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| DEPARTMENT OF HEALTH SERVICES | | | | | | | | | | **STATE OF WISCONSIN** | |
| Division of Quality Assurance | | | | | | | | | | Wis. Stat. § 49.45(42)(d)3.e | |
| F-00119 (04/2024) | | | | | | | | | | Page 1 | |
|  | | | | | | | | | | | |
| PERSONAL CARE AGENCY APPLICATION | | | | | | | | | FOR DQA OFFICE USE ONLY | | |
| Approval No.: | | |
|  | TYPE OF APPLICATION:  Initial  Change of Ownership | | | | | | |  | Fee: | | |
|  |  | | | | | | |  | Effective Date: | | |
| The Division of Quality Assurance (DQA) personal care agency (PCA) application is part of the process to become Medicaid certified. Approval of this application to provide personal care services does not constitute Medicaid approval. An agency will need to submit this application and undergo a DQA survey in order for DQA to determine compliance with Wis. Admin. Code § DHS 105.17 and to provide a recommendation for certification to the Division of Medicaid Services.  Completion of this form is required by provisions of Wis. Stat. § Chapter 49.45(42)(d)3.e and Wis. Admin. Code § DHS 105.17(5(ag) for personal care agencies. Failure to complete this form completely and accurately may result in a delay in processing or denial of the application for a personal care agency. The personally identifiable information collected on this form will be used to determine program eligibility and for statistical information and for no other purpose.  *The department may not approve an applicant who does not comply with any provision of this chapter, Wis. Admin. Code § DHS 107.112, Wis. Admin. Code § DHS 105.17, or Wis. Stat. ch.* [*50*](https://docs.legis.wisconsin.gov/document/statutes/ch.%2050)*, or who is not fit and qualified as specified in § DHS 105.17(1e)(e), or who has failed to pay any fee or any outstanding amounts due to the department. [DHS 105.17(5)(c)].*  **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.** Questions about this application may be directed to the Bureau of Health Services by calling 608-266-2702 or emailing [DHSDQALCCS@dhs.wisconsin.gov](mailto:DHSDQALCCS@dhs.wisconsin.gov). | | | | | | | | | | | |
| **RETURN THE COMPLETED APPLICATION TO:** | | | | | Department of Health Services  DQA BHS  ATTN PCA Certification  PO Box 2969 Madison, WI 53701-2969 | | | | | |
| **APPLICATION PROCESS** | | | | | | | | | | |
| **Step 1** | | | | **Background Check –** EntityBackground Checks are conducted by the Office of Caregiver Quality. | | | | | | |
| **Step 2** | | | | **Complete Application –** A fully completed application is received and reviewed by the department. Incomplete applications will be returned to the applicant without processing. | | | | | | |
| **Step 3** | | | | **Initial Survey –** An initial survey is completed by department staff to determine compliance with all regulatory requirements for program certification. | | | | | | |
| **STEP 1 – ENTITY BACKGROUND CHECK** | | | | | | | | | | |
| **DO NOT SUBMIT BACKGROUND MATERIALS WITH THIS CERTIFICATION APPLICATION.**  Submit DHS forms F-82064, Background Information Disclosure (BID), and F-82069, BID Appendix, with required fees to the Office of Caregiver Quality. Refer to [www.dhs.wisconsin.gov/caregiver/entity-cbc.htm](http://www.dhs.wisconsin.gov/caregiver/entity-cbc.htm). Background checks are completed by the Office of Caregiver Quality for the principals, owners, operator, managing employees, and all non-client household members age 10 and older. (Wis. Stat. § 50.065(2)(am))  To facilitate the coordination of information between the Office of Caregiver Quality and licensing associates, provide the name(s) of all persons whose background checks were submitted for this application. (Attach an additional list if necessary.) | | | | | | | | | | |
| Name | | | |  | | Name |  | | | |
|  | | | | | | | | | | |
| **STEP 2 – COMPLETE APPLICATION** | | | | | | | | | | |
| The following items and documents must be included with this completed and signed application form. | | | | | | | | | | |
|  | | 1. Non-refundable application fee of $300.00 | | | | | | | | |
|  | | 1. Program description [Wis. Admin. Code § DHS 105.17(1e)(b)]:   The PCA program must include: | | | | | | | | |
|  | |  | 2.1 Documents cost-effective provision of services [Wis. Admin. Code § DHS 105.17(1e)(b)1.] | | | | | | | |
|  | |  | 2.2 Documents a quality assurance mechanism and quality assurance activities [Wis. Admin. Code § DHS 105.17(1e)(b)2.] | | | | | | | |
|  | |  | 2.3 Demonstrates that employees possess knowledge of and training and experience with special needs, including independent living needs, of the client group or groups receiving services [Wis. Admin. Code § DHS 105.17(1e)(b)3.]. | | | | | | | |
|  | |  | 2.4 Provide a written plan of operation describing the entire process from referral through delivery of services and follow-up [Wis. Admin. Code § DHS 105.17(1e)(c)] | | | | | | | |
|  | |  | 2.5 Statement of Services [Wis. Admin. Code § DHS 105.17(1e(g)] | | | | | | | |
|  | | 1. Finances [Wis. Admin. Code § DHS 105.17(1g)]   Documentation must be submitted that demonstrates: | | | | | | | | |
|  | |  | 3.1 DQA form F-26274A, Model Balance Sheet, [Wis. Admin. Code § DHS 105.17(1g)(a)] | | | | | | | |
|  | |  | 3.2 Cash Flow: Evidence of financial ability to maintain a cash flow sufficient to cover operating expenses for 60 days [Wis. Admin. Code § DHS 105.17(1g)(a)] | | | | | | | |
|  | | 1. Administrator Qualifications [Wis. Admin. Code § DHS 105.17 (1k):   Documentation must be submitted that demonstrates: | | | | | | | | |
|  | |  | 4.1 Twenty-one (21) years of age [Wis. Admin. Code § DHS 105.17(1k)(a)1.] | | | | | | | |
|  | |  | 4.2 Administrator has either an associate degree or higher in a healthcare related field from an accredited college, or a bachelor’s degree in a field other than in healthcare from an accredited college and one year experience working in a healthcare related field [Wis. Admin. Code § DHS 105.17(1k)(3)] | | | | | | | |
|  | |  | 4.3 Administrator has training or experience in health care administration and at least one year of supervisory or administrative experience in home health care or personal care, or related health program [Wis. Admin. Code § DHS 105.17(1k)(a)4.] | | | | | | | |
|  | | 1. RN Supervisor Qualifications [Wis. Admin. Code § DHS 105.17]:   Documentation must be submitted that demonstrates: | | | | | | | | |
|  | |  | 5.1 Current licensure as a registered nurse under s. 441.06, Stats. [Wis. Admin. Code § 105.17(2)(a)1.] | | | | | | | |
|  | |  | 5.2 Training and experience in the provision of personal care services or in a related program [Wis. Admin. Code § DHS 105.17(2)(a)2.] | | | | | | | |
|  | |  | 5.3 At least one year of supervisory or administrative experience in personal care services or in a related program [Wis. Admin. Code § DHS 105.17(2)(a)3.] | | | | | | | |

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| I. GENERAL INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| I. A. AGENCY AND APPLICANT INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name – **PERSONAL CARE AGENCY** (PCA) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | County (where PCA is located) | | | | | | | | | | | | |
| Street (Physical) Address | | | | | | | | | | | | | | | | | | | | | | | | City | | | | | | | | | | | | | | | | | | State | | | | | Zip Code | | |
| Mailing Address | | | | | | | | | | | | | | | | | | | | | | | | City | | | | | | | | | | | | | | | | | | State | | | | | Zip Code | | |
| Email Address | | | | | | | | | | | | | Phone No. | | | | | | | | | | | | | | | Alternate Phone No. | | | | | | | | | | | | | | Fax No. | | | | | | | |
| Name – **APPLICANT** *(Person or entity applying)* | | | | | | | | | | | | | | | | | Email Address | | | | | | | | | | | | | | | | | | | | | | | | | Phone No. | | | | | | | |
| Mailing Address | | | | | | | | | | | | | | | | | | | | | | | | City | | | | | | | | | | | | | | | | | | State | | | | | Zip Code | | |
| **I. B. GEOGRAPHICAL AREA OF SERVICE (Counties Served***)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *Indicate, by county(ies), your service area.* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| I. C. SERVICES PROVIDED | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **1. Services.** Check type of services provided. Place a “**1**” if service will be provided directly and a “**2**” if the service will be provided by contracting with another provider of service. If services will be provided both directly and by contract, insert a “**3**.” | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Service** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Accompanying recipient to obtain medical diagnosis and treatment | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| Bathing | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| Changing and washing bed linens and personal clothing | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| Dressing and undressing | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| Eyeglass and hearing aid care | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| Getting recipient in and out of bed | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| Light cleaning in essential area of home for performing personal care services | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| Meal preparation, food purchasing, and meal serving | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| Mobility and ambulation, including use of walker, cane, or crutches | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| Simple transfers --- bed to chair or wheelchair and reverse | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| Skin care, excluding wound care | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| Teeth, mouth, denture, and hair care | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| Toileting, including use of a bed pan, urinal, commode, or toilet | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| Other *(Specify.)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| Other *(Specify.)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| **2. 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:   * Names * Addresses and phone numbers * Effective dates of service Completed Not Applicable | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **II. ADMINISTRATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **II. A. ADMINISTRATOR** *[Wis. Admin. Code §**DHS 105.17(1k)(a)]* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name – Administrator | | | | | | | | | | | | | | | | | Phone Number | | | | | | | | | | | | | | | | | | | | | | Effective Date *(MM/dd/yyyy)* | | | | | | | | | | |
| Title | | | | | | | | | | | Email Address | | | | | | | | | | | | | | | | | | | | | | | | | | | | Date of Birth *(MM/dd/yyyy)* | | | | | | | | | | |
| **Describe the duties performed, in detail, for each section below and provide the names of the agencies, type of agency, and months/years that administrator experience was obtained.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. All training and experience in health care administration. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. All supervisory or administrative experience in health care or personal care including oversight of supervisors, RNs, and health care aides. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. All experience following and applying Wisconsin Administrative Rules. (*Name the specific rules.)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4. All experience and responsibility for training, evaluating competency, and supervision of employees. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5. All experience creating health care related policies and procedures. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 6. All experience of overseeing and managing agency finances. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7. All experience of overseeing and managing of an agency infection control program. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **II. B. SUBSTITUTE ADMINISTRATOR** *[Wis. Admin. Code §**DHS 105.17(1k)(a)]* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name – Substitute Administrator | | | | | | | | | | | | | | | Title | | | | | | | | | | | | | | | | | | | | | | | | Effective Date *(MM/dd/yyyy)* | | | | | | | | | | |
| Phone Number | | | | | | | | | | | | | | | Email Address | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **II. C. MANAGING EMPLOYEE** *(If different than Administrator and Substitute Administrator)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name – Managing Employee | | | | | | | | | | | | | | | Title | | | | | | | | | | | | | | | | | | | | | | | Effective Date *(MM/dd/yyyy)* | | | | | | | | | | | |
| Phone Number | | | | | | | | | | | | | | | Email Address | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **II. D. REGISTERED NURSE SUPERVISOR**  *[Wis. Admin. Code §**DHS 105.17(2)(a)1-3]* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ***Attach copy of Wisconsin RN license and resume,*** *which includes education and work experience.* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name – Registered Nurse Supervisor | | | | | | | | | | | | | | Title | | | | | | | | | | | | | | | | | | | | | | | | | Effective Date *(MM/dd/yyyy)* | | | | | | | | | | |
| If the above-named RN Supervisor holds a Wisconsin professional license, complete the following. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Type of License | | | | | | | | | | | | | | | | | | | | | | | | | | Date Issued *(MM/dd/yyyy)* | | | | | | | | | | | | | Expiration Date *(MM/dd/yyyy)* | | | | | | | | | | |
| If the above-named RN Supervisor holds a professional license in another state, complete the following. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Type of License | | | | | | | | | | | | | | | | | | State | | | | | | | | Date Issued *(MM/dd/yyyy)* | | | | | | | | | | | | | Expiration Date *(MM/dd/yyyy)* | | | | | | | | | | |
| **Describe the duties performed, in detail, for each section below and provide the names of the agencies, type of agency, and months/years that RN supervisor experience was obtained.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. All Health Care supervisory or administration experience. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. All experience completing patient assessments related to need for services including performance of staff evaluations and competency determinations and experience making referrals for patient services. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. All experience obtaining written orders from physicians. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4. All experience developing patient plans of care, managing changes to patient plans of care and instruction of care staff. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5. All experience training staff and performing staff competency assessments and performance evaluations. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 6. All experience developing, instructing, and managing time reporting systems/mechanisms for staff. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7. All experience creating or managing mentoring programs. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 8. All experience conducting unannounced home visits to monitor care given to clients by health care workers. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **III. OWNERSHIP** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Provide the following information, if applicable:   * List all names, principal business addresses, and the percentage and type of ownership interest of all persons or business entities having any ownership interest in the facility, whether direct or indirect, and whether the interest is in the profits, land or building, including owners of any business that owns any part of the land or building. * If a partnership, list each partner. * If a corporation, list each officer and director of the corporation.   + If any person or business entity named is a bank, credit union, savings and loan association, investment association, or insurance corporation, it is sufficient to name the entity involved without providing information regarding the officers and directors of the entity. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **III. A. APPLICANT/OWNER** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *Provide the following information for the person(s) or business entity having the authority to direct agency management or policies.* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name – Applicant - Owner | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | FEIN or SSN | | | | | | | | | | |
| Street (Physical) Address | | | | | | | | | | | | | | | | | | | | City | | | | | | | | | | | | | | | | | | | State | | | | | Zip Code | | | | | |
| County | | | | | | Email Address | | | | | | | | | | | | | | | | | | | | | Fax No. | | | | | | | | | | | | | | Phone No. | | | | | | | | |
| **III. B. TYPE OF ORGANIZATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *Check type of ownership.* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Governmental** | | | | | **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 | | | | | | | | | | | | | | | |
| *All incorporated applicants* ***must*** *provide the following information*: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| State Where Incorporated | | | | | | | Date Incorporated *(MM/dd/yyyy)* | | | | | * A copy of the **Articles of Incorporation** or **LLC document** * **Internal Revenue Service (IRS) document with the FEIN number** * If a foreign corporation, **evidence of authority to do business in Wisconsin** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **III. C. INTERESTED PARTIES** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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 – Interested Party | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Ownership Percentage | | | | | | | | |
| Principal Business Address | | | | | | | | | | | | | | | | | | | | | | | | | | City | | | | | | | | | | | | | | | State | | | | Zip Code | | | | |
| Name – Interested Party | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Ownership Percentage | | | | | | | | |
| Principal Business Address | | | | | | | | | | | | | | | | | | | | | | | | | | City | | | | | | | | | | | | | | | State | | | | Zip Code | | | | |
| Name – Interested Party | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Ownership Percentage | | | | | | | | |
| Principal Business Address | | | | | | | | | | | | | | | | | | | | | | | | | | City | | | | | | | | | | | | | | | State | | | | Zip Code | | | | |
| III. D. SUBSIDIARY / PARENT INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Is the applicant a subsidiary company, either wholly or partially owned by another organization or business? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | | *If* ***Yes****, attach* ***organization chart identifying parent company and subsidiaries*** *and provide the following information.* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Legal Business Name – Parent Company | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name – DBA (Doing Business As) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Type of Ownership | | | | | | | | | | | | | | | | | | |
| Street (Physical) Address | | | | | | | | | | | | | | | | | | | | | | City | | | | | | | | | | | | | | | | | | | State | | | | | Zip Code | | | |
| Name – Contact Person | | | | | | | | | | Email Address | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Phone No. | | | | | | | | |
| IV. FIT AND QUALIFIED *[Wis. Admin. Code § DHS 105.17(1e)(e)1-8]* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| An applicant and all principals must meet all fit and qualified requirements as stated in the regulations. A “principal” is defined as an administrator, substitute administrator, a person with management responsibility for the applicant, an officer or person owning directly or indirectly 5% or more of shares or other ownership in the PCA. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. Has any adverse action ever been initiated by any state licensing agency against the applicant or any principal that resulted in the  denial (**D**), suspension (**S**), revocation (**R**), or injunction **(I)** of a personal care agency, health care agency, or health care facility  approval notice?  Yes  No *If* ***Yes****, complete the following. Attach additional pages, if necessary.* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name – Facility | | | | | | | | | | | | | | | | | | | | | | Type of Health Care Provider | | | | | | | | | | | | | | | | | Type of Adverse Action  D  S  R  I | | | | | | | | | | |
| Street (Physical) Address | | | | | | | | | | | | | | | City | | | | | | | | | | | | | | State | | | Effective Dates of Adverse Action | | | | | | | | | | | | | | | | | |
| 2. Has any adverse action every been initiated by a state or federal agency against the applicant or any principal that was based on non-compliance and that 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. Attach additional pages, if necessary.* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name – Facility | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Type of Health Care Provider | | | | | | | | | | | | | | | | | | |
| Street (Physical) Address | | | | | | | | | | | | | | | | | | | | | | | | | | | | City | | | | | | | | | | | | | | | | | | | State | | |
| Type of Adverse Action  CMP  TPA  SOP  TMF | | | | | | | | Effective Dates of Adverse Action | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Federal  State | | | | | | | |
| 3. Has the applicant or any principal ever been convicted of a crime involving neglect or abuse of recipients or of the elderly or involving assaultive behavior, wanton disregard for the health and safety of others, or any act of abuse under Wis. Stat. §§ 940.285 or 940.295 or similar law in another jurisdiction?  Yes  No *If* ***Yes****, explain and provide documentation.* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4. Has the applicant or any principal ever been convicted of a crime related to the delivery of personal care or other health care related services or items or for providing personal care or other health care without a license or other form of permission required by law?  Yes  No *If* ***Yes****, explain and provide documentation.* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 5. Has the applicant or any principal ever been convicted of a crime involving controlled substances under Wis. Stat. Chapter 961 or similar law in another jurisdiction?  Yes  No *If* ***Yes****, explain and provide documentation.* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. Has the applicant or any principal ever been convicted of a crime involving a sexual offense?   Yes  No *If* ***Yes****, explain and provide documentation.* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. Has the applicant or any principal had any prior financial failure that resulted in bankruptcy or in the closing of a human services agency, health care agency, or health care facility or in the relocation or discharge of human service agency, health care agency, or health care facility patients?   Yes  No *If* ***Yes****, explain and provide documentation.* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. Does the applicant or any principal owe any debts that are 90 days past due or have any unsatisfied judgements against them?   Yes  No *If* ***Yes****, explain on a separate page. Provide the names and addresses of creditors, amounts, and reasons for non-payment and provide documentation.* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **IV. ATTESTATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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 IN FULL** – Applicant or Owner | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Date Signed | | | | | | | | | | | | | | |
| Name – Applicant or Owner *(Print or type.)* | | | | | | | | | | | | | | | | | | | | | | | | Title – Applicant | | | | | | | | | | | | | | | | | | | | | | | | | |
| Email Address | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |