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| **DEPARTMENT OF HEALTH SERVICES**  Division of Quality Assurance  F-02109D (08/2022) | | | | | **STATE OF WISCONSIN**  Wis. Admin. Code ch. DHS 88 | | | |
| **ADULT FAMILY HOME (AFH) NEW PROVIDER LICENSURE APPLICATION CHECKLIST** | | | | | | | | |
| Name – Facility | | | | | | | Capacity | Date *(mm/dd/yyyy)* |
|  | | | | | | |  |  |
| Street Address | | | City | Zip Code | | County | | Reviewer |
|  | | |  |  | |  | |  |
| **A completed application includes submission of all the items in Section A and C as well as review of the items found on the Initial Survey Checklist by an assisted living surveyor to ensure compliance with applicable regulations.** | | | | | | | | |
| 1. **A COMPLETED APPLICATION CONTAINS THE FOLLOWING** | | | | | | | | |
|  | | 1. Background check completed by Office of Caregiver Quality on the licensee, and all non-residents age 10 and older. All required background checks must be completed within the same calendar year as the current facility application. New applicants for licensure must submit a Background Information Disclosure (BID) form and a BID Appendix form for each individual as described above, following the [Caregiver Background Check Process](https://www.dhs.wisconsin.gov/misconduct/backgroundchecks.htm). | | | | | | |
|  | | 1. Completed DQA form F-62674A, *Assisted Living Facility Model Balance Sheet*, or equivalent *[DHS 88.03] and supporting documentation* | | | | | | |
|  | | 1. Evidence of financial ability to operate for 60 days *[DHS 88.04(3)] and supporting documentation* | | | | | | |
|  | | 1. Floor plan (no larger than 11” x 17”) with room measurements, showing exits and use of the rooms *[DHS 88.05]* | | | | | | |
|  | | 1. Program statement *[DHS 88.03(2)(b)2]* | | | | | | |
|  | | 1. Admission/service agreement *[DHS 88.06(2)(c)1 – 8]* | | | | | | |
|  | | 1. Well water test results, if applicable *[DHS 88.05(3)(d)]* | | | | | | |
|  | | 1. Furnace and chimney inspection results *[DHS 88.05(3)(e)]* | | | | | | |
|  | | 1. If the home is currently licensed, a letter of intent to sell by the current owner/operator/licensee | | | | | | |
|  | | 1. If this is a leased property, provide a copy of the lease associated with this property along with a statement from the landlord (unless included in the lease) that (s)he is aware of your intention to use the property for business use. If a mortgage expense, please provide proof of ownership. | | | | | | |
|  | | 1. If applicable, documentation showing the type of business entity designated as Licensee:  * Corporation – Articles of Incorporation and Bylaws * Limited Liability Company (LLC) - Articles of Organization and Operation * Limited Liability Partnership (LLP) - Partnership Agreement | | | | | | |
| 1. **INITIAL SURVEY VISIT** | | | | | | | | |
| **Refer to the** [Adult Family Home (AFH) Initial Survey Checklist, F-02634A](https://www.dhs.wisconsin.gov/forms/f02634a.docx)**for a list of items to be reviewed during the initial survey. Applicant is responsible for knowing and meeting all regulation requirements.** | | | | | | | | |
| 1. HOME AND COMMUNITY BASED SERVICES CERTIFICATION REQUIREMENTS – ELIGIBILITY FOR MEDICAID WAIVER FUNDING | | | | | | | |
| **Home and Community-Based Services Rule 42 CFR 441.301(c)4 and 441.710**  To be eligible to receive Medicaid waiver funding, please complete the [Home and Community-Based Services (HCBS) Compliance Review Request Form, F-02138](https://www.dhs.wisconsin.gov/library/f-02138.htm)(hyper-link here).  For additional information regarding this requirement, visit <https://www.dhs.wisconsin.gov/regulations/assisted-living/hcbs.htm>. | | | | | | | |