

ADULT FAMILY HOME INITIAL LICENSE APPLICATION

- Completion of this form is required by Chapter 50.033(2m), Wis. Stats., and DHS 88.03(2)(a), (b) and (4)(b), Wis. Admin. 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 Division of Quality Assurance (DQA) regional office assigned to the county in which the facility is located. Contact the appropriate regional office if you have questions about completion of this form. Regional office locations can be found at: <http://dhs.wisconsin.gov/bqaconsumer/AssistedLiving/ALSreglmap.htm>
- **The following items must be submitted:**
 - Vehicle insurance coverage
 - License fee (**NON-REFUNDABLE**) - Check payable to: **DQA**
 - Documentation of home owners or renters insurance
 - Floor plan with room dimensions, exits, and usage
 - Program Statement
 - DQA form F-62674A, *Assisted Living Facility Model Balance Sheet*
 - Evidence of 60 day operating funds
 - Verification of Completion of AFH webcast

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

YES NO Did you submit form F-82064 (BID) and form F-82069 (BID Appendix) to the Office of Caregiver Quality at the address listed below?

**DHS / Division of Quality Assurance
Office of Caregiver Quality
P.O. Box 2969
Madison, WI 53701-2969**

YES NO Does the licensee currently hold another type of license or certification?

FACILITY INFORMATION				
Name – Facility				FEIN
Street Address - Facility		City	State	Zip Code
County	FEIN	Telephone Number - Facility	Fax Number - Facility	E-mail Address - Facility
Facility Administrator Information				
Name - Administrator			Birth Date - Administrator	
Mailing Address - Administrator		City	State	Zip Code
Telephone Number - Administrator	E-mail Address - Administrator			
Designated Mail Recipient (Provide contact information for the individual to whom mail from DHS/DQA is to be sent.)				
Name – Designated Mail Recipient		Telephone Number	E-mail Address	
Mailing Address		City	State	Zip Code
RESIDENT INFORMATION				
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 agency or managed care organization to serve publicly funded individuals?	
<input type="checkbox"/> Three <input type="checkbox"/> Four			<input type="checkbox"/> Yes <input type="checkbox"/> No	

Check the box indicating the **primary client group(s)** you are requesting to serve.

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

List the **days** when residents are **NOT** in the facility.

List the **hours** when residents are **NOT** in the facility.

LICENSEE INFORMATION (Check only one box.)

Governmental	Proprietary	Voluntary Non-Profit	
<input type="checkbox"/> City <input type="checkbox"/> County <input type="checkbox"/> State <input type="checkbox"/> Tribal	<input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Limited Liability Co.	<input type="checkbox"/> Corporation <input type="checkbox"/> Church <input type="checkbox"/> Limited Liability Co.	
Name - Licensee [Individual or Corporation (legal entity)]		Name - Owner or President	
Birth Date - Licensee			
Mailing Address - Licensee		City	State Zip Code
Telephone Number - Licensee	E-mail Address - Licensee		

If the licensee currently holds another type of license or certification, 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 (Specify.) _____	<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 (Specify.) _____	<input type="checkbox"/> Residential Care Apartment Complex

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.

- 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:

MONTHLY FEES

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
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MONTHLY OPERATING EXPENSES

- **A current balance sheet must be submitted with this application.** (See DQA form F-62674A, *Assisted Living Facility Model Balance Sheet.*)
- **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.**

All Salaries (i.e., licensee, caregivers, contract providers, etc.)	\$
Lease or Mortgage	\$
All Other (food, supplies, utilities, insurance, taxes, etc.)	\$
TOTAL Monthly Expenses	\$

If income from residents would not be adequate to pay your 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.

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 or managed care organization) | <input type="checkbox"/> Loan |
| <input type="checkbox"/> Outside employment | <input type="checkbox"/> Other (<i>Specify.</i>) _____ |

LICENSEE OWNERSHIP

The licensee owns the: Building Land Operation

NON RESIDENT INFORMATION

List below the names of all persons, age 10 and older, who live in the facility and are not a resident.

Name	Relationship to Licensee	Date of Birth			
<table style="width:100%"> <tr> <td style="width:30%">Last Name</td> <td style="width:30%">First Name</td> <td style="width:40%">MI</td> </tr> </table>	Last Name	First Name	MI		
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FIRE DEPARTMENT INFORMATION

Local fire departments have requested knowing where licensed facilities exist. The Division 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 or PO Box)	City	State	Zip Code

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

The licensee is responsible for notifying the Division 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 (Chapter 946.32, Wis. Stats.).

SIGNATURE (FULL) – Licensee or Designee		Date Signed
Name – Licensee or Designee (Print or type.)	Title	