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| **DEPARTMENT OF HEALTH SERVICES**  Division of Quality Assurance  F-03264 (01/2024) | | | | | | | | | **STATE OF WISCONSIN**  Wis. Admin. Code §. DHS 105.17  Page 1 of 2 | | | | | | | | | | | |
| **PERSONAL CARE AGENCY (PCA)**  **BRANCH OFFICE REQUEST** | | | | | | | | | | | | | | | | | | | | |
| **INSTRUCTIONS AND DEFINITIONS** | | | | | | | | | | | | | | | | | | | | |
| * This form is designed to assist a certified personal care agency (PCA) open a branch office by providing information and regulatory guidance for the branch office request process. Regulations related to branch offices for PCAs are found at Wis. Admin. Code ch. [DHS 105.17 (5).](https://docs.legis.wisconsin.gov/code/admin_code/dhs/101/105/17/5) * Only PCAs that are already certified in Wisconsin should use this form to request branch office location(s). * Review information about the criteria for approval of a branch office at [DHS § 105.17(5)(ar)](https://docs.legis.wisconsin.gov/code/admin_code/dhs/101/105/17/5/ar). * Information gathered on this form will be used only for approval or denial of PCA branch office locations. * Return completed form via e-mail or fax to:   **Email:** [DHSDQALCCS@dhs.wisconsin.gov](mailto:DHSDQALCCS@dhs.wisconsin.gov) **Fax:** 608-283-7481 | | | | | | | | | | | | | | | | | | | | |
| **PROVIDER INFORMATION** | | | | | | | | | | | | | | | | | | | | |
| Personal Care Agency Name | | | E-mail Address | | | | | | | | | | Phone Number | | | | License or Certification No. | | | |
| PCA Address – Street | | | | | | City | | | | | | | | State | Zip Code | | | County | | |
| **BRANCH OFFICE QUESTIONNAIRE** | | | | | | | | | | | | | | | | | | | | |
| New Branch Office – Name | | | | | | E-mail Address | | | | | | | | | | | | Phone Number | | |
| Branch Office Address – Street | | | | | | City | | | | | | | | State | Zip Code | | | County | | |
| **Completed** | | **Topic** | | | | | | | | | | | | | | | | | |
|  | | **Projected branch office opening date:** | | | | | | | | | | | | | | | | | |
|  | | **Distance between parent and branch location** (in miles):  Given the distance between sites, describe how supervision and administration will be shared between the parent and branch locations: | | | | | | | | | | | | | | | | | |
|  | | **Counties to be served by branch office** (list all): | | | | | | | | | | | | | | | | | |
|  | | **Clients served by branch office**:  Projected number of clients served through branch office:      Potential referral sources: | | | | | | | | | | | | | | | | | |
|  | | **Services to be provided through the branch location.** Note for each service who is responsible for monitoring and whether this service is also provided at the parent location. (Attach another page if more space is needed)**:**   |  |  |  | | --- | --- | --- | | **Service** | **Staff responsible to monitor** | **Provided at parent location? Y/N** | |  |  |  | |  |  |  | |  |  |  | | | | | | | | | | | | | | | | | | |
|  | | **Other Approved branch locations:** Please list the name and address of any branches that have already been approved for this agency: | | | | | | | | | | | | | | | | | |
|  | | **Provide an organizational chart or describe the lines of authority and administration between the parent office and all branch offices:** | | | | | | | | | | | | | | | | | |
|  | | **Adequate and qualified staffing -** Please list staff who will work at the branch location including staff job title(s), number of projected hours at the branch, and whether staff person is a contracted or permanent employee. (Note: attach another page if more space is needed.)   |  |  |  |  | | --- | --- | --- | --- | | **Staff Name** | **Job Title** | **Hours per week** | **Contract staff? Yes/No** | |  |  |  |  | |  |  |  |  | |  |  |  |  |   **Will the branch office have a new administrator?** Yes  No  If yes, review qualifications at [DHS § 105.17(1k)(a)](https://docs.legis.wisconsin.gov/code/admin_code/dhs/101/105/17/1k/a) and attach a resume for the new administrator.    **Will the branch office have a new RN supervisor?** Yes  No  If yes, review the qualifications at [DHS § 105.17(2)(a)](https://docs.legis.wisconsin.gov/code/admin_code/dhs/101/105/17/2/a) and attach a resume for the new RN supervisor.  **If contracted staff will be utilized, who is responsible for developing and monitoring the contract/agreement?** | | | | | | | | | | | | | | | | | |
|  | | **Coordination between parent and branch offices:**  Describe how supervision will be provided to branch office staff:  Who will oversee provision of care to branch office clients?  Who will be responsible for providing new and continuing education for branch office staff?  Describe the system and frequency of communication between the branch and parent office:  Describe the system to monitor and ensure that the branch office follows policies and procedures of the parent office. Or note if the branch office will have separate policies and procedures:  Describe how personnel files will be managed between the parent and branch offices:  Describe the system in place to ensure security and confidentiality of branch office records: | | | | | | | | | | | | | | | | | |
| **Additional Comments:** | | | | | | | | | | | | | | | | | | | | |
| **REQUESTOR INFORMATION** | | | | | | | | | | | | | | | | | | | | |
| Name – Person Completing Form | | | | | Email Address | | | | | | | | | | | Phone Number | | | | |
| **SIGNATURE** – Person Completing Form | | | | | | | Title | | | | | | | | | | | Date Signed | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **DQA**  **USE**  **ONLY** | Deny  Approve | | | If not approved, Reason: | | | |  | | | | | | | | | | |  | |
| Comments: | | | | | | | | | ***This approval may be rescinded as determined by the Department.*** | | | | | | | | | | |
| **SIGNATURE** – ACCS Surveyor: | | | | | | | | | | | ACCS Surveyor Printed Name: | | | | | | Date Approved | | |
| **SIGNATURE** – Licensing/Cert LPPA: | | | | | | | | | | Licensing/Cert LPPA Printed Name: | | | | | | | Date Approved | | |