

COMMUNITY BASED RESIDENTIAL FACILITY (CBRF) INITIAL LICENSE APPLICATION

- Completion of this form is required by Chapter 50.03(3)(b), Wis. Stats.
- Failure to complete this form completely and accurately may result in licensure denial and/or delay in processing.
- Send the completed form with the items listed below to the Division of Quality Assurance (DQA) regional office assigned to the county in which the facility is located. DQA regional office locations are found at: http://dhs.wisconsin.gov/rl_dsl/Contacts/ALSreglmap.htm
- Contact the appropriate regional office if you have questions about completion of this form.
- **THE FOLLOWING ITEMS MUST BE SUBMITTED WITH THE APPLICATION FORM:**
 - Program statement
 - Resident Rights and House Rules policies
 - Background check
 - Grievance procedure
 - Floor plan with dimensions, exits, room usage
 - Evidence of site approval, if zoned
 - Fire inspection
 - Verification of Completion of CBRF webcast, if a new provider
 - Emergency plan
 - Biennial license fee (**NON-REFUNDABLE**) – Check payable to: **DQA**
 - Admission agreement
 - *Assisted Living Facility Model Balance Sheet* (DQA form F-62674A)
 - Community Advisory Committee documentation
 - Evidence of 60-day operating funds

NOTE: The licensee is responsible for notifying the Division of Quality Assurance in writing of any change in the information provided on this application.

Yes No Did you submit form F-82064 (BID) and form F-82069 (BID Appendix) to the Office of Caregiver Quality at the address listed below?

**DHS / Division of Quality Assurance
 Office of Caregiver Quality
 P.O. Box 2969
 Madison, WI 53701-2969**

Yes No Does the Community Based Residential Facility have a contract with a county agency or managed care organization to serve publicly funded individuals?

I. GENERAL INFORMATION

Name – Facility				FEIN
Address – Facility (Street / PO Box)	City	State	Zip Code	County

Provide specific directions to the facility from the closest major STATE highway.

Telephone Number - Facility	FAX Number - Facility	E-mail Address – Facility
Name – Administrator	Birth Date – Administrator	E-mail Address - Administrator

Size of CBRF <i>(Check one.)</i>	Class / Type of CBRF <i>(Check one.)</i>	
<input type="checkbox"/> Small (5-8 residents)	<input type="checkbox"/> Ambulatory Class A (AA)	<input type="checkbox"/> Ambulatory Class C (CA)
<input type="checkbox"/> Medium (9-20 residents)	<input type="checkbox"/> Semi-Ambulatory Class A (AS)	<input type="checkbox"/> Semi-ambulatory Class C (CS)
<input type="checkbox"/> Large (21 or more residents)	<input type="checkbox"/> Non-Ambulatory Class A (ANA)	<input type="checkbox"/> Non-ambulatory Class C (CNA)

NOTE: Any change in the above information requires submission of new documents.

Name – Licensee [Individual or Corporation (legal entity)]				Birth Date - Licensee
Street Address – Licensee		City	State	Zip Code
Telephone Number - Licensee	FAX Number - Licensee	E-mail Address - Licensee		

Designated Mail Recipient (Provide the name and contact information of the person to whom mail from DHS/DQA is to be addressed.)

Name – Designated Mail Recipient	Title	E-mail Address	
Mailing Address	City	State	Zip Code

List the names of all persons, age 10 and older, who live in the facility and are not a resident. If more than four names, attach an additional sheet.

Last Name, First Name, and MI	Relationship to Licensee	Birth Date

II. RESIDENT INFORMATION

Total Resident Capacity	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Both
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Check the box indicating the **primary client group(s)** you are requesting to serve.

- | | |
|--|---|
| <input type="checkbox"/> AA - Advanced aged | <input type="checkbox"/> PD - Physically disabled |
| <input type="checkbox"/> ALZ - Irreversible dementia/Alzheimer's | <input type="checkbox"/> PWC - Pregnant women who need counseling |
| <input type="checkbox"/> DD - Developmentally Disabled | <input type="checkbox"/> CC - Correctional clients |
| <input type="checkbox"/> MH - Emotionally disturbed/Mental illness | <input type="checkbox"/> TI - Terminally ill |
| <input type="checkbox"/> ADA - Alcohol/Drug dependent | <input type="checkbox"/> TBI - Traumatic brain injury |

List the days and hours when residents are **NOT** in the facility.

Days	Hours
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III. FINANCIAL INFORMATION

A current balance sheet must be submitted with this application.

Monthly Operating Expenses	
All Salaries (licensee, caregivers, contract providers, etc.)	\$
Lease or Mortgage	\$
All Other (food, supplies, utilities, insurance, taxes, etc.)	\$
TOTAL Monthly Expenses	\$

If income from residents would not be adequate to pay your monthly operating expenses, you must have other sources of funds or income that may be used to continue the operation of the facility for at least a 60-day period.

All Other Sources of Income

Check all that apply.

- | | |
|---|---|
| <input type="checkbox"/> Savings or other financial reserves | <input type="checkbox"/> Line of credit |
| <input type="checkbox"/> Purchase contract (county agency or managed care organization) | <input type="checkbox"/> Loan |
| <input type="checkbox"/> Outside employment | <input type="checkbox"/> Other (Specify.) |

Submit copies of financial documents (e.g., copies of bank balance sheets, evidence of line of credit) verifying your ability to operate the facility for 60 days. This amount must be equal to or more than two times your monthly operating expenses.

Indicate the minimum and maximum **monthly** fees charged for resident care. If you charge the same fee to all of your residents, indicate the amount as the "Maximum" rate.

MINIMUM Monthly Rate	MAXIMUM Monthly Rate
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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. Have you ever applied for licensure for a residential facility, health care facility, or a day care program for adults or children and been denied licensure?

Yes No If "Yes," explain and provide relevant information.

2. Have you ever operated a residential facility, health care facility, or a day care program for adults or children in Wisconsin or in any other state?

Yes No If "Yes," provide the name, address, and phone number of the facility/program.

3. Was the facility/program licensed, certified, or otherwise regulated by any government or private agency?

Yes No If "Yes," provide the name, address, and phone number of that agency.

4. Have you ever had any license, certification, or governmental approval to operate a facility/program denied, revoked, suspended, or not renewed in Wisconsin or any other state?

Yes No If "Yes," specify the type of license, certification, or approval affected, in which state the action occurred, which agency took the enforcement action, and the name, address, phone number, and type of facility/program that was affected. *(continued on next page)*

5. Do you presently have or intend to apply for another type of license, certification, or registration at this location?

Yes No If "Yes," check below all that apply.

License Type	Certification Type	Registration Type
<input type="checkbox"/> a. Foster Home (Children) <input type="checkbox"/> b. Group Foster Home (Children) <input type="checkbox"/> c. Residential Care Ctr. for Children & Youth <input type="checkbox"/> d. Shelter Care (Children) <input type="checkbox"/> e. Adult Family Home <input type="checkbox"/> f. Nursing Home <input type="checkbox"/> g. Hospital <input type="checkbox"/> h. Community Based Residential Facility <input type="checkbox"/> i. Day Care Center (family or group) <input type="checkbox"/> j. Other (Specify.)	<input type="checkbox"/> a. Alcohol and Other Drug Abuse Program <input type="checkbox"/> b. Mental Health Program <input type="checkbox"/> c. Adult Day Care <input type="checkbox"/> d. Certified Residential Care Apt Complex <input type="checkbox"/> e. Other (Specify.)	<input type="checkbox"/> a. Residential Care Apartment Complex

Local fire departments have requested knowing where licensed facilities are located. Provide the name, address, and telephone number of your local fire department.

Name - Local Fire Department		Telephone Number (Do NOT enter 911.)	
Address - Street / PO Box	City	State	Zip Code

A request will be sent to the city, township, or village to identify any possible hazard that may affect the health and safety of the residents. No license may be granted until a 30-day period has expired or until we receive a response from the city, township, or village.

- City
 Township
 Village

Name - Municipality	Name - Clerk		
Address - Street / PO Box	City	State	Zip Code

V. OWNERSHIP

Attach separate sheet(s) with 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, then list each partner.
- If a corporation, then 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.

VI. LICENSEE

Additional Submittals

- If the applicant is a **Corporation**, submit a copy of the Articles of Incorporation and by-laws.
- If the applicant is a **LLC**, submit a copy of the articles of organization and operation.
- If the applicant is a **LLP**, submit a copy of the partnership agreement.

NOTE: Attach additional pages if needed for the following questions.

1. The Licensee owns the:

Operation	Building	Land
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

2. Type of Licensee (Check one of the following.)

Governmental	Proprietary	Voluntary Non-Profit
<input type="checkbox"/> City <input type="checkbox"/> County <input type="checkbox"/> State <input type="checkbox"/> Tribal	<input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Limited Liability Corp	<input type="checkbox"/> Corporation <input type="checkbox"/> Church <input type="checkbox"/> Limited Liability Corp

3. List the interested parties relative to the entity named as licensee. [Chapter 50.03(3), Wis. Stats.]

Name (Last, First, MI)		Title		Percent of Financial Interest	
Address – Street / P.O. Box			City	State	Zip Code
Name (Last, First, MI)		Title		Percent of Financial Interest	
Address – Street / P.O. Box			City	State	Zip Code
Name (Last, First, MI)		Title		Percent of Financial Interest	
Address – Street / P.O. Box			City	State	Zip Code
Name (Last, First, MI)		Title		Percent of Financial Interest	
Address – Street / P.O. Box			City	State	Zip Code

4. Has the licensee ever been adjudicated bankrupt?
 Yes No If "Yes," give full details on a separate page including dates, court, and the disposition of each matter.

5. Are there any unsatisfied judgments against the licensee?
 Yes No If "Yes," list all judgments on a separate page listing names and addresses of creditors, amounts, and reasons for non-payment.

6. Does the licensee owe any debts that are 90 days past due?
 Yes No If "Yes," list all debts 90 days past due on a separate page listing the names and addresses of creditors, amounts, and reasons for non-payment.

7. Are any liens filed against the licensee or the licensee's property?
 Yes No If "Yes," indicate on a separate page who filed the lien(s), where filed, when filed, and amount of each lien.

If someone other than the licensee / operator has ownership interest in the building and/or land, complete questions 8 through 11 and, if applicable, questions 12 through 15, allowing one set of questions for each different partnership, corporation, and other type of owner.

8. Owner of the: Building Land

9. Type of Owner (Check **one** of the following.)

Governmental	Proprietary	Voluntary Non-Profit
<input type="checkbox"/> City <input type="checkbox"/> County <input type="checkbox"/> State <input type="checkbox"/> Tribal	<input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Limited Liability Corp	<input type="checkbox"/> Corporation <input type="checkbox"/> Church <input type="checkbox"/> Limited Liability Corp

10. Name and Address of the Owner

Name – Individual, Partnership, Corporation, etc.

Address – Street / P.O. Box		City	State	Zip Code
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11. List the interested parties relative to the entity in question 10. [Chapter 50.03(3), Wis. Stats.]

Name (First, Last, MI)		Percent of Financial Interest	
Address – Street / P.O. Box	City	State	Zip Code

Name (First, Last, MI)		Percent of Financial Interest	
Address – Street / P.O. Box	City	State	Zip Code

12. Owner of the Building Land

13. Type of Owner (Check one of the following.)

Governmental	Proprietary	Voluntary Non-Profit
<input type="checkbox"/> City <input type="checkbox"/> County <input type="checkbox"/> State <input type="checkbox"/> Tribal	<input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Limited Liability Corp	<input type="checkbox"/> Corporation <input type="checkbox"/> Church <input type="checkbox"/> Limited Liability Corp

14. Name and Address of the Owner

Name - Individual, Partnership, Corporation, etc.

Address – Street / P.O. Box	City	State	Zip Code
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15. List the interested parties relative to the entity in question 14. [Chapter 50.03(3), Wis. Stats.]

Name (First, Last, MI)	Title	Percent of Financial Interest
Name (First, Last, MI)	Title	Percent of Financial Interest

VII. CREDITORS

1. List the names, principal business addresses, telephone numbers, and type and extent of obligation, in dollars, for all creditors holding a security interest in the premises, whether land or building. Include any mortgage, note, deed of trust, or other obligation secured in whole or in part by the land on which, or building in which, the facility is located. Attach additional pages if necessary.

Name - Individual, Partnership, Corporation, etc.

Address – Street / P.O. Box	City	State	Zip Code
Telephone Number	Type of Obligation	Extent of Obligation	

Name - Individual, Partnership, Corporation, etc.

Address – Street / P.O. Box	City	State	Zip Code
Telephone Number	Type of Obligation	Extent of Obligation	

Name - Individual, Partnership, Corporation, etc.

Address – Street / P.O. Box	City	State	Zip Code
Telephone Number	Type of Obligation	Extent of Obligation	

2. List the names, principal business addresses, telephone numbers, and type and extent of agreement, in dollars, for all persons and business entities holding any lease or sublease for the land where the building is located. Attach additional pages if necessary.

Name - Individual, Partnership, Corporation, etc.

Address – Street / P.O. Box		City	State	Zip Code
Telephone Number	Type of Agreement	Extent of Agreement		

Name - Individual, Partnership, Corporation, etc.

Address – Street / P.O. Box		City	State	Zip Code
Telephone Number	Type of Agreement	Extent of Agreement		

The licensee is responsible for notifying the Division of Quality Assurance, in writing, of any changes in the information provided on this application.

VIII. 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 6 years, or both (Chapter 946.32, Wis. Stats.).

SIGNATURE (In Full) - Licensee or Designee Ø	Date Signed
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Name (<i>Print or type.</i>)	Title (Must be Owner or Board Member)
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