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| **DEPARTMENT OF HEALTH SERVICES**  Division of Quality Assurance  F-02106A (11/2022) | | | | | | **STATE OF WISCONSIN**  Adult Day Care Center Certification  Page 1 of 3 | | | | | | | | |
| **ADULT DAY CARE CENTER (ADCC)**  **CERTIFICATION APPLICATION** | | | | | | | | | | | | | | |
| Completion of this form is required by Wis. Stat. § 49.45(47)(b) and Wis. Admin. Code § DHS 105.14(2)(a). Adult day care centers (ADCC) serving publicly funded clients must meet state certification requirements in order to receive funds for the cost of care for these participants. Failure to complete this form completely and accurately may result in a delay in processing and/or denial of certification.  Send the completed form with the items listed in Step 2 below to: **Division of Quality Assurance**  **BHS Licensing and Certification Section**  **PO Box 2969**  **Madison, WI 53701-2969**  If you have questions regarding the completion of this form, call **608-266-7297** or email [DHSDQALCCS@dhs.wisconsin.gov](mailto:DHSDQALCCS@dhs.wisconsin.gov). | | | | | | | | | | | | | | |
| **APPLICATION PROCESS**  **Step 1 Background Check** —Background 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.  **An ADCC may not be located on a parcel of land zoned for industrial or manufacturing use.**  **Step 3** **Initial Visit** — An initial visit is completed by department staff to determine compliance with all regulatory requirements for program certification.   |  |  |  |  | | --- | --- | --- | --- | | **STEP 1 – 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 operator 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 must be included with this completed and signed application form. | | | | | | | | | | | | | | |
|  | 1. | Non-refundable certification fee of $127.00 | | | | | | | | | | | | |
|  | 2. | Fully completed DQA form F-02111, Fit and Qualified Application | | | | | | | | | | | | |
|  | 3. | Program description (Wis. Admin. Code § DHS 105.14(2)(b)1.a-k) | | | | | | | | | | | | |
|  | 4. | DQA form F-26274A, Assisted Living Facility Model Balance Sheet, or equivalent (Wis. Admin. Code § DHS 105.14(2)(a)2.e) | | | | | | | | | | | | |
|  | 5. | Evidence of financial ability to operate for 60 days (Wis. Admin. Code § DHS 105.14(2)(a)2.f) | | | | | | | | | | | | |
|  | 6. | Proof of transportation liability insurance, if applicable (Wis. Admin. Code § DHS 105.14(2)(a)2.g) | | | | | | | | | | | | |
|  | 7. | Well water test results, if applicable (Wis. Admin. Code § DHS 105.14(8)(b)2) | | | | | | | | | | | | |
|  | 8. | Fire inspection report (Wis. Admin. Code § DHS 105.14(9)(b)) | | | | | | | | | | | | |
|  | 9. | Floor plan showing total space (dimensions, exits, and room usage) (Wis. Admin. Code § DHS 105.14(8)(a)2). Delayed egress doors need department approval (Wis. Admin. Code § DHS 105.14(8)(e)). Request to be emailed to regional office. See [www.dhs.wisconsin.gov/dqa/bal-regionalmap.htm](http://www.dhs.wisconsin.gov/dqa/bal-regionalmap.htm) for contact information | | | | | | | | | | | | |
|  | 10. | If the ADCC is currently certified, a letter of intent to sell by the current owner/certificate holder | | | | | | | | | | | | |
|  | 11. | Program evaluation plan (Wis. Admin. Code § DHS 105.14(2)(a)2.i) | | | | | | | | | | | | |
| **General Information** | | | | | | | | | | | | | | |
| Name — Program | | | | | | | | | | | | | | |
| Street Address — Program | | | | | City | | | State | | Zip Code | | | County | |
| Phone — Program | | | Fax — Program       3 | | | | Email — Program | | | | | | | |
| Name — Program Director | | | | | | | | | | | Date of Birth — Program Director | | | |
| **Designated Mail Recipient** | | | | | | | | | | | | | | |
| **The individual named below will be the main point of contact for all communication from the bureau, including certification renewal.** | | | | | | | | | | | | | | |
| Name — Designated Mail Recipient | | | | Title | | | | | Email | | | | | |
| Mailing Address — Street or PO Box | | | | | | | City | | | | | State | | Zip Code |
| **Program Information** | | | | | | | | | | | | | | |
| The ADCC is located in: | | | | | | | | | | | | | | |
| Private Family Home  Multi-Use Facility (Nursing home, community based residential facility, residential care apartment complex or  pre-vocational program)  Other — Please describe: | | | | | | | | | | | | | | |

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| Certificate Holder Type (**Check one.** Do not check “Government — State” unless program will be owned and operated by a state agency.) | | |
| Church  Corporation For-Profit  Corporation Non-Profit | Government – County  Government – State  Government – Other  Tribal | Limited Liability Corporation (LLC)  Partnership  Proprietorship (individual) |
| Other — Specify: |

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| **Owner / Operator / Certificate Holder Information** | | | | | | | | | |
| Name — Corporation/Legal Entity (if applicable) | | | | | | FEIN (Federal Employer Identification No.) | | | |
| Name — Certificate Holder or Corporate Representative | | | | | | Date of Birth — Certificate Holder or Corporate Rep. | | | |
| Address — Certificate Holder/Corporate Representative | | | | City | | | | State | Zip Code |
| Phone | Fax | | | Email | | | | | |
| Provide the name(s) of any other facilities associated with this certificate holder or corporate entity. Attach an additional list if needed. | | | | | | | | | |
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| **Participant Information** | | | | | | | | | |
| Total Number of ADCC Participants Served: | |  | | | | | | | |
| Check only the box(es) indicating the **primary** participant group(s) you will serve. | | | | | | | | | |
| AA — Advanced Age  DD — Developmentally Disabled (Intellectually Impaired)  PD — Physically Disabled | | | | | ALZ — Irreversible Dementia/Alzheimer’s  MH — Emotionally Disturbed/Mental Illness  TBI — Traumatic Brain Injury | | | | |
| Will you accept public funding?  Yes  No | | | | | | | | | |
| **To be eligible to receive Medicaid waiver funding, facilities must demonstrate compliance with the Centers for Medicare & Medicaid Services (CMS) Home and Community-Based Services (HCBS) settings rule. Review the** HCBS Settings Rule: Compliance for Nonresidential Services Providers **(**[www.dhs.wisconsin.gov/hcbs/nonresidential.htm](http://www.dhs.wisconsin.gov/hcbs/nonresidential.htm)) **for more information.** | | | | | | | | | |
| **Safety** | | | | | | | | | |
| Local fire departments have requested the locations of regulated facilities. Provide the details of your local fire department. | | | | | | | | | |
| Name — Local Fire Department | | | | | | | Phone (do not enter “911”) | | |
| Street Address/PO Box | | | City | | | | State | | Zip Code |
| **Attestation** | | | | | | | | | |
| The signatory of this document is duly authorized by the applicant / certificate holder to sign this agreement on its behalf. The applicant/certificate holder hereby accepts responsibility for knowing and ensuring compliance with all certification and operational requirements for this program. **An ADCC may not be located on a parcel of land zoned for industrial or manufacturing use.** | | | | | | | | | |
| **I attest, under penalty of law, that the information provided above is truthful and accurate to the best of my knowledge.**  **I understand that knowingly providing false information or omitting information may result in denial of licensure, a fine of up to $10,000, or imprisonment not to exceed six years or both (Wis. Stat. § 946.32).** | | | | | | | | | |
| **SIGNATURE** (In full) — Applicant or Designee | | | | | | | | Date Signed | |
| Name — Applicant or Designee (Print or type.) | | | Title — Applicant or Designee (must be owner or board member) | | | | | | |
| **STEP 3 – INITIAL SURVEY VISIT** | | | | | | | | | |
| **Refer to the Adult Day Care Center Initial Survey Checklist, F-02634 for a list of items to be reviewed during the initial survey (**[**www.dhs.wisconsin.gov/forms/f02634.docx**](http://www.dhs.wisconsin.gov/forms/f02634.docx)**). Applicant is responsible for knowing and meeting all certification requirements.** | | | | | | | | | |

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| **COMPLETION OF APPLICATION PROCESS** |
| * If the application does not include all the required documents and information, the application packet will be returned to the applicant without further processing. DQA will include a checklist identifying what item(s) are missing. * The applicant may choose to resubmit the application with the required documentation. * After a second unsuccessful submission, no further application materials will be accepted from this applicant for this location for a period of one year. * **Applications not completed within six months after department review will be closed without further processing.** |
| **ADDITIONAL INFORMATION FOR APPLICANTS** |

Reference the DQA Listserv for updates, memos, and other information at [www.dhs.wisconsin.gov/regulations/listserv-signup.htm](file:///C:\Users\dishnkl\AppData\Local\Microsoft\Windows\INetCache\Content.Outlook\2S5399UK\www.dhs.wisconsin.gov\regulations\listserv-signup.htm).