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| DEPARTMENT OF HEALTH SERVICESDivision of Quality AssuranceF-62062 (07/2020) | STATE OF WISCONSINWis. Stat. § 50.93(1)Wis. Admin. Code ch. DHS 131Page 1 of 12 |
| HOSPICE LICENSE APPLICATION | DQA OFFICE USE ONLY |
| Type of Application: [ ]  Initial [ ]  Change of Ownership |
| License No.: |
| License Fee: |
| Caregiver Background Check Fee: |
| Effective Date: |
| PART I. GENERAL INFORMATION |
| Penalties: Per Wis. Stat. § 946.3, 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. |
| Completion of this form is required under the provisions of Wis. Stat. § 50.93(1) for hospices. Failure to complete this form may result in non-issuance of a hospice license.The personal identifiable information collected on this form will be used to determine licensure eligibility and for statistical information and for no other purpose.* There are five parts to this application:

Part I – General InformationPart II – AdministrationPart III – OwnershipPart IV – Management CompanyPart V – Contact Person, Designee, and Attestation* Questions about completion of this application may be directed to: **Hospice Licensure Specialist / 608-266-2702**
* **Return this completed application (Parts I – V) to:** DHS / Division of Quality Assurance

Bureau of Health ServicesATTN: Hospice LicensurePO Box 2969Madison, WI 53701-2969 |
| A. HOSPICE LOCATION *[Wis. Admin. Code § DHS 131.14]* |
| Name – Hospice Facility      |
| Street (physical) Address      | Mailing Address      |
| City      | County      | State   | Zip Code      |
| Telephone No.      | Fax No.      | Email Address      |
| Medicare-Approved Accrediting Organization[ ]  The Accreditation Commission for Health Care (ACHC) [ ]  The Joint Commission [ ]  Community Health Accreditation Partner (CHAP) |
| **B. CHANGE OF OWNERSHIP** *[Wis. Admin. Code § DHS 131.14]* |
| *Provide the previous owner’s name and their license, Medicare, and Medicaid numbers.* |
| Name – Previous Owner      |
| License No. – Previous Owner      | Medicare No. – Previous Owner      | Medicaid No. – Previous Owner      |
| C. MULTIPLE / BRANCH LOCATION *[Wis. Admin. Code § DHS 131.14(1)(b)]* |
| Name – Hospice Facility      |
| Street (physical) Address      | Mailing Address      |
| City      | County      | State   | Zip Code      |
| Telephone No.      | Fax No.      | Email Address      |
| D. GEOGRAPHICAL AREA OF SERVICE (Counties Served) *[Wis. Admin. Code § DHS 131.14(2)(b)4]* |
| 1. Main Office *Indicate, by county, the geographical service area.* |
|       |
| 2. Branch / Multiple Location(s) *Indicate, by county, geographical service area. If more than one location, attach additional pages.* |
|       |
| E. SERVICES PROVIDED |
| Type of Hospice Services *[Wis. Admin. Code § DHS 131.14(2)(b)5] Check type of services provided. Provide information separately for EACH multiple location. Attach additional pages, if necessary. Place a “1” if service will be provided directly and “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 “3.”* |
| Services | Main Office | Multiple Office | Services | Main Office | Multiple Office |
| Bereavement Services |   |   | Patient and Family Companion |   |   |
| Dietary Services |   |   | Physical Therapy |   |   |
| Homemaker Services |   |   | Respite |   |   |
| Hospice Aide Services |   |   | Speech / Language Pathology |   |   |
| LPN Services |   |   | Spiritual Counseling |   |   |
| Medical Services |   |   | Social Services |   |   |
| Nursing Services |   |   | Other *(Specify.)*  |       |   |   |
| Occupational Therapy |   |   | Other *(Specify.)*  |       |   |   |
| Other Counseling Services |   |   | Other *(Specify.)*  |       |   |   |
| 2. Contract Services *[Wis. Admin. Code § DHS 131.42(2)(b)6] Attach a list of all individuals, agencies, and institutions with whom the agency has a contractual arrangement to provide patient care services. Include the names, addresses, types of services provided (e.g., PT, OT, SPT), the effective date of services, and provider type (rehabilitation agency, home health agency, hospital, etc.)* |

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| F. STAFFING *[Wis. Admin. Code § DHS 131.14(2)(b)8]* |
| JOB TITLE | **Full Time** | **Part Time** | **Contract** | **Volunteers** |
| No. of Persons | Total No. of Hours Per Week | No. of Persons | Total No. of Hours Per Week | No. of Persons | Total No. of Hours | No. of Persons |
| Managing Employee / Admin*. 131.14(2)(b)3* |       |       |       |       |       |       |       |
| Physicians *131.25(3)* |       |       |       |       |       |       |       |
| Registered Nurses *131.25(4)* |       |       |       |       |       |       |       |
| LPNs / Lic. Vocational Nurses *131.25(4)(c)* |       |       |       |       |       |       |       |
| Nurse Aides (Hospice) *131.26(2)* |       |       |       |       |       |       |       |
| Physical Therapists *131.26(a)(1)* |       |       |       |       |       |       |       |
| Occupational Therapists *131.26(a)(1)* |       |       |       |       |       |       |       |
| Speech / Language Pathologists *131.26(a)(1)* |       |       |       |       |       |       |       |
| Bereavements *131.25(6)(a)* |       |       |       |       |       |       |       |
| Social Workers *131.25(5)* |       |       |       |       |       |       |       |
| Counselors *131.25(6)* |       |       |       |       |       |       |       |
| Dietary *131.25(6)(b)* |       |       |       |       |       |       |       |
| Other *(Specify.)*  |       |       |       |       |       |       |       |       |
| TOTAL |  |  |  |  |  |  |  |
|  |  |
| **Enter the number of hours in your official workweek.** (Enter a three digit number, e.g., 35.0, 37.5.) |       |
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| **G. TYPE OF HOSPICE AFFILIATION** *[Wis. Admin. Code § DHS131.14(2)(b)3]* |
| [ ]  Hospital [ ]  Home Health Agency [ ]  Other *(Specify.)* |       |
| Name      |
| Physical Address      | City      | State   | Zip Code      |
| [ ]  Yes [ ]  No Does your facility provide a place of residence for individuals with terminal illness? *If* ***Yes****, complete the following.* |
| **1. Residential Facility** (a permanent living arrangement) *[Wis. Admin. Code §§ DHS 131.13(9)(c) and 131.35(2)]* |
| [ ]  Yes [ ]  No Is this a free-standing facility? [ ]  Yes [ ]  No Is this a separate part of your structure?  |
| Name (if different from the primary hospice)      |
| Address      | City      | County       | State   | Zip Code      |
| Telephone No.      | Fax No.      | No. of Beds      | No. of Beds in Each Room      |
| 1. **Short Term Inpatient Facility** (a temporary arrangement for respite or symptom management care) *[Wis. Admin. Code §§ DHS*

*131.13(21), 131.13(9)(b),and 131.5]*[ ]  Yes [ ]  No Is respite or symptom management care service directly provided by the hospice in an inpatient setting?[ ]  Yes [ ]  No Is respite or symptom management care a contracted service? |
| Name – Provider or Agency      |
| Address      | City      | County       | State   | Zip Code      |
| Telephone No.      | Fax No.      | No. of Beds      |
| **PART II. ADMINISTRATION** |
| **A. HOSPICE ADMINISTRATOR** *(Wis. Admin. Code § DHS 131.29)* |
| Name – Administrator or Managing Employee      | Status [ ]  Interim [ ]  Acting [ ]  Permanent | Effective Date *(MM/dd/yyyy)*      |
| *If the above individual holds a Wisconsin professional license, provide the following.* |
| Type of License      | Date Issued *(MM/dd/yyyy)*      | Expiration Date *(MM/dd/yyyy)*      |
| *If the above individual holds a professional license in another state, provide the following.* |
| Type of License      | State   | Date Issued *(MM/dd/yyyy)*      | Expiration Date *(MM/dd/yyyy)*      |
| Is the administrator / managing employee in charge of more than one agency? [ ]  Yes [ ]  No *If* ***Yes****, provide the following.* |
| Name – Agency      | City      | Type of Health Care Provider      |
| **B. PERSON IN CHARGE IN ABSENCE OF HOSPICE ADMINISTRATOR** |
| Name      | Title      | Effective Date *(MM/dd/yyyy)*      |
| *If the above individual holds a Wisconsin professional license, provide the following.* |
| Type of License      | Date Issued *(MM/dd/yyyy)*      | Expiration Date *(MM/dd/yyyy)*      |
| *If the above individual holds a professional license in another state, provide the following.* |
| Type of License      | State   | Date Issued *(MM/dd/yyyy)*      | Expiration Date *(MM/dd/yyyy)*       |
| **C. HOSPICE MEDICAL DIRECTOR** *[Wis. Admin. Code § DHS 131.32]* |
| Name - Medical Director      | Effective Date *(MM/dd/yyyy)*      |
| *If the above individual holds a Wisconsin professional license, provide the following.* |
| Type of License      | Date Issued *(MM/dd/yyyy)*      | Expiration Date *(MM/dd/yyyy)*      |
| *If the above individual holds a professional license in another state, provide the following.* |
| Type of License      | State   | Date Issued *(MM/dd/yyyy)*      | Expiration Date *(MM/dd/yyyy)*      |
| **D. INDIVIDUAL RESPONSIBLE FOR QUALITY ASSURANCE PROGRAM** *[Wis. Admin. Code § DHS 131.22(6)(c)]* |
| Name      | Professional License *(type and number)*      |
| **E. ADDITIONAL CORE TEAM MEMBERS** *[Wis. Admin. Code § DHS 131.25 (2-6)]* |
| Name – Physician      | Name – Volunteer      |
| Name – Nurse      | Name – Bereavement       |
| Name – Social Worker      | Name – Other Counseling      |
| ***Attach a resume, and a copy of the professional license, if applicable, for the administrator, managing employee, and medical director that includes their educational and work experience.*** |
| **PART III. OWNERSHIP** |
| **A. APPLICANT / LICENSEE** [person(s) or business entity having the authority to direct the management or policies of the agency]*[Wis. Admin. Code § DHS 131.14(2)(b)]* |
| Name – Applicant      |
| Street (physical) Address      | City      | County      | State   | Zip Code      |
| Telephone No.      | Fax No.      | Email Address      |
| **B. TYPE OF ORGANIZATION**  |
| *Check type of ownership.* |
| **GOVERNMENTAL** | **PROPRIETARY** | **VOLUNTARY NON-PROFIT** | Date Incorporated (if incorporated)      |
| [ ]  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 |
|  |
| ***Attach a copy of the articles of incorporation or, if a foreign corporation, evidence of authority to do business in Wisconsin.*** |
| **C. INTERESTED PARTIES** |
| *List all names, principal business addresses, and the percentage of ownership interest of all officers, directors, stockholders, 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      | Ownership Percentage      |
| Street Address      | City      | State   | Zip Code      |
| Name      | Ownership Percentage      |
| Street Address      | City      | State   | Zip Code      |
| Name      | Ownership Percentage      |
| Street Address      | City      | State   | Zip Code      |
| **D. OTHER TYPES OF PROVIDERS OWNED BY THE APPLICANT / LICENSEE** |
| *List other types of providers. If more than two, check here [ ]  and attach additional pages.* |
| Name – Provider      | City      | State   | Zip Code      |
| Relationship Type [ ]  Nursing Home [ ]  Home Health Agency [ ]  Community-based Residential Facility [ ]  Hospital |
| Name – Provider      | City      | State   | Zip Code      |
| Relationship Type [ ]  Nursing Home [ ]  Home Health Agency [ ]  Community-based Residential Facility [ ]  Hospital |
| E. SUBSIDIARY / PARENT INFORMATION |
| 1. [ ]  Yes [ ]  No Is the applicant a subsidiary company, either wholly or partially owned by another organization or business?*If* ***Yes****, provide the following information.* |
| Legal Business Name – Parent Company      |
| DBA (Doing Business As)      |
| Type of Ownership[ ]  Nursing Home [ ]  Home Health Agency [ ]  Community-based Residential Facility [ ]  Hospital |
| Address      | City      | State   | Zip Code      |
| Name – Contact Person      | Telephone No.      | Email Address      |
| 2. [ ]  Yes [ ]  No Is the applicant affiliated with any subsidiaries in the health care field in this state or any other state?*If* ***Yes****, provide one of the following.* |
| * Names and addresses of all subsidiaries owned by the parent company, in this state or any other state, (relationship type: nursing homes, home health agencies, hospices, hospitals, rehabilitation facilities, etc.)
* Organizational chart exhibiting the legal business names and, if applicable, the DBA name of all the subsidiaries currently owned by the parent company in the health care field in this state or any other state, (relationship type: nursing homes, home health agencies, hospices, hospitals, rehabilitation facilities, etc.)
* Complete annual report to shareholders.
 |
| 3. [ ]  Yes [ ]  No Is the applicant under the control of a chain organization?“Chain organization” is defined as multiple providers, and/or suppliers owned, leased, or through any other devices, **controlled** by a **single business entity** (defined as chain home office). Each entity in the chain may have a different owner but the “home office” maintains **uniform procedures** in each facility for handling utilization review, reimbursement, handling admissions, and also maintains and controls centrally, provider / suppliers cost reports, etc.In addition, a chain facility would not necessarily be a subsidiary of the parent corporation. But, the chain facility or facilities could be owned by different subsidiaries of the same corporate parent. |
| Name – Chain Organization      |
| F. FIT AND QUALIFIED *[Wis. Admin. Code § DHS 131.14(3)(b)]* |
| *The following information will be used to determine if the applicant meets the fit and qualified requirements under Wis. Stat. ch. 50.* |
| 1. [ ]  Yes [ ]  No Has the applicant been affiliated in the past five years with a hospice **(HSP)**, a home health agency **(HHA)**, a Community Based Residential Facility **(CBRF)**, an Adult Family Home **(AFH)**, or a health care facility **(HCF)** (e.g., hospital, nursing home, or facility for the developmentally disabled) in the State of Wisconsin or in any other state?*[Wis. Admin. Code § DHS 131.14(3)(b)]**If* ***Yes****, complete all items in Section F below. If the answer is* ***No****, complete items 4 –12.* |
| Name – Facility      | Provider No. – Owner/Operator/Mgr./Vendor       |
| Address      | City      | State   |
| Facility Type[ ]  Hospice [ ]  HHA [ ]  CBRF [ ]  AFH [ ]  HCF | Dates of Affiliation      |
| Name – Facility      | Provider No. – Owner/Operator/Mgr./Vendor       |
| Address      | City      | State   |
| Facility Type[ ]  Hospice [ ]  HHA [ ]  CBRF [ ]  AFH [ ]  HCF | Dates of Affiliation      |
| Name – Facility      | Provider No. – Owner/Operator/Mgr./Vendor       |
| Address      | City      | State   |
| Facility Type[ ]  Hospice [ ]  HHA [ ]  CBRF [ ]  AFH [ ]  HCF | Dates of Affiliation      |
| 2. [ ]  Yes [ ]  No Has any adverse action initiated by any state licensing agency resulted in the denial **(D)**, suspension **(S)**, or revocation **(R)** of a license?*[Wis. Admin. Code § DHS 131.14(3)(b)1]**If* ***Yes****, provide the following. Use the above abbreviations to describe the type of adverse action and refer to III.F.1. for information regarding abbreviations for facility types.* |
| Name – Facility      |
| Address      | City      | State   |
| Facility Type[ ]  Hospice [ ]  HHA [ ]  CBRF [ ]  AFH [ ]  HCF | Type of Adverse Action[ ]  D [ ]  S [ ]  R | Effective Dates of Adverse Action      |
| Name – Facility      |
| Address      | City      | State   |
| Facility Type[ ]  Hospice [ ]  HHA [ ]  CBRF [ ]  AFH [ ]  HCF | Type of Adverse Action[ ]  D [ ]  S [ ]  R | Effective Dates of Adverse Action      |
| Name – Facility      |
| Address      | City      | State   |
| Facility Type[ ]  Hospice [ ]  HHA [ ]  CBRF [ ]  AFH [ ]  HCF | Type of Adverse Action[ ]  D [ ]  S [ ]  R | Effective Dates of Adverse Action      |
| 3. [ ]  Yes [ ]  No Has any adverse action initiated by a state or federal agency based on noncompliance 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)**?*[Wis. Admin. Code § DHS 131.14(3)(b)2 and 3]**If* ***Yes****, provide the following. Use abbreviations to describe the type of adverse action and refer to III.F.1. for information regarding abbreviations for facility types.* |
| Name – Facility      | [ ]  State [ ]  Federal |
| Address      | City      | State   |
| Facility Type[ ]  Hospice [ ]  HHA [ ]  CBRF [ ]  AFH [ ]  HCF | Type of Adverse Action[ ]  CMP [ ]  TPA [ ]  SOP [ ]  TMF | Effective Dates – Adverse Action      |
| Name – Facility      | [ ]  State [ ]  Federal |
| Address      | City      | State   |
| Facility Type[ ]  Hospice [ ]  HHA [ ]  CBRF [ ]  AFH [ ]  HCF | Type of Adverse Action[ ]  CMP [ ]  TPA [ ]  SOP [ ]  TMF | Effective Dates – Adverse Action      |
| Name – Facility      | [ ]  State [ ]  Federal |
| Address      | City      | State   |
| Facility Type[ ]  Hospice [ ]  HHA [ ]  CBRF [ ]  AFH [ ]  HCF | Type of Adverse Action[ ]  CMP [ ]  TPA [ ]  SOP [ ]  TMF | Effective Dates – Adverse Action      |
| 4. [ ]  Yes [ ]  No Has the applicant ever had a denial, suspension, enjoining, or revocation of a health care provider license, in this state or any other state, as defined in Wis. Stat. § 146.81, or any conviction for providing health care without a license?*[Wis. Admin. Code § DHS 131.14(3)(b)4]**If* ***Yes****, explain.* |
|        |
| 5. [ ]  Yes [ ]  No Has the applicant ever been convicted of a crime involving neglect or abuse of patients, or been involved in assaultive behavior, wanton disregard for the health and safety of others, or any act of elder abuse under Wis. Stat. § 46.90? *[Wis. Admin. Code § DHS 131.14(3)(b)5]* *If* ***Yes****, explain.* |
|       |
| 6. [ ]  Yes [ ]  No Has the applicant ever been convicted of a crime related to the delivery of health care services or items? *[Wis. Admin. Code § DHS 131.14(3)(b)6]**If* ***Yes****, explain.* |
|       |
| 7. [ ]  Yes [ ]  No Has the applicant ever been convicted of a crime involving controlled substances under Wis. Stat. ch.161?*[Wis. Admin. Code § DHS 131.14(3)(b)7]* *If* ***Yes****, explain.* |
|       |
| 8. [ ]  Yes [ ]  No Has the applicant had any prior financial failure that resulted in bankruptcy or in the closing of a hospice, home  health agency, or inpatient health care facility (e.g., nursing home or hospital) or the relocation of its patients?*[DHS 131.14(3)(b)9, Wis. Adm. Code]**If* ***Yes****, explain.*  |
|       |
| 9. [ ]  Yes [ ]  No Has the applicant / licensee been adjudicated bankrupt?*If* ***Yes****, explain on a separate page. Provide the dates, court, and disposition of each action.* |
| 10. [ ]  Yes [ ]  No Are there any unsatisfied judgments against the applicant / licensee?*If* ***Yes****, explain on a separate page. Provide the names and addresses of creditors, amounts, and the reasons for non-payment.* |
| 11. [ ]  Yes [ ]  No Does the applicant / licensee owe any debts that are 90 days past due?*If* ***Yes****, explain on a separate page. Provide the names and addresses of creditors, amounts, and reasons for non-payment.* |
| 12. [ ]  Yes [ ]  No Does the applicant/licensee plan to provide care to patients who are unable to pay for service? |
| 13. Financial References ***This item must be completed by the APPLICANT.*** *Include information for and* ***one letter of reference from at least one bank****. Do not include relatives. Attach additional pages, if necessary.* |
| Name      | Telephone No.      |
| Address      | City      | State   | Zip Code      |
| Name      | Telephone No.      |
| Address      | City      | State   | Zip Code      |
| IV. MANAGEMENT COMPANY |
| **A.** [ ]  Yes [ ]  No **Is the operation of the facility under a management contract?** *If* ***Yes****, provide following information regarding any management company retained to operate this facility or program.* |
| Type of Management Company: [ ]  Corporation [ ]  Partnership [ ]  Individual [ ]  Government |
| Name – Management Company      |
| Address      | City      | State   | Zip Code      |
| Name – Contact Person      | Telephone No.      | Email Address      |
| **B. Identify officers, directors, trustees, or supervisors of the management company. Attach additional pages, if necessary.** |
| Name      | Title      |
| Address      | City      | State   | Zip Code      |
| Name      | Title      |
| Address      | City      | State   | Zip Code      |
| ***C. Identify other facilities the management company has owned, operated, or managed in the last five years. Attach additional pages, if necessary.*** |
| Name      | Dates of Involvement      |
| Address      | City      | State   | Zip Code      |
| Name      | Dates of Involvement      |
| Address      | City      | State   | Zip Code      |
| Name      | Dates of Involvement      |
| Address      | City      | State   | Zip Code      |
| **D. While managing any of the above facilities identified in item C:**1. [ ]  Yes [ ]  No Has any adverse action initiated by any state licensing agency resulted in the denial **(D)**, suspension **(S)**, or revocation **(R)** of a license? *[Wis. Admin. Code § DHS 131.14(3)(b)1]**If* ***Yes****, provide the following information. Use abbreviations to describe the type of adverse action and refer to III.F.1. for information regarding abbreviations for facility types.* |
| Name – Facility      |
| Address      | City      | State   |
| Facility Type[ ]  Hospice [ ]  HHA [ ]  CBRF [ ]  AFH [ ]  HCF | Type of Adverse Action[ ]  D [ ]  S [ ]  R | Effective Dates of Adverse Action      |
| Name – Facility      |
| Address      | City      | State   |
| Facility Type[ ]  Hospice [ ]  HHA [ ]  CBRF [ ]  AFH [ ]  HCF | Type of Adverse Action[ ]  D [ ]  S [ ]  R | Effective Dates of Adverse Action      |
| Name – Facility      |
| Address      | City      | State   |
| Facility Type[ ]  Hospice [ ]  HHA [ ]  CBRF [ ]  AFH [ ]  HCF | Type of Adverse Action[ ]  D [ ]  S [ ]  R | Effective Dates of Adverse Action      |
| 2. [ ]  Yes [ ]  No Has any adverse action been initiated by a state or federal agency based on non-compliance 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)?** *[Wis. Admin. Code § DHS 131.14(3)(b)2 and 3]**If* ***Yes****, provide the following information. Use abbreviations to describe the type of adverse action and refer to* *III.F.1. for Information regarding abbreviations for facility types.* |
| Name – Facility      | [ ]  State [ ]  Federal |
| Address      | City      | State   |
| Facility Type[ ]  Hospice [ ]  HHA [ ]  CBRF [ ]  AFH [ ]  HCF | Type of Adverse Action[ ]  CMP [ ]  TPA [ ]  SOP [ ]  TMF | Effective Dates – Adverse Action      |
| Name – Facility      | [ ]  State [ ]  Federal |
| Address      | City      | State   |
| Facility Type[ ]  Hospice [ ]  HHA [ ]  CBRF [ ]  AFH [ ]  HCF | Type of Adverse Action[ ]  CMP [ ]  TPA [ ]  SOP [ ]  TMF | Effective Dates – Adverse Action      |
| Name – Facility      | [ ]  State [ ]  Federal |
| Address      | City      | State   |
| Facility Type[ ]  Hospice [ ]  HHA [ ]  CBRF [ ]  AFH [ ]  HCF | Type of Adverse Action[ ]  CMP [ ]  TPA [ ]  SOP [ ]  TMF | Effective Dates – Adverse Action      |
| ***E. Attach a copy of the signed contract with the management company.*** |
| **PART V. CONTACT PERSON, DESIGNEE, ATTESTATION** |
| **CONTACT PERSON** |
| *Identify the person responsible for completing this application and who can be contacted if we have questions.* |
| Name – Contact Person      | Title      |
| Telephone No.      | Fax No.      |
| Email Address      | Date Application Completed *(MM/dd/yyyy)*      |
| **DESIGNEE** *(The “designee” is the person authorized to accept personal service and receive registered and certified mail.)* |
| [ ]  Yes [ ]  No Is the administrator also the designee? *If* ***No****, provide the following information.* |
| Name – Designee      | Title      |
| **ATTESTATION** |
| ***Note:*** *The management company cannot attest to or sign on behalf of the applicant (potential licensee).* |
| I understand, under penalty of law, that the information provided throughout this application 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 (Wis. Stat. § 946.32). |
| **SIGNATURE IN FULL** – Applicant (Potential Licensee) | Date Signed *(MM/dd/yyyy)* |
| Printed Name – Applicant      | Title – Applicant      |