

ADULT DAY CARE INITIAL CERTIFICATION APPLICATION

- In accordance with 42 CFR 441.352(a)(1) and (2), adult day care centers serving publicly funded clients must meet State certification requirements in order to receive funds for the cost of care for these participants.
- Completion of this form is required to become certified as an adult day care center. Failure to accurately complete and submit this form will result in denial of certification.
- Send the completed form with the attachments listed below to the Division of Quality Assurance (DQA) regional office assigned to the county in which the facility is located.
- DQA regional office locations are found at: http://dhfs.wisconsin.gov/rl_DSL/Contacts/ALSreglmap.htm Contact the appropriate regional office if you have questions about completion of this form.
- **ATTACH THE FOLLOWING TO THIS APPLICATION.**
 - Diagram of floor plan of TOTAL space to be used by the center. Indicate dimensions, exits, and room usage.
 - **Certification fees (NON-REFUNDABLE)** --- Check payable to: **DQA**

Yes No **Does the licensee currently hold other types of licenses or certifications?** If "yes," list all below.

Check one of the following.

Currently serving publicly funded clients (*Identify the county agency or managed care agency providing funding.*)

Anticipate serving publicly funded clients within the next 90 days

Name- Facility		FEIN	Total No. of Clients Served	
Street Address - Facility	City	State	Zip Code	County

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	Fax Number - Facility	E-mail Address		
Mailing Address – Facility (if different from street address)	City	State	Zip Code	County	

Name – Owner / Applicant			Telephone Number	
Address	City	State	Zip Code	

Name – Administrator			Telephone Number	
Address	City	State	Zip Code	

Name – Center Director	Days of Operation	Hours of Operation
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Identify client groups to be served [e.g., advanced age, developmentally disabled, Alzheimers / dementia, physically disabled, mentally ill / emotionally disturbed, terminally ill, traumatic brain injury (TBI)].

The adult day care is located in: <input type="checkbox"/> Provider's Home <input type="checkbox"/> Nursing Home <input type="checkbox"/> CBRF	Will meals be provided? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are any clients non-ambulatory? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Provide directions to the facility from the closest STATE highway.

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 (Chapter 946.32, Wis. Stats.).

SIGNATURE – Owner / Applicant	Title	Date Signed
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