or non-profit, interested parties are the officers and directors. If there is a separate listing already in existence, and that listing contains all the required information, attach a copy of that listing to this application. If a complete listing is attached, completion of this portion of the application will be considered satisfied.

Name	Title
------	-------

Address	Begin Date
---------	------------

City	State	Zip Code	Ownership Percentage
------	-------	----------	----------------------

Name	Title
------	-------

Address	Begin Date
---------	------------

City	State	Zip Code	Ownership Percentage
Name		Title	
Address			Begin Date
City	State	Zip Code	Ownership Percentage
Name		Title	
Address			Begin Date
City	State	Zip Code	Ownership Percentage
Name		Title	
Street			Begin Date
City	State	Zip Code	Ownership Percentage

**I. OWNER OF LAND**

Complete this section if the owner of the land is not the same entity as the owner of the operation or the owner of the building.

Holding:  Land

Name			Telephone Number
Mailing Address			Fax Number
City	County	State	Zip Code

**Type of Organization**

Check type of ownership.

Governmental	Proprietary	Voluntary Non-Profit
<input type="checkbox"/> City <input type="checkbox"/> County <input type="checkbox"/> State <input type="checkbox"/> Federal <input type="checkbox"/> City / County <input type="checkbox"/> Tribal	<input type="checkbox"/> Sole Proprietary <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Limited Liability Company <input type="checkbox"/> Limited Liability Partnership <input type="checkbox"/> Trust	<input type="checkbox"/> Corporation <input type="checkbox"/> Church <input type="checkbox"/> Association <input type="checkbox"/> Church / Corporation <input type="checkbox"/> Private Non-Profit <input type="checkbox"/> Limited Liability Company <input type="checkbox"/> Limited Liability Partnership <input type="checkbox"/> Trust

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Name	Title
------	-------

Address			Begin Date
City	State	Zip Code	Ownership Percentage
Name		Title	
Address			Begin Date
City	State	Zip Code	Ownership Percentage
Name		Title	
Address			Begin Date
City	State	Zip Code	Ownership Percentage
Name		Title	
Address			Begin Date
City	State	Zip Code	Ownership Percentage
Name		Title	
Address			Begin Date
City	State	Zip Code	Ownership Percentage
Name		Title	
Address			Begin Date
City	State	Zip Code	Ownership Percentage

**IV. LEASE AGREEMENT**

Is there a lease agreement?  Yes  No If "yes," list the name and address of the lease holder.

Name \_\_\_\_\_

Mailing Address \_\_\_\_\_

City	State	Zip Code	Lease Agreement End Date
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**V. MANAGEMENT COMPANY**

**A. MANAGEMENT CONTRACT**

Is the operation of the facility under a management contract?  Yes  No

If "yes," provide the following information regarding any management company retained to operate this facility or program.

Type of Management Company

Corporation  Partnership  Individual  Government

Name – Management Company \_\_\_\_\_

Name – Contact Person	Telephone Number
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Address \_\_\_\_\_

City	State	Zip Code
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**B. OFFICERS, DIRECTORS, TRUSTEES, OR SUPERVISORS OF THE MANAGEMENT COMPANY**

Identify officers, directors, trustees, or supervisors of the management company. Attach additional pages if necessary.

Name	Title
------	-------

Address

City	State	Zip Code
------	-------	----------

Name	Title
------	-------

Address

City	State	Zip Code
------	-------	----------

**C. OTHER MANAGEMENT COMPANY FACILITIES**

Identify other facilities the management company has owned, operated, or managed in the last five years. Attach additional pages, if necessary.

Name

Address

City	State	Zip Code
------	-------	----------

Dates of Involvement

Name

Address

City	State	Zip Code
------	-------	----------

Dates of Involvement

Name

Address

City	State	Zip Code
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Dates of Involvement

**D. ADVERSE ACTIONS**

The following questions refer to **any of the facilities identified in item C.**

1. Has any adverse action initiated by any state licensing agency resulted in the denial (D), suspension (S), or revocation (R) of a license?

Yes  No

If "yes," please complete the following table. Use abbreviations to describe the type of adverse action and refer to IV.G.1. for abbreviations for type of health care provider.

Facility Name and Address	City and State	Type of Health Care Provider	Type of Adverse Action	Effective Dates of Adverse Action

2. Has any adverse action been initiated by a state or federal agency based on noncompliance resulted in civil money penalties (CMP), termination of provider agreement (TPA), suspension of payments (SOP), or the appointment of temporary management of the facility (TMF)?

Yes  No

If "yes," please complete the following table. Use abbreviations to describe the type of adverse action and refer to IV.G.1. for abbreviations for type of health care provider.

Facility Name and Address	City and State	Type of Health Care Provider	Type of Adverse Action	Effective Dates of Adverse Action

**E. COPY OF MANAGEMENT CONTRACT**

Attach a copy of the signed contract with the management company.

**VI. CONTACT PERSON**

Identify the person responsible for completing this application and who can be contacted to address questions.

Name – Contact Person (Print.)		Title		
Telephone Number	Fax Number	Date Application Completed		

**VII. DESIGNEE**

Identify the person authorized to accept personal service and receive registered and certified mail.

Is the administrator also the Designee?  Yes  No If "no," provide the following information.

Name – Designee	Title
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### VIII. ATTESTATION

**The Management Company CANNOT attest to or sign on behalf of the applicant (Owner).**

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 six years, or both per Chapter 946.32, Wis. Stats.

**SIGNATURE** - Applicant's (Owner's) Legal Representative

Date Signed

Name (Printed or Typed) - Legal Representative

Title - Legal Representative

**RETURN THE COMPLETED APPLICATION TO:**

Division of Quality Assurance  
 Bureau of Technology, Licensing and Education  
 PO Box 2969  
 Madison WI 53701-2969