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| **WISCONSIN MEDICAID STANDARDS FOR CERTIFIED 1-2 BED ADULT FAMILY HOMES (AFH)**  **ANNUAL RECERTIFICATION REVIEW: Evidentiary Document Checklist** | | | | | | |
| **Setting Information** (Please update any incorrect or missing information) | | | | | | |
| Name of AFH | | Contact Name | | | | |
| AFH Address | City | | | State | Zip Code | County |
|  |  | | |  |  |  |
| Contact Email Address: | | Contact Phone Number | | | | |
| Date Current Certification Expires: | | Target Group(s) Served by AFH: | | | | |
| Number of Beds in AFH: | | Respite Provided by AFH  Yes  No | | | | |
| **Evidentiary Materials** | | | | | | |
| **Please provide all requested documentation within 30 days via email to:** [dhsirisafh@dhs.wisconsin.gov](mailto:dhsirisafh@dhs.wisconsin.gov) | | | | | | |
| **AFH Program Statement, at a minimum, must include:** (pg. 17 of 1-2 Bed AFH Standards)   * Target group of number of individuals the applicant is musting to serve * Whether home is physically accessible to individuals who require such assistance * AFH physical features, ground and community resources that can be accessed by residents who live in the AFH with or without transportation assistance * Services and skills the AFH has to offer the resident * Operator’s intentions for the AFH to be licensed or certified under other standards for serving adults or children * Operator’s intentions that the AFH be used for respite care, including a statement as to the maximum number of temporary adult or child residents that may be in AFH at one time. Include description of physical space within the AFH that must be used for temporary respite residents, how frequently the AFH may be used for respite care, whether or not the respite care must involve additional staff being present in the AFH and whether these staff might work at night. * Household members and their relationship, if any, with the sponsor * Anything either the AFH or certifying agency deems appropriate to help prospective residents or placement agencies make decisions related to the use of the AFH | | | **Required Documents to be submitted.** In addition to the documents required by the sections below, provider must also submit the following documents. Check applicable boxes below to identify documentation being submitted:  Provider Application Form (F-02601)  Restrictive Measures, Restrictive Measures plan for each IRIS participant, if applicable  Evidence of DHS approved exception to any article or subpart in the Wisconsin Medicaid Standards for Certified 1-2 Bed Adult Family Homes, if applicable. | | | |

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| **INSTRUCTIONS:** This section is required to demonstrate compliance with each standard. Providers must specify all documents submitted as well as the location within each document, where applicable, in which evidence of compliance can be found. **Documentation sent without completion of this form must be considered incomplete and must not be reviewed.** |

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| **BACKGROUND CHECKS**  **The certifying agency shall ensure that an up-to-date caregiver and criminal background check has been conducted on all applicants or current providers in accordance with Wis. Admin. Code ch. DHS 12. This includes new applicants, the sponsor or operator seeking renewal of certification, all staff including prospective substitute providers, and all household members who are at/ over the age of 18 years. Background checks of people under the age of 18 are at the discretion of the certifying agency. This information shall be contained in any application for initial certification or recertification.**  **Prior to issuing a certification, and not less than once every 4 years thereafter, background checks that conform to the requirements in Article IV.B.3. shall be done.**  **Refer to Wisconsin Medicaid Standards for Certified 1-2 Bed Adult Family Homes, pgs. 16-17, 33** | | | | |
| **STANDARD** | | **TITLE OF DOCUMENT SUBMITTED**  (Completed by Provider) | **PAGE /SECTION**  **(Where applicable)**  (Completed by Provider) | **NOTES**  (Completed by Provider) |
| Provider must submit current list of all employees of the home including everyone that meets the definition of caregiver, and other household members 18 years or older. | |  |  |  |
| Provider must submit a current BID form for every employee of the home including everyone that meets the definition of caregiver, and other household members 18 years or older, **every 4 years**. Use box for notes at right to explain when BID forms must be due, if not due this year. | |  |  |  |
| Provider must submit current results of completed DOJ background checks for all employees including everyone that meets the definition of caregiver and other household members 18 years or older, **every 4 years**. Use box for notes at right to explain when DOJ background checks must be due, if not due this year. | |  |  |  |
| **IRIS PROVIDER EDUCATION – HEALTH AND SAFETY – INCIDENT REPORTING – SIGNED AGREEMENT (F-01203) This is not a requirement of the Wisconsin Medicaid Standards for Certified 1-2 Bed AFHs, however, it is required by IRIS for each sponsor/provider.** | | | | |
| **STANDARD** | **TITLE OF DOCUMENT SUBMITTED**  (Completed by Provider) | | **PAGE/ SECTION**  (Completed by Provider) | **NOTES**  (Completed by Provider) |
| Provider must submit a current copy of the IRIS Provider Education form (F-01203) signed and dated by each provider/ operator of the AFH. |  | |  |  |
| **PROGRAM STATEMENT**  **All AFHs shall have a Program Statement which shall, at a minimum, describe all of the items included on page 1-2 of this document. Refer to the Wisconsin Medicaid Standards for Certified 1-2 Bed Adult Family Homes, pg. 17** | | | | |
| Provider must submit a Program Statement that has been signed by the resident and includes each item described on pages 1-2 of this document. |  | |  |  |
| **STATEMENT OF HEALTH AND STATEMENT REGARDING COMMUNICABLE DISEASES**  **If at any time, the certifying agency suspects, is informed by the placement agency, or has reason to believe that the applicant, sponsor, operator, substitute provider, staff or other household member has been exposed to a potentially dangerous disease or infection, or may pose a threat to the health, safety, or welfare of residents, the certifying agency may require a physical exam, a screen for communicable disease (including TB), an alcohol or drug abuse assessment, or a mental health evaluation of the person. The placing agency may also require such an exam as a condition of the continued placement of the resident(s).**  **Refer to Wisconsin Medicaid Standards for Certified 1-2 Bed Adult Family Homes, pg. 34, 47-48** | | | | |
| **STANDARD** | | **TITLE OF DOCUMENT SUBMITTED**  (Completed by Provider) | **PAGE /SECTION**  (Completed by Provider) | **NOTES**  (Completed by Provider) |
| Provider must submit current evidence, **for any new resident admitted since the last review**, of a health examination to identify health problems, as well as evidence that resident was screened for communicable disease, including TB. Screening must have taken place within 90 days prior to admission to the home or within 14 days after admission. | |  |  |  |
| **SELF-DETERMINATION AND GUARDIANSHIP**  **Each resident of a 1-2 Bed AFH has the right to be treated as mentally competent unless there has been a court determination of incompetency under Wis Stat. 54.10. A resident who has been adjudicated incompetent has the right to have his or her guardian fully informed and involved in all aspects of his or her support and service in the AFH. A resident who has been adjudicated incompetent shall be allowed participation in decision-making to the extent that the resident is capable.**  **Refer to Wisconsin Medicaid Standards for Certified 1-2 Bed Adult Family Homes, pg. 57** | | | | |
| **STANDARD** | | **TITLE OF DOCUMENT SUBMITTED**  (Completed by Provider) | **PAGE /SECTION**  (Completed by Provider) | **NOTES**  (Completed by Provider) |
| Provider must submit a current copy of the court appointed guardianship, Power of Attorney for Healthcare and Activation of Power of Attorney for Healthcare for the applicable resident(s). | |  |  |  |
| **AFH SERVICE PLAN**  **The AFH service plan is a plan that describes the amount, type, manner of delivery and provider of any service that must be provided in and/or by the sponsor, operator or staff of the AFH.**  **Each resident of an AFH shall have an AFH service plan. The plan shall be developed prior to or at the time of the resident’s placement in the home, except in urgent situations when the resident requires placement immediately. In this case, the AFH service plan shall be developed within seven days of placement.**  **Refer to Wisconsin Medicaid Standards for Certified 1-2 Bed Adult Family Homes, pgs. 4, 45-46** | | | | |
| **STANDARD** | | **TITLE OF DOCUMENT SUBMITTED**  (Completed by Provider) | **PAGE /SECTION**  (Completed by Provider) | **NOTES**  (Completed by Provider) |
| Provider must submit a current, setting-specific (not developed by the ICA) service plan for each resident that has been signed by the resident and/ or their guardian. | |  |  |  |
| **SERVICE AGREEMENT AND EVICTION PROTECTION**  **An AFH shall have an agreement for services with each resident of the home. The agreement for services should be completed prior to and by the time of the resident’s placement unless there is an urgent need for immediate placement. In urgent situations when the resident requires immediate placement, the agreement for services must be completed within seven days after placement. The term of the agreement shall be for not more than one calendar year.**  **The agreement should make clear that the unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the person receiving services and that the person has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city or other designated entity. A sponsor or provider may terminate a resident’s placement only after giving 30 days’ written notice to the resident, the resident’s guardian, if any, the resident’s service coordinator, and the placing agency.**  **Refer to Wisconsin Medicaid Standards for Certified 1-2 Bed Adult Family Homes, pgs. 46-47** | | | | |
| **STANDARD** | | **TITLE OF DOCUMENT SUBMITTED**  (Completed by Provider) | **PAGE /SECTION**  (Completed by Provider) | **NOTES**  (Completed by Provider) |
| Provider shall provide a current copy of the service agreement between the AFH and each IRIS resident of the AFH. Document must be signed and dated by the provider and the resident or the resident’s guardian. | |  |  |  |
| Copy of resident’s service agreement must include language explaining the AFH policy on eviction prevention that complies with applicable language from Article IX of the 1-2 Bed AFH Standards as cited above. Provider must identify where in the service agreement this language can be found. | |  |  |  |
| **MEDICATION ADMINISTRATION RECORDS (MARS)**  **Records shall be kept by the sponsor, operator or staff of all prescription medications controlled or administered by sponsor, operator or staff and shall document the following: a. Name of resident, b. Name of medication, c. Date and time medication was given, d. The dose taken, e. The initials of the sponsor, operator or staff that the medication was given, and, f. Any refusal by the resident to take the medication.**  **Refer to the Wisconsin Medicaid Standards for Certified 1-2 Bed Adult Family Homes, pg. 50** | | | | |
| **STANDARD** | | **TITLE OF DOCUMENT SUBMITTED**  (Completed by Provider) | **PAGE /SECTION**  (Completed by Provider) | **NOTES**  (Completed by Provider) |
| Provider must submit a current, redacted MAR for each IRIS member that includes each detail outlined above. | |  |  |  |
| **COMMUNITY INTEGRATION**  **The setting is integrated in and supports full access of people receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.**  **The setting must also demonstrate that it is not institutional in nature and does not have the effect of isolating Medicaid HCBS residents from the broader community. It is not located in a publicly or privately owned facility that also provides inpatient treatment, and is not located on the grounds of or adjacent to a public institution.**  **Refer to page 25 of the Wisconsin Medicaid Standards for 1-2 Bed Adult Family Homes** | | | | |
| **STANDARD** | | **TITLE OF DOCUMENT SUBMITTED**  (Completed by Provider) | **PAGE /SECTION**  (Completed by Provider) | **NOTES**  (Completed by Provider) |
| Provider must submit evidence that they are integrated in the community and support the resident full access to the community to the extent outlined above. Evidence may include photos or screenshots of setting on Google Maps, language in the Program Statement, Person-Centered Assessments and Plans and other setting or resident specific documents. | |  |  |  |
| If setting is not in close proximity to or does not have easy access to the broader community, provider must submit evidence of the steps taken by the setting to ensure that resident is not isolated. Such evidence may include person-centered assessments and plans, activity calendars, person-specific schedules, etc. | |  |  |  |
| **RESIDENT RIGHTS, GRIEVANCES, AUTONOMY AND INDEPENDENCE**  **Residents of AFHs retain all of their civil, legal and human rights.**  **Refer to the Wisconsin Medicaid Standards for Certified 1-2 Bed Adult Family Homes, pgs. 56-61** | | | | |
| **STANDARD** | | **TITLE OF DOCUMENT SUBMITTED**  (Completed by Provider) | **PAGE /SECTION**  (Completed by Provider) | **NOTES**  (Completed by Provider) |
| Provider must submit a copy of the Resident Rights document signed by the resident(s). | |  |  |  |
| Provider must submit a copy of the House Rules and Responsibilities shared with residents. | |  |  |  |
| Provider must submit a copy of the Grievance Procedure signed by the resident(s). | |  |  |  |
| Setting must provide evidence that a telephone is available for resident use, in private and for a reasonable amount of time, and a list of emergency contact numbers that resident may use if needed. (pg. 31 of Standards) | |  |  |  |
| Setting must submit written evidence that the waiver agency provided information allowing the person to select the AFH from among setting options. | |  |  |  |
| **RESIDENT PRIVACY AND CONFIDENTIALITY**  **Setting must keep all resident records confidential in accordance with Wis. Stat. 51.30 and Wis. Admin. Code ch. DHS 92 and any other applicable state or federal law rule or program statement.**  **An individual’s rights of privacy, dignity, and respect must be ensured. The AFH must provide space and adequate physical features, such as doors and interior sound control, so that residents can have privacy when the resident wishes to be alone or undisturbed.**  **Residents have the right to have physical and personal privacy when receiving treatment and services; in the living arrangement; in caring for personal needs such as toileting, bathing, and dressing; and when he or she desires time alone.**  **Refer to the Wisconsin Medicaid Standards for Certified 1-2 Bed Adult Family Homes, pgs. 26, 56** | | | | |
| **STANDARD** | | **TITLE OF DOCUMENT SUBMITTED**  (Completed by Provider) | **PAGE /SECTION**  (Completed by Provider) | **NOTES**  (Completed by Provider) |
| Provider must submit evidence, such as language in the Resident Rights Document and/ or a policy on privacy and confidentiality, indicating that home maintains all resident records in a confidential manner. Resident records include the MAR, person-centered assessment plan, financial records and any records containing Personally Identifiable Information (PII) and Personal Health Information (PHI).  Home may be asked to submit a photo of the area(s) in which records are stored, as evidence that home maintains all resident records in a confidential manner, if no photos of these areas are already on file for your home. | |  |  |  |
| Provider must submit evidence, such as language in the Resident Rights and/ or in a policy on privacy and confidentiality that includes how setting respects physical and personal privacy as outlined above.  Setting may be asked to submit photos of bedroom and bathroom doors that lock if no such photos are already on file for your home. | |  |  |  |

| **PHYSICAL PLANT AND SAFETY**  **Most aspects of the physical plant and safety requirements have been approved in the past and must be evaluated by reviewer during the onsite visit without submission of additional documents. The following items must be submitted prior to the onsite review. An onsite review must not be scheduled in the absence of these documents.**  **Refer to the Wisconsin Medicaid Standards for Certified 1-2 Bed Adult Family Homes, pgs. 27-31** | | | |
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| **STANDARD** | **TITLE OF DOCUMENT SUBMITTED**  (Completed by Provider) | **PAGE /SECTION**  (Completed by Provider) | **NOTES**  (Completed by Provider) |
| Provider must submit an updated floor plan for setting **ONLY** if changes to the floor plan were made since provider last submitted the floor plans. Floor plans must include accurate dimensions, names/ purpose of each room, location of fire extinguishers, smoke detectors, carbon monoxide detectors and exits. |  |  |  |
| Provider must submit a copy of their fire safety evacuation plan (see pgs. 30-31 in Standards) |  |  |  |
| Provider must submit current Fire Drill Log showing that setting has conducted semi-annual fire drills with all household members. Logs must include date, time and evacuation time for each drill. (pg. 31 of Standards) |  |  |  |
| Provider must submit current evidence that smoke detector tests have been conducted monthly. (pg. 30 of Standards) |  |  |  |
| Provider must submit current evidence that fire extinguishers have been checked annually. (pg. 29-30 of Standards) |  |  |  |
| Provider must submit evidence (such as a receipt for new detectors) that they have replaced the carbon monoxide detectors not less than every 6 years. Please indicated in the notes when the detectors were last changed if not submitting a receipt for new detectors. |  |  |  |
| Provider must submit a policy on storage of weapons and ammunition in the home that complies with pg. 27 of the Standards. If setting does not allow weapons or ammunition to be stored or carried on the premises, the provider must submit a photo of a No Weapons sign posted at the entrance to the setting. |  |  |  |
| Provider must submit current evidence, if applicable, that well water samples were tested annually. (pg. 26 of Standards) |  |  |  |
| Provider must submit current water temperature logs showing that water temps have been monitored monthly and remain between 110-115 degrees. |  |  |  |

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| **PET VACCINATIONS**  **Cats, dogs and other pets vulnerable to rabies, which are owned by resident or household members, must be vaccinated as required under local ordinance.**  **Refer to the Wisconsin Medicaid Standards for Certified 1-2 Bed Adult Family Homes, pg. 31** | | | |
| **STANDARD** | **TITLE OF DOCUMENT SUBMITTED**  (Completed by Provider) | **PAGE /SECTION**  (Completed by Provider) | **NOTES**  (Completed by Provider) |
| Provider must submit current health and vaccination records for each pet residing in the home. |  |  |  |
| **ONGOING CAREGIVER TRAINING REQUIREMENTS**  **Training requirements apply to the operator(s), substitute provider(s), and all staff who regularly provide service in the home and who meet the definition of caregiver and have completed no fewer than 8 hours of training approved by the certifying agency related to the health, safety, welfare, rights, community integration and treatment of residents. Training must be completed annually.**  **Refer to the Wisconsin Medicaid Standards for Certified 1-2 Bed Adult Family Homes, pg. 35** | | | |
| **STANDARD** | **TITLE OF DOCUMENT SUBMITTED**  (Completed by Provider) | **PAGE /SECTION**  (Completed by Provider) | **NOTES**  (Completed by Provider) |
| Provider must submit training records for each person outlined above, as evidence that they have completed at least 8 hours of the requisite training requirements. |  |  |  |
| **IF SETTING INCLUDES NEW EMPLOYEE(S) SINCE LAST REVIEW:** Provider must submit training records for each **new** employee as evidence that that they have completed no fewer than 10 hours of requisite training as outlined above. |  |  |  |
| Provider must submit evidence that each **new** employee who has not provided AFH services in the past, has completed training in Fire Safety and First Aid. |  |  |  |
| **INSURANCE COVERAGE**  **See below for list of insurance verifications required for this review.** | | | |
| **STANDARD** | **TITLE OF DOCUMENT SUBMITTED**  (Completed by Provider) | **PAGE /SECTION**  (Completed by Provider) | **NOTES**  (Completed by Provider) |
| Provider must submit copy of active homeowner’s or renter’s insurance policy. |  |  |  |
| Provider must submit copy of active liability insurance policy. (pg. 35 of Standards) |  |  |  |
| **IF** setting provides transportation to residents, provider must submit verification of current insurance policy **AND** current driver’s license for **EACH** person who must provide transportation to residents. |  |  |  |

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| * **Documentation submitted should not include any personally identifiable information regarding any individual receiving waiver services.**   If you are submitting examples of individual service plans/care plans, or other participant-specific documentation, you MUST ensure that any personally identifiable information is redacted. | |
| **Additional Resources for Medicaid Home and Community-Based Services (HCBS)** | |
| Wisconsin Medicaid Standards for Certified  1-2 Bed Adult Family Homes  <https://www.dhs.wisconsin.gov/publications/p0/p00638.pdf> |  |
| Please contact the 1-2 Bed AFH Certification Team with questions by email at [dhsirisafh@dhs.wisconsin.gov](mailto:dhsirisafh@dhs.wisconsin.gov) | |