

ADULT DAY CARE CENTER INITIAL CERTIFICATION APPLICATION

- In accordance with 42 CFR 441.352(a)(1) and (2), adult day care (ADC) centers serving publicly funded clients must meet state certification requirements in order to receive funds for the cost of care for these participants.
- Completion of this form is required to become certified as an adult day care center. Failure to accurately complete and submit this form will result in denial of certification.
- **ATTACH THE FOLLOWING TO THIS APPLICATION.**
 - Diagram of floor plan of **TOTAL SPACE** to be used by the center. Indicate dimensions, exits, and room usage.
 - Certification fees (**non-refundable**); check payable to: **Division of Quality Assurance**
- Send the completed form with the required attachments and fees to:

DHS / Division of Quality Assurance
Bureau of Assisted Living
ATTN: Licensing Associates
P.O. Box 7940
Madison, WI 53707-7940
- If you have questions regarding the completion of this form, contact a Bureau of Assisted Living Licensing Associate at:

dhsdqballicensing@dhs.wisconsin.gov
608-266-8482

GENERAL INFORMATION

Name – ADC Center				FEIN	
Street Address		City	State	Zip Code	County
Mailing Address (if different than street address)		City	State	Zip Code	County
Telephone No.	Fax No.		Email Address		
Location of ADC Center <input type="checkbox"/> Provider's Home <input type="checkbox"/> Nursing Home <input type="checkbox"/> CBRF		Days of Operation		Hours of Operation	
<i>Provide directions to the ADC center from the closest STATE highway.</i>					

OTHER TYPES OF LICENSES OR CERTIFICATIONS

Yes No Does the licensee currently hold other types of licenses or certifications? *If "yes," list all below.*

CONTACTS

Provide contact information for the individual to whom mail from DHS/DQA is to be sent.

Name – Designated Mail Recipient		Telephone No.	Email Address	
Name – Director		Telephone No.	Email Address	
Name – Owner / Applicant			Telephone No.	
Address		City	State	Zip Code

Name – Administrator		Telephone No.	
Address	City	State	Zip Code

CLIENTS

Total No. of Clients Served	Will meals be provided to clients? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are any clients non-ambulatory? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Identify client groups to be served.

- | | |
|---|---|
| <input type="checkbox"/> Advanced age | <input type="checkbox"/> Physically disabled |
| <input type="checkbox"/> Irreversible dementia/Alzheimer's | <input type="checkbox"/> Terminally ill |
| <input type="checkbox"/> Developmentally disabled | <input type="checkbox"/> Traumatic brain injury |
| <input type="checkbox"/> Emotionally disturbed/mental illness | |
| <input type="checkbox"/> Other (<i>Specify.</i>) | |

Check one of the following.

- Currently serving publicly funded clients (*Identify the county agency or managed care agency providing funding.*)
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- Anticipate serving publicly funded clients within the next 90 days

ATTESTATION

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 (Wis. Stat. § 946.32).

SIGNATURE – Owner / Applicant ➤	Title	Date Signed (<i>MM/dd/yyyy</i>)
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