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| DEPARTMENT OF HEALTH SERVICES | **STATE OF WISCONSIN** |
| Division of Quality Assurance | Wis. Stat. § 50.49(5)(b) |
| F-62674 (08/2023) |  Page 1 of 9 |
|  |
| HOME HEALTH AGENCY LICENSE APPLICATION | FOR OFFICE USE ONLY |
| License No.: |
| License Fee: |
|  | TYPE OF APPLICATION |  | Caregiver Background Fee: |
|  | [ ]  Initial [ ]  Change of Ownership |  | Effective Date: |
| Completion of this form is required by provisions of Wis. Stat. § 50.49(5)(b) for home health agencies. Failure to complete this form may result in non-issuance of a home health agency license. 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 Wis. Stat. § 50.498(1). 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.Questions about completion of this application may be directed to the **Bureau of Health Services / Licensing, Certification and CLIA Section (LCCS)** at **608-266-7297.****RETURN THIS COMPLETED APPLICATION TO:** Department of Health ServicesDivision of Quality Assurance/BHS/LCCSP.O. Box 2969Madison, WI 53701-2969**Penalties:** Per Wis. Stat. § 946.32, knowingly providing false information or omitting information when completing this form may result in a fine of up to $10,000 or imprisonment not to exceed six years, or both. |
| I. GENERAL INFORMATION |
| A. Home Health Agency Information |
| Name – Home Health Agency |
| Email Address | Telephone Number | Fax Number |
| Street (physical) Address | City | State | Zip Code |
| Mailing Address | County |
| Medicare-Approved Accrediting Organization[ ]  The Accreditation Commission for Health Care (ACHC) [ ]  The Joint Commission [ ]  Community Health Accreditation Partner (CHAP) |
| [ ]  Yes [ ]  No Will you use this accrediting organization for a combined initial state licensure and Medicare certification survey? |
| **Hours of Operation** |
| Mon: |  | Wed: |  | Fri.: |  | Sun: |  |
| Tues: |  | Thur: |  | Sat.: |  |  |
| **B. Change of Ownership** –*§ DHS 133.03(6)* |
| *List the previous owner’s name and license, Medicare, and Medicaid numbers.* |
| Name – Previous Owner |
| License Number – Previous Owner | Medicare Number – Previous Owner | Medicaid Number – Previous Owner |

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| **C. Geographical Area of Service (Counties Served*)*** –*§ DHS 133.03(3)(f)* |
| 1. Counties Served by Parent Office |
|       |       |       |       |       |
|       |       |       |       |       |
| 2. Branch Office Location(s) and Counties Served  |
| Branch Office | Counties Served From Branch Office |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| D. Services Provided |
| 1. Type of Home Health Services–*§ DHS 133.03(3)(f)*

 *Indicate whether services provided through the parent office and branch office are provided directly, contracted, or both.* |
| **Service** | **Parent Office** |  **Branch Office** | **Service** | **Parent Office** | **Branch Office** |
|  | **Direct** | **Cont.** | **Direct** | **Cont.** |  | **Direct** | **Cont.** | **Direct** | **Cont.** |
| Appliance/Equipment  | [ ]  | [ ]  | [ ]  | [ ]  | Occupational Therapy | [ ]  | [ ]  | [ ]  | [ ]  |
| Home Health Aide | [ ]  | [ ]  | [ ]  | [ ]  | Personal Care Worker | [ ]  | [ ]  | [ ]  | [ ]  |
| Homemaker/Companion  | [ ]  | [ ]  | [ ]  | [ ]  | Pharmaceutical  | [ ]  | [ ]  | [ ]  | [ ]  |
| Laboratory  | [ ]  | [ ]  | [ ]  | [ ]  | Physical Therapy  | [ ]  | [ ]  | [ ]  | [ ]  |
| Medical Social Work | [ ]  | [ ]  | [ ]  | [ ]  | Speech and Language Pathology  | [ ]  | [ ]  | [ ]  | [ ]  |
| Nursing Care | [ ]  | [ ]  | [ ]  | [ ]  | Other *(Specify below.)* |
| Nutritional Guidance | [ ]  | [ ]  | [ ]  | [ ]  |       | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. Contracted Services

*Attach a list of all individuals, agencies, and institutions with whom the agency has a contractual arrangement to provide patient care services. Include the names, addresses, types of services provided (e.g., PT, OT, SLP), the effective date of service, and provider type (e.g., rehabilitation agency, home health agency, hospital).* |
| E. Staffing – *§ DHS 133.03(3)* |
| Job Title | DHS Administrative Code | Full-Time | Part-Time | Contract |
|  |  | Number ofPersons | Total Hours Per Week | Number ofPersons | Total Hours Per Week | Number ofPersons |  Total Hours |
| Administrator | *133.06(1) and (2)* |       |       |       |       |       |       |
| Companion |  |       |       |       |       |       |       |
| Dietitian |  |       |       |       |       |       |       |
| Homemaker |  |       |       |       |       |       |       |
| Home Health Aides | *133.17* |       |       |       |       |       |       |
| Medical Social Workers | *133.16* |       |       |       |       |       |       |
| Personal Care Workers |  |       |       |       |       |       |       |
| Physical Therapists | *133.15* |       |       |       |       |       |       |
| Occupational Therapists | *133.15* |       |       |       |       |       |       |
| Registered Nurses | *133.14* |       |       |       |       |       |       |
| RN Supervisor | *133.18* |       |       |       |       |       |       |
| Speech/Lang. Pathologists | *133.15* |       |       |       |       |       |       |
| Other *(Specify below.)* |
|       |  |       |       |       |       |       |       |
|       |  |       |       |       |       |       |       |
| TOTAL |       |       |       |       |       |       |
|  |
| *Enter the number of hours in your official work week. (Enter a three-digit number, e.g., 35.0, 37.5.)* |       |
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| **II. ADMINISTRATION** |
| **A. Home Health Agency Administrator** –*§**DHS 133.06(1) and (2)* |
| Name – Administrator | Effective Date *(MM/dd/yyyy)*      |
| Title | Status[ ]  Interim [ ]  Permanent |
| *If the above individual holds a professional license, complete the following:* |
| Type of License | State   | Date Issued *(MM/dd/yyyy)*      | Expiration Date (*MM/dd/yyyy)* |
| Is the administrator in charge of other health care providers? [ ]  Yes [ ]  No  *If* ***Yes****, provide:* |
| Name – Agency | City | Type of Health Care Provider |
| **B. Substitute Administrator in Absence of Home Health Administrator** – *§§ DHS 133.03(3)(h) and 133.05(1)(e)* |
| Name | Title | Effective Date *(MM/dd/yyyy)*      |
| *If the above individual holds a professional license, complete the following:* |
| Type of License | State   | Date Issued *(MM/dd/yyyy)*      | Expiration Date *(MM/dd/yyyy)*      |
| **C. Nurse Supervisor** –*§ DHS 133.14(1)* |
| Name – Nurse Supervisor | Effective Date *(MM/dd/yyyy)*      |
| Type of Nursing License      | State   | Date Issued *(MM/dd/yyyy)*      | Expiration Date *(MM/dd/yyyy)*      |
| *Attach a resume and a copy of the professional license, if applicable, for the administrator, substitute administrator, and nurse supervisor, which includes their educational and work experience.* |
| **III. APPLICANT/OWNER INFORMATION** |
| 1. **Applicant** –*§ DHS 133.03(3)*
 |
| Name – Applicant      | SSN or Tax ID Number *(Wis. Stat. §* *50.498)*      |
| Street (physical) Address      | City      | County      | State   | Zip Code      |
| Email Address      | Telephone Number      | Fax Number      |
| 1. **Owner** –*§ DHS 133.03(3)*
 |
| Name – Applicant      | FEIN *(Wis. Stat. § 50.498)*      |
| Street (physical) Address      | City      | County      | State   | Zip Code      |
| Email Address      | Telephone Number      | Fax Number      |
| 1. **Type of Ownership** –*§ DHS 133.03(3)(b) Check type of ownership.*
 |
| **Government** | **Proprietary** | **Voluntary Non-Profit** |
| [ ]  City[ ]  County[ ]  State[ ]  Federal[ ]  City/County[ ]  Tribal | [ ]  Sole Proprietary[ ]  Partnership[ ]  Corporation[ ]  Limited Liability Company[ ]  Limited Liability Partnership[ ]  Trust | [ ]  Corporation[ ]  Church[ ]  Association[ ]  Church/Corporation | [ ]  Private Non-Profit[ ]  Limited Liability Company[ ]  Limited Liability Partnership[ ]  Trust |
| Date Incorporated (if incorporated) *(MM/dd/yyyy)*      | ***Attach a copy of the articles of incorporation or, if a foreign corporation,******attach evidence of authority to do business in Wisconsin.*** |
| **D. Interested Parties** –*§**DHS 133.03(3)(d)* |
| *List all names, principal business addresses, and the percentage of ownership interest of all officers, directors, stockholders owning 10% or more of stock, 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      | Ownership Percentage      |
| Street (physical) Address      | City      | State   | Zip Code      |
| Name      | Ownership Percentage      |
| Street (physical) Address      | City      | State   | Zip Code      |
| Name      | Ownership Percentage      |
| Street (physical) Address      | City      | State   | Zip Code      |
| Name      | Ownership Percentage      |
| Street (physical) Address      | City      | State   | Zip Code      |
| Name      | Ownership Percentage      |
| Street (physical) Address      | City      | State   | Zip Code      |
| **E. Other Health Care Providers Owned by the Applicant and/or Owner**  |
| *List other types of health care providers. If more than two, check here [ ]  and attach additional pages.* |
| Name – Provider      |
| City      | State   | Zip Code      | Relationship Type\*      |
| Name – Provider      |
| City      | State   | Zip Code      | Relationship Type\*      |
| \*Nursing home, home health agency, community-based residential facility, hospital, or other health care provider |
| F. Subsidiary/Parent Information – *42 CFR 484.12* |
| 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      | Type of Ownership      |
| DBA (Doing Business As)      |
| Address      | City      | State   | Zip Code      |
| Name – Contact Person      | Telephone Number      | Email Address      |
| 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.
 |
| 1. 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, and 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** –*Wis. Stat. § 50.29(a)* |
| The following information will be used to determine if the applicant meets the fit and qualified requirements under Wis. Stat. ch. 50. |
| 1. Has the applicant and/or owner been affiliated in the past five years with a hospice, home health agency, residential care, or assisted living facility (e.g., community-based residential facility, adult family home, residential care apartment complex), health care facility (e.g., hospital, nursing home, or facility for the developmentally disabled), or personal care agency in the state of Wisconsin or in any other state?

[ ]  Yes [ ]  No *If* ***Yes****, complete all items in Section G, items 1 – 11. Attach additional sheets, as needed.**If* ***No****, complete Section G, items 4 – 11.* |
| Name – Facility      |
| Address      | City      | State   |
| Owner/Operator/Manager Vendor/Provider Number      | Dates of Affiliation      |
| Name – Facility      |
| Address      | City      | State   |
| Owner/Operator/Manager Vendor/Provider Number      | Dates of Affiliation      |
| 1. Has any adverse action initiated against the applicant or owner by any state licensing agency resulted in the denial, suspension, injunction, or revocation of a health care agency or health care facility license? *§ DHS 133.03(3)(i)1*

[ ]  Yes [ ]  No *If* ***Yes****, complete the following. Attach additional sheets, as needed.* |
| Name – Facility      |
| Address      | City      | State   |
| Type of Adverse Action  [ ]  Denial [ ]  Suspension [ ]  Injunction [ ]  Revocation | Effective Dates of Adverse Action      |
| Name – Facility      |
| Address      | City      | State   |
| Type of Adverse Action [ ]  Denial [ ]  Suspension [ ]  Injunction [ ]  Revocation | Effective Dates of Adverse Action      |
| 1. Has any adverse action against the applicant or owner 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)? *§* *DHS 133.03(3)(i)2*

[ ]  Yes [ ]  No *If* ***Yes****, complete the following. Indicate the appropriate abbreviation to describe the type of adverse action. Attach additional sheets, as needed.*  |
| Name – Facility      | [ ]  State [ ]  Federal |
| Address      | City      | State   |
| Type of Adverse Action [ ]  CMP [ ]  TPA [ ]  SOP [ ]  TMF | Effective Dates of Adverse Action      |
| Name – Facility      | [ ]  State [ ]  Federal |
| Address      | City      | State   |
| Type of Adverse Action [ ]  CMP [ ]  TPA [ ]  SOP [ ]  TMF | Effective Dates of Adverse Action      |
| 1. Has the applicant or owner ever been convicted of a crime involving neglect or abuse of patients or of the elderly, been involved in assaultive behavior or wanton disregard for the health or safety of others, or engaged in any act of abuse under Wis. Stat. §§ 940.285 or 940.295? *§ DHS 133.03(3)(i)3*

[ ]  Yes [ ]  No *If* ***Yes****, explain.* |
|       |
| 1. Has the applicant or owner ever been convicted of a crime related to the delivery of health care services or items or for providing healthcare without a license? *§ DHS 133.03(3)(i)4*

[ ]  Yes [ ]  No *If* ***Yes****, explain.* |
|       |
| 1. Has the applicant or owner ever been convicted of a crime involving controlled substances under Wis. Stat. ch. 161? *§ DHS 133.03(3)(i)5*

[ ]  Yes [ ]  No *If* ***Yes****, explain.* |
|       |
| 1. Has the applicant or owner ever been convicted of a crime involving a sexual offense? *§ DHS 133.03(3)(i)6*

[ ]  Yes [ ]  No *If* ***Yes****, explain.* |
|       |
| 1. Has the applicant had any prior financial failure that resulted in bankruptcy or in the closing of a health care agency or health care facility or the relocation or discharge of a health care agency’s or health care facility’s patients? *§ DHS 133.03(3)(i)7*

[ ]  Yes [ ]  No *If* ***Yes****, explain.* |
|       |
|  |
| 1. Are there any unsatisfied judgments against the applicant or owner or any debts that are at least 90 days past due?

*§ DHS 133.03(3)(i)8*[ ]  Yes [ ]  No If **Yes**, explain. |
|       |
| 1. Proof of Sufficient Financial Resources – *§ DHS 133.03(3)(e)*

*Attach proof of sufficient resources as may be necessary to operate the agency for at least 90 days. Proof of sufficient financial resources may include income/expense statements. See attached DQA form F-62674A, Model Balance Sheet, for assistance.*  |
| 1. Financial References – *§ DHS 133.03(3)(e)*

*This item is to be completed by the APPLICANT. Do not include relatives. Include at least one bank. Attach additional pages, if necessary.* |
| Name      | Telephone Number      |
| Address      | City      | State    | Zip Code      |
| Name      | Telephone Number      |
| Address      | City      | State   | Zip Code      |
| **IV. MANAGEMENT COMPANY** |
| *Provide the following information for the person(s) or business entity having authority to direct the management or policies of the agency.* |
| 1. **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      |
| Address      | City      | State   | Zip Code      |
| Name – Contact Person      | Telephone Number      | Email Address      |
| 1. ***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      |
| 1. ***Identify other facilities the management company has owned, operated, or managed in the last five years. Attach additional sheets, if necessary.***
 |
| Name       | Dates of Involvement      |
| Address      | City      | State   | Zip Code      |
| Name       | Dates of Involvement      |
| Address      | City      | State   | Zip Code      |
| 1. **While managing any of the above facilities identified in item C:**
 |
| 1. Has any adverse action initiated by any state agency resulted in the denial, suspension, injunction, or revocation of a license?

[ ]  Yes [ ]  No *If* ***Yes****, complete the following table.* |
| Name – Facility       |
| Address      | City      | State   |
| Type of Adverse Action [ ]  Denial [ ]  Suspension [ ]  Injunction [ ]  Revocation | Effective Dates of Adverse Action      |
| Name – Facility      |
| Address      | City      | State   |
| Type of Adverse Action [ ]  Denial [ ]  Suspension [ ]  Injunction [ ]  Revocation | Effective Dates of Adverse Action      |
| 1. Has any adverse action been 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****, complete the following table.* |
| Name – Facility      |  [ ]  State [ ]  Federal |
| Address      | City      | State   |
| Type of Adverse Action [ ]  CMP [ ]  TPA [ ]  SOP [ ]  TMF | Effective Dates of Adverse Action      |
| Name – Facility      |  [ ]  State [ ]  Federal |
| Address      | City      | State   |
| Type of Adverse Action [ ]  CMP [ ]  TPA [ ]  SOP [ ]  TMF | Effective Dates of Adverse Action      |
| 1. ***Attach a copy of the signed contract with the management company.***
 |
| **V. CONTACT PERSON** |
| *Identify the person responsible for completing this application and who can be contacted if questions arise.* |
| Name       | Title      |
| Telephone Number      | Email Address      | Date Application Completed *(MM/dd/yyyy)*      |
| **VI. DESIGNEE** |
| The “designee” is a 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      |
| **VII. ATTESTATION** |
| **NOTE: The management company cannot attest to or sign on behalf of the applicant (potential licensee).** |
| 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 Wis. Stat. § 946.32. |
| **SIGNATURE** – Applicant (potential licensee) | Date Signed |
| Name – Applicant *(Print or type)*      | Title – Applicant      |