

RESIDENT CENSUS

- HFS 132.45(1), Wisconsin Administrative Code, requires that the administrator or the administrator's designee provide information needed to document compliance with HFS 132, Wis. Admin. Code, and Chapter 50.04(2)(d), Wis. Stats. This information will be used to determine compliance with HFS 132.62(3)(a)1 and HFS 132.62(3)(a)2.
- Instructions for this form are available on form F-62022A.

| | | |
|-----------------|----------------|-----------------------------------|
| Name - Facility | | Date |
| City | License Number | Date from Instructions (F-62022A) |

Please provide the following information about the number of residents in your facility on this date:

**Any resident who has any diagnosis of developmental disability (DD) must be counted on line 1.
 All other residents are counted on line 2.**

| ISN LEVEL OF CARE | TITLE 18 (A) | TITLE 19 (B) | ALL OTHER (C) | TOTAL |
|---------------------|--------------|--------------|---------------|-------|
| 1. Any DD Diagnosis | | | | |
| 2. No DD Diagnosis | | | | |
| SUBTOTALS | | | | |

TOTAL ISN A + B + C

| SNF LEVEL OF CARE | TITLE 18 (A) | TITLE 19 (B) | ALL OTHER (C) | TOTAL |
|---------------------|--------------|--------------|---------------|-------|
| 1. Any DD Diagnosis | | | | |
| 2. No DD Diagnosis | | | | |
| SUBTOTALS | | | | |

TOTAL SNF A + B + C

| ICF 1 LEVEL OF CARE | TITLE 18 (A) | TITLE 19 (B) | ALL OTHER (C) | TOTAL |
|---------------------|--------------|--------------|---------------|-------|
| 1. Any DD Diagnosis | | | | |
| 2. No DD Diagnosis | | | | |
| SUBTOTALS | | | | |

TOTAL ICF-1 B + C

| ICF 2 LEVEL OF CARE | TITLE 18 (A) | TITLE 19 (B) | ALL OTHER (C) | TOTAL |
|---------------------|--------------|--------------|---------------|-------|
| 1. Any DD Diagnosis | | | | |
| 2. No DD Diagnosis | | | | |
| SUBTOTALS | | | | |

TOTAL ICF-2 B + C

| ICF 3 LEVEL OF CARE | TITLE 18 (A) | TITLE 19 (B) | ALL OTHER (C) | TOTAL |
|---------------------|--------------|--------------|---------------|-------|
| 1. Any DD Diagnosis | | | | |
| 2. No DD Diagnosis | | | | |
| SUBTOTALS | | | | |

TOTAL ICF-3 B + C

| ICF 4 LEVEL OF CARE | TITLE 18 (A) | TITLE 19 (B) | ALL OTHER (C) | TOTAL |
|---------------------|--------------|--------------|---------------|-------|
| 1. Any DD Diagnosis | | | | |
| 2. No DD Diagnosis | | | | |
| SUBTOTALS | | | | |

TOTAL ICF-4 B + C

| | | | | |
|----------------------|--|--|--|--|
| COLUMN TOTALS | | | | |
|----------------------|--|--|--|--|

| | |
|-----------------------------------------------|-------------|
| SIGNATURE and TITLE - Facility Representative | Date Signed |
|-----------------------------------------------|-------------|