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| DEPARTMENT OF HEALTH SERVICES | **STATE OF WISCONSIN** |
| Division of Quality AssuranceF-62019 (12/2014) | Chapter 50, Wis. Stats.DHS 132 and 134, Wis. Admin. Code |
|  |  |
| **LICENSE APPLICATION FOR NURSING HOME,****INTERMEDIATE CARE FACILITY - INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF-IID), OR****INSTITUTE FOR MENTAL DISEASE (IMD)** | **FOR DQA OFFICE USE ONLY** |
| License Number |
| License Type |
| Effective Date |
| Expiration Date |

|  |  |  |
| --- | --- | --- |
| Type of Facility[ ]  Nursing Home [ ]  Intermediate Care Facility – Individuals with Intellectual Disabilities (FDD / ICF-IID) [ ]  Institute for Mental Disease (IMD) |  | Type of Application[ ]  Initial [ ]  Change of Ownership [ ]  Replacement Facility |
| Completion of this form is required by Chapter 50.50.03(3)(b), Wis. Stats., and DHS 132.14(2) and DHS 134.14(1), Wis. Admin. Code. The department will not issue a license until the applicant has supplied all requested information. The personally identifiable information collected on this form will be used to determine licensure eligibility and for statistical information and for no other purpose. **RETURN THE COMPLETED APPLICATION AND ADDITIONAL MATERIALS TO:** Division of Quality Assurance Bureau of Nursing Home Resident Care P.O. Box 2969 Madison, WI 53701-2969 |
| I. GENERAL INFORMATION |
| Name – Facility      |
| Previous Name (if applicable)      |
| Street (physical) Address      |
| City      | County      | State   | Zip Code      |
| Mailing Address (if different from physical address)      | City      | State   | Zip Code      |
| Telephone Number      | FAX Number      | Email Address      |
| **Level of License** |
| **DHS 132**[ ]  Skilled Care – Nursing Home[ ]  Intermediate Care – Nursing Home[ ]  Skilled Care – Institute for Mental Disease (IMD)**DHS 134**[ ]  Facility Serving People with Developmental Disabilities (FDD / ICF-IID) |
| Licensed Bed Capacity      | Fiscal Year End Date      |
| Type of Certification |
|  [ ]  Medicare (Title XVIII) - [ ]  Distinct Part [ ]  Fully Participating  [ ]  Medicaid (Title XIX) [ ]  Medicare and Medicaid (Dual Certification) [ ]  State Licensed Only (No Certification) |
| II. ADMINISTRATION |
| A. Administrator |
| Status [ ]  Permanent [ ]  Acting (temporary and unlicensed) [ ]  Interim (temporary and licensed) |
| Name – Administrator      | License Number      | Begin Date      |
| Is the administrator also the **designee** (person authorized to accept personal service and receive registered and certified mail)?  [ ]  Yes [ ]  No If “No,” complete the Designee section below.  |
| B. Designee |
| Name – Designee      | Title      | Begin Date      |
| C. Director of Nursing |
| Name – Director of Nursing      | Status [ ]  Permanent [ ]  Interim (temporary) | Begin Date      |
| D. Medical Director |
| Name – Medical Director      | Begin Date      |
| III. OWNERSHIP INFORMATION |
| **A. Applicant / Licensee – General** [person(s) or business entity having authority to direct management or policies of the facility] |
| Name – Applicant      | FEIN      |
| Street (physical) Address      | City      | State   | Zip Code      | County      |
| Mailing Address (if different from physical address)      | City      | State   | Zip Code      | County      |
| Telephone Number      | Fax Number      | Email Address      |
| Name - Contact Person      | Telephone Number      |
| **B. Applicant / Licensee – Type of Organization** (Check type of ownership.) |
| Governmental | Proprietary | Voluntary Non-Profit |
| [ ]  City[ ]  County[ ]  City / County[ ]  Federal[ ]  State[ ]  Tribal | [ ]  Individual[ ]  Partnership[ ]  Corporation[ ]  Limited Liability Company[ ]  Limited Liability Partnership | [ ]  Corporation[ ]  Church-Related[ ]  Limited Liability Company[ ]  Limited Liability Partnership[ ]  Other |
| C. Applicant / Licensee – Interested Parties |
| List all names, principal business addresses, and the percentage of ownership interest of all officers, directors, stockholders owning 5% 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 addresses of all officers, directors, and board members. Attach additional pages, if necessary.If the interested party is a Limited Liability Company (LLC), provide the names and addresses of the members of the LLC. |
| Name      | Title      | Ownership Percentage      |
| Street      | City      | State   | Zip Code      |
| Name      | Title      | Ownership Percentage      |
| Street      | City      | State   | Zip Code      |
| Name      | Title      | Ownership Percentage      |
| Address      | City      | State   | Zip Code      |
| Name      | Title      | Ownership Percentage      |
| Address      | City      | State   | Zip Code      |
| Name      | Title      | Ownership Percentage      |
| Address      | City      | State   | Zip Code      |
| Name      | Title      | Ownership Percentage      |
| Street      | City      | State   | Zip Code      |
| Name      | Title      | Ownership Percentage      |
| Address      | City      | State   | Zip Code      |
| **D. Applicant / Licensee – Subsidiary / Parent Information** |
| 1. Is the applicant a subsidiary company either wholly or partially owned by another organization or business? [ ]  No [ ]  Yes If “Yes,” complete the following information. |
| Name - Legal Business Name of Parent Company      | Type of Ownership      |
| Name - DBA (Doing Business As)       |
| Address      | City      | State   | Zip Code      |
| Name - Contact Person      | Telephone Number      |
| 2. Is the applicant affiliated with any subsidiaries in the health care field in this state or any other state?  [ ]  No [ ]  Yes 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
 |
|  |
| **E. Applicant / Licensee – Chain Organization** |
| Is the applicant under the control of a chain organization?  [ ]  No [ ]  Yes Chain organization is defined as multiple providers and/or suppliers owned, leased, or through any other devises **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, admissions, and also centrally maintains and controls 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      |
| If the applicant / licensee is a Limited Liability Company (LLC) or Limited Liability Partnership (LLP):* Provide the names and addresses of all LLC’s, LLP’s, or any other type of entity of which any of the applicant members are also members, officers, directors, and/or board members.
* Provide an organizational chart exhibiting the legal business names of any and all subsidiaries, LLC’s, LLP’s involved with this applicant and its members.
 |
| **F. Ownership of Building - General** |
|  **Is the applicant / licensee the owner of the building?**  [ ]  Yes [ ]  No If “No,” complete all of Sections F. - H. below.  |
| Name – Owner of the Building      |
| Street (physical) Address      |
| City      | State   | Zip Code      | County      |
| Mailing Address (if different from physical address)      |
| City      | State   | Zip Code      | County      |
| Telephone Number      | Fax Number      | Email Address      |
| Name - Contact Person      | Telephone Number      |
| **G. Ownership of Building - Type of Organization** (Check type of ownership.) |
| Governmental | Proprietary | Voluntary Non-Profit |
| [ ]  City[ ]  County[ ]  State[ ]  Federal[ ]  City / County[ ]  Tribal | [ ]  Individual[ ]  Partnership[ ]  Corporation[ ]  Limited Liability Company[ ]  Limited Liability Partnership | [ ]  Corporation[ ]  Church-Related[ ]  Limited Liability Company[ ]  Limited Liability Partnership[ ]  Other |
| H. Ownership of Building - Interested Parties |
| List all names, principal business addresses, and the percentage of ownership interest of all officers, directors, stockholders owning 5% 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 addresses of all officers, directors, and board members. Attach additional pages, if necessary. |
| Name      | Title      | Ownership Percentage      |
| Address      | City      | State   | Zip Code      |
| Name      | Title      | Ownership Percentage      |
| Address      | City      | State   | Zip Code      |
| Name      | Title      | Ownership Percentage      |
| Address      | City      | State   | Zip Code      |
| Name      | Title      | Ownership Percentage      |
| Street Address      | City      | State   | Zip Code      |
| Name      | Title      | Ownership Percentage      |
| Street Address      | City      | State   | Zip Code      |
| Name      | Title      | Ownership Percentage      |
| Street Address      | City      | State   | Zip Code      |
| IV. FIT AND QUALIFIED |
| The following information will be used to determine if the applicant meets the fit and qualified requirements under Chapter 50, Wis. Stats. |
| 1. Has the applicant, any of the interested parties and/or any of the members of a LLC / LLP, been affiliated in the past five years with a hospice (HSP), a home health agency (HHA), a residential care facility, e.g., Community Based Residential Facility (CBRF), Adult Family Home (AFH), or a health care facility (HCF), e.g., hospital, nursing home, or ICF-IID in the State of Wisconsin or in any other state?

 [ ]  No [ ]  Yes **If the answer is “Yes,” complete items A. – I. below.**  |
| Name - Facility |       |
| City and State |       |
| Owner / Operator / Mgr. Vendor / Provider No. |       |
| Type of Health Care Provider | [ ]  Hospice [ ]  HHA [ ]  CBRF [ ]  AFH [ ]  HCF (hospital, nursing home, ICF-IID) |
| Dates of Affiliation |       |
| Name - Facility |       |
| City and State |       |
| Owner / Operator / Mgr. Vendor / Provider No. |       |
| Type of Health Care Provider | [ ]  Hospice [ ]  HHA [ ]  CBRF [ ]  AFH [ ]  HCF (hospital, nursing home, ICF-IID) |
| Dates of Affiliation |       |
| Name - Facility |       |
| City and State |       |
| Owner / Operator / Mgr. Vendor / Provider No. |       |
| Type of Health Care Provider | [ ]  Hospice [ ]  HHA [ ]  CBRF [ ]  AFH [ ]  HCF (hospital, nursing home, ICF-IID) |
| Dates of Affiliation |       |
| Name - Facility |       |
| City and State |       |
| Owner / Operator / Mgr. Vendor / Provider No. |       |
| Type of Health Care Provider | [ ]  Hospice [ ]  HHA [ ]  CBRF [ ]  AFH [ ]  HCF (hospital, nursing home, ICF-IID) |
| Dates of Affiliation |       |
| B. Has any adverse action initiated by any state licensing agency resulted in the denial, suspension, or revocation of a license? [ ]  No [ ]  Yes If “Yes,” complete the following table.  |
| Name - Facility |       |
| Address / City / State |       |
| Type of Health Care Provider | [ ]  Hospice [ ]  HHA [ ]  CBRF [ ]  AFH [ ]  HCF (hospital, nursing home, ICF-IID) |
| Type of Adverse Action | [ ]  Denial [ ]  Suspension [ ]  Revocation  |
| Effective Dates of Adverse Action |       |
| Name - Facility |       |
| Address / City / State |       |
| Type of Health Care Provider | [ ]  Hospice [ ]  HHA [ ]  CBRF [ ]  AFH [ ]  HCF (hospital, nursing home, ICF-IID) |
| Type of Adverse Action | [ ]  Denial [ ]  Suspension [ ]  Revocation  |
| Effective Dates of Adverse Action |       |
| Name - Facility |       |
| Address / City / State |       |
| Type of Health Care Provider | [ ]  Hospice [ ]  HHA [ ]  CBRF [ ]  AFH [ ]  HCF (hospital, nursing home, ICF-IID) |
| Type of Adverse Action | [ ]  Denial [ ]  Suspension [ ]  Revocation  |
| Effective Dates of Adverse Action |       |
| Name - Facility |       |
| Address / City / State |       |
| Type of Health Care Provider | [ ]  Hospice [ ]  HHA [ ]  CBRF [ ]  AFH [ ]  HCF (hospital, nursing home, ICF-IID) |
| Type of Adverse Action | [ ]  Denial [ ]  Suspension [ ]  Revocation  |
| Effective Dates of Adverse Action |       |
| 1. Has any adverse action 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)?

 [ ]  No [ ]  Yes If “Yes,” complete the following table.  |
| Name - Facility |       |
| Address / City / State |       |
| Type of Health Care Provider | [ ]  Hospice [ ]  HHA [ ]  CBRF [ ]  AFH [ ]  HCF (hospital, nursing home, ICF-IID) |
| Type of Adverse Action | [ ]  CMP [ ]  TPA [ ]  SOP [ ]  TMF  |
| Federal or State | [ ]  Federal [ ]  State |
| Effective Dates of Adverse Action |       |
| Name - Facility |       |
| Address / City / State |       |
| Type of Health Care Provider | [ ]  Hospice [ ]  HHA [ ]  CBRF [ ]  AFH [ ]  HCF (hospital, nursing home, ICF-IID) |
| Type of Adverse Action | [ ]  CMP [ ]  TPA [ ]  SOP [ ]  TMF  |
| Federal or State | [ ]  Federal [ ]  State |
| Effective Dates of Adverse Action |       |
| Name - Facility |       |
| Address / City / State |       |
| Type of Health Care Provider | [ ]  Hospice [ ]  HHA [ ]  CBRF [ ]  AFH [ ]  HCF (hospital, nursing home, ICF-IID) |
| Type of Adverse Action | [ ]  CMP [ ]  TPA [ ]  SOP [ ]  TMF  |
| Federal or State | [ ]  Federal [ ]  State |
| Effective Dates of Adverse Action |       |
| Name - Facility |       |
| Address / City / State |       |
| Type of Health Care Provider | [ ]  Hospice [ ]  HHA [ ]  CBRF [ ]  AFH [ ]  HCF (hospital, nursing home, ICF-IID) |
| Type of Adverse Action | [ ]  CMP [ ]  TPA [ ]  SOP [ ]  TMF  |
| Federal or State | [ ]  Federal [ ]  State |
| Effective Dates of Adverse Action |       |
| D. Has the applicant, any of the interested parties and/or any of the members of a LLC / LLP, ever had a denial, suspension, enjoining or revocation of a health care provider license, in this state or any other state, as defined in Chapter 146.81, Wis. Stats., or any conviction for providing health care without a license? [ ]  No [ ]  Yes If “Yes,” explain. |
|        |
| 1. Has the applicant, any of the interested parties and/or any of the members of a LLC / LLP, ever been convicted of a crime involving neglect or abuse of patients, or involved in assaultive behavior, wanton disregard for the health and safety of others, or any act of elder abuse under Chapter 46.90, Wis. Stats.

 [ ]  No [ ]  Yes If “Yes,” explain. |
|        |
| 1. Has the applicant, any of the interested parties and/or any of the members of a LLC / LLP, ever been convicted of a crime related to the delivery of health care services or items?

 [ ]  No [ ]  Yes If “Yes,” explain. |
|        |
| 1. Has the applicant, any of the interested parties and/or any of the members of a LLC / LLP, ever been convicted of a crime involving controlled substances under Chapter 161, Wis. Stats.?

 [ ]  No [ ]  Yes If “Yes,” explain. |
|        |
| 1. Has the applicant, any of the interested parties, and/or any of the members of a LLC / LLP had any prior circumstances that resulted in bankruptcy or in the closing of a hospice, home health agency, or an inpatient health care facility (e.g., nursing home or hospital), or the relocation of its patients or residents?

 [ ]  No [ ]  Yes If “Yes,” explain. |
|        |
| 1. Identify the other types of providers owned by the applicant / licensee.

 If more than two, check here [ ]  and attach additional pages. |
| Name – Provider      |
| City      | State   | Zip Code      |
| Provider Type  [ ]  Nursing Home [ ]  Home Health Agency [ ]  Community-Based Residential Facility [ ]  Hospital [ ]  Hospice |
| Name – Provider      |
| City      | State   | Zip Code      |
| Provider Type  [ ]  Nursing Home [ ]  Home Health Agency [ ]  Community-Based Residential Facility [ ]  Hospital [ ]  Hospice |
| V. FINANCIAL RESPONSIBILITY |
| **The questions in this section are to be answered ONLY by the applicant / licensee.** |
| 1. Has the applicant / licensee, any of the interested parties, and/or any of the members of a LLC / LLP been adjudicated bankrupt?

 [ ]  No [ ]  Yes If “Yes,” explain on a separate page. Provide the dates, court, and disposition of each action. |
| 1. Are there any unsatisfied judgments against the applicant / licensee, any of the interested parties, and/or any of the members of a LLC / LLP?

 [ ]  No [ ]  Yes If “Yes,” explain on a separate page. Provide the names and addresses of creditors, amounts, and the  reasons for non-payment. |
| 1. Does the applicant / licensee, any of the interested parties, and/or any of the members of a LLC / LLP owe any debts that are 90 days past due?

 [ ]  No [ ]  Yes If “Yes,” explain on a separate page. Provide the names and addresses of creditors, amounts, and the reasons for non-payment. |
| 1. Are there any liens filed against the applicant / licensee, any of the interested parties, and/or any of the members of a LLC / LLP or their property?

 [ ]  No [ ]  Yes If “Yes,” explain on a separate page. |
| E. Estimated Average Gross Annual Revenues from All Sources. Round to the nearest thousand dollars. |
|  | Daily Rate: Title XIX  | $  |        |  |
|  | Private Pay | $  |        |  |
|  | Other | $  |        |  |
|  | Other Revenues | $  |        |  |
|  | **TOTAL** | $  |        |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_F. Estimated Annual Costs. Round to the nearest thousand dollars. |
|  | Operating Expenses | $  |        |  |
|  | Capital Outlays | $  |        |  |
|  | **TOTAL** | $  |        |  |
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|  |
| 1. DHS 132.14(3)(a)4(c), Wis. Admin. Code, **requires** the applicant to have sufficient financial resources to permit operation of the facility for six (6) months. This amount is one-half of the amount shown in your answer to question F. (estimated annual costs). **NOTE:** Daily rate charges are automatically taken into consideration.
* Complete the following Division of Healthcare Access and Accountability (DHCAA) forms F-01022 A - E, located in the DHS Forms Library at <http://www.dhs.wisconsin.gov/forms/F-0.asp>.
* F-01022 A Instructions for Projected Financial Statements
* F-01022 B Projected Income Statements
* F-01022 C Projected Cash Flow
* F-01022 D Related Party Transactions
* F-01022 E Projected Balance Sheet
* Include the following information (if applicable):
* Certified statement of line of credit; or
* Personal financial statement along with a signed affidavit committing personal resources or a copy of the corporation’s annual report along with a signed affidavit committing corporate resources; or
* Other financial documentation to support sufficient resources to cover operating losses.
 |
| H. Do you have any other commitments to transfer residents from other facility closings or phase-downs? [ ]  No [ ]  Yes If “Yes,” explain on a separate page. |
| I. Provide projected patient days, by month and by type of payer, for the first six months of operation. |
| 1. Provide the following, if applicable.
* Explain large variances in the projected revenues and/or expenses from those of the current operator’s latest cost report.
* Explain changes in occupancy rate or mix from those of the current owner’s latest cost report.
* Provide proof of commitment of mortgages when the purchase of the real estate is involved in the change of ownership.
* Evidence of commitment of a working capital loan and/or a line of credit from the financial institution providing financing.
 |
| VI. APPLICANT / LICENSEE |
| If the applicant / licensee has never been licensed to operate a nursing home in Wisconsin, we request that you provide resumes for each officer (if the applicant is a corporation), or each partner (if partnership), or member (if limited liability company), etc. to assist the Department in determining the applicant’s ability to operate a long term care facility. |
| VII. MANAGEMENT COMPANY |
| 1. Is the operation of the facility under a management contract?

 [ ]  No [ ]  Yes If “yes,” provide the following information regarding any management company retained to operate this  facility or program. |
| Type of Management Company  [ ]  Corporation [ ]  Partnership [ ]  LLC [ ]  Other (Specify.): |       |
| Name - Management Company      |
| Name - Contact Person      | Telephone Number      |
| Address      | City      | State   | Zip Code      |
| 1. 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      |
| 1. Identify other facilities the management company has owned, operated, or managed in the last five (5) 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. Has any adverse action initiated by any state licensing agency resulted in the denial, suspension, or revocation of a license? [ ]  No [ ]  Yes If “Yes,” complete the following.  |
| Name - Facility |       |
| Address / City / State |       |
| Type of Health Care Provider | [ ]  Hospice [ ]  HHA [ ]  CBRF [ ]  AFH [ ]  HCF (hospital, nursing home, ICF-IID) |
| Type of Adverse Action | [ ]  Denial [ ]  Suspension [ ]  Revocation  |
| Effective Dates of Adverse Action |       |
| Name - Facility |       |
| Address / City / State |       |
| Type of Health Care Provider | [ ]  Hospice [ ]  HHA [ ]  CBRF [ ]  AFH [ ]  HCF (hospital, nursing home, ICF-IID) |
| Type of Adverse Action | [ ]  Denial [ ]  Suspension [ ]  Revocation  |
| Effective Dates of Adverse Action |       |
| Name - Facility |       |
| Address / City / State |       |
| Type of Health Care Provider | [ ]  Hospice [ ]  HHA [ ]  CBRF [ ]  AFH [ ]  HCF (hospital, nursing home, ICF-IID) |
| Type of Adverse Action | [ ]  Denial [ ]  Suspension [ ]  Revocation  |
| Effective Dates of Adverse Action |       |
| 1. Has any adverse action 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)?

 [ ]  No [ ]  Yes If “Yes,” complete the following.  |
| Name - Facility |       |
| Address / City / State |       |
| Type of Health Care Provider | [ ]  Hospice [ ]  HHA [ ]  CBRF [ ]  AFH [ ]  HCF (hospital, nursing home, ICF-IID) |
| Type of Adverse Action | [ ]  CMP [ ]  TPA [ ]  SOP [ ]  TMF  |
| Federal or State | [ ]  Federal [ ]  State |
| Effective Dates of Adverse Action |       |
| Name - Facility |       |
| Address / City / State |       |
| Type of Health Care Provider | [ ]  Hospice [ ]  HHA [ ]  CBRF [ ]  AFH [ ]  HCF (hospital, nursing home, ICF-IID) |
| Type of Adverse Action | [ ]  CMP [ ]  TPA [ ]  SOP [ ]  TMF  |
| Federal or State | [ ]  Federal [ ]  State |
| Effective Dates of Adverse Action |       |
| Name - Facility |       |
| Address / City / State |       |
| Type of Health Care Provider | [ ]  Hospice [ ]  HHA [ ]  CBRF [ ]  AFH [ ]  HCF (hospital, nursing home, ICF-IID) |
| Type of Adverse Action | [ ]  CMP [ ]  TPA [ ]  SOP [ ]  TMF  |
| Federal or State | [ ]  Federal [ ]  State |
| Effective Dates of Adverse Action |       |
| E. If there is a management company involved, how will you monitor the success of this management company in complying with DHS 132, Wisconsin Administrative Code, and CFR (Code of Federal Regulation)?  Provide resumes for each individual of the management company who will exercise operational or managerial control in the long term care facility. |
| F. Attach a copy of the signed contract with the management company.  |
| VII. CONTACT PERSON |
| Identify the person responsible for completing this application and who can be contacted if we have questions. |
| Name – Person Completing Application       | Title      |
| Telephone Number      | FAX Number      | Date Application Completed      |
| **VIII. ATTESTATION** |
| **NOTE:**  **The Management Company cannot attest to or sign on behalf of the applicant (potential licensee).** |

I attest, 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 Chapter 946.32, Wis. Stats.

|  |  |
| --- | --- |
| **SIGNATURE (FULL)** – Applicant (Potential Licensee) | Name - Applicant (Print or type.)      |
| Title – Applicant      | Date Signed      |