

FREE-STANDING COMMUNITY-BASED RESIDENTIAL FACILITY (CBRF) PLAN APPROVAL APPLICATION

INSTRUCTIONS

GENERAL

- A “free-standing CBRF” is not physically attached to a hospital or a nursing home. If a CBRF is attached to a hospital or nursing home, do not use this form; complete DQA form F-62333, *Plan Approval Application*.
- A separate plan approval application form and fee must be submitted for each new building, addition to an existing facility, and remodeling projects, or for equipment upgrades.
- **DQA Contact Information**
Phone: 608-264-7748 (Madison) or 414-227-4085 (Milwaukee)
Email: DHSDQAPlanReview@dhs.wisconsin.gov
Website: http://dhs.wisconsin.gov/rl_dsl/planreview/index.htm

SUBMISSION OF MATERIALS AND FEES

Materials to be Submitted

- ORIGINAL**, completed DQA form F-62496, *Free-Standing CBRF Plan Approval Application* (All sections of this form must be completed.)
- A minimum of **one (1) bound set** of plans (Plans shall be drawn to scale.)
- Three (3) additional copies of the index sheet bearing the required signature and seals
- ONE (1) bound set** of specifications and calculations bearing the required signature and seals
- Fee** that reflects the current scope of work (Make check payable to: **Division of Quality Assurance** or **DQA**.)

Digital submittal is also available. Contact: Kathleen.Treacy@dhs.wisconsin.gov

Signatures

- All signatures must be **ORIGINAL**. Stamped and electronic signatures are not acceptable.

Submission Locations

- ALL MATERIALS MUST BE SUBMITTED TO ONE OF THE TWO ADDRESSES LISTED BELOW.** Sending materials to other DQA regional offices will delay the plan review process.

Although project plans may be submitted to either address listed below, it is more expedient for projects in the southeastern part of the state (Kenosha, Milwaukee, Ozaukee, Racine, Washington, and Waukesha counties) to be submitted to the Milwaukee office.

MADISON Mailing Address	MILWAUKEE Mailing Address
DHS / Division of Quality Assurance ATTN: Plan Intake Coordinator P.O. Box 2969 / 1 W. Wilson Street, Rm. 451 Madison, WI 53701-2969	DHS / Division of Quality Assurance ATTN: Plan Intake Coordinator 819 N. 6 th Street, Rm. 609B Milwaukee, WI 53203-1606

**FREE-STANDING
 COMMUNITY BASED RESIDENTIAL FACILITY (CBRF)
 PLAN APPROVAL APPLICATION**

DQA Office Use Only	
Project No.	Plan No.
Check No.	
Transaction No.	Amount
Check Provider	
Reviewer	

1. PROJECT INFORMATION

Name – Facility (Legal Name)

Building Occupancy Chapter(s) and Use	Municipal Zoning Designation	County	
Physical (Street) Address - Facility	City	State	Zip Code

Project Description (*Provide a brief description.*)

2. PLAN REVIEW CONTACT PERSON

The contact person indicated below will receive the DHS-assigned reference number and instructions about online verification via email. The reference number will enable the applicant to verify the status of the plan application. A LEGIBLE EMAIL ADDRESS IS NECESSARY.

Name - Contact Person	Telephone No.	Email Address
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3. LICENSE INFORMATION

New License <input type="checkbox"/> AA <input type="checkbox"/> AS <input type="checkbox"/> ANA <input type="checkbox"/> CA <input type="checkbox"/> CS <input type="checkbox"/> CNA	No. of Beds	This building project will change license from	to
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4. SUBMITTAL REQUEST

A. Type of Project (*Check all that apply.*)

- New Building
 Alteration (Level: 1 2 3)
 New Addition
 Use Change
 Revisions to Previously Approved Plans
 Other (*Specify*) _____

B. Type of Review(s) Requested (*Check all work that is included in this application.*)

1. Building
 2. HVAC
 3. Lighting
 4. Fire Alarm System
 5. Fire Sprinkler System
 6. Essential Electrical System
 7. Nurse Call System
 8. Structural Elements
 9. Footing and Foundation
 10. Other (*Specify*) _____

5. BUILDING INFORMATION

COMPLETE Sprinkler – NFPA _____ Mixed Use Separated Un-separated
 PARTIAL Sprinkler – NFPA _____ Fire Alarm System Construction Type
 Total Number of Stories: _____
 Entire Building Footprint Area: _____ sq. ft.

6. CALCULATION OF FEES

PROJECT FEE ESTIMATION <i>Costs must be itemized as indicated. Do not combine costs.</i>		FEE TABLE	
Building	\$ _____	Total Estimated Project Cost	Fee
HVAC	\$ _____	Less than \$2,000	\$ 100
Lighting	\$ _____	\$2,000 – \$24,999	\$ 300
Fire Protection – Fire Alarm	\$ _____	\$25,000 – \$99,999	\$ 500
Fire Protection – Sprinkler	\$ _____	\$100,000 – \$499,999	\$ 750
Component Work Separate from Bldg.	\$ _____	\$500,000 – \$999,999	\$ 1,500
Other (Specify.)	\$ _____	\$1,000,000 – \$4,999,999	\$ 2,500
Other (Specify.)	\$ _____	\$5,000,000 and over	\$ 5,000
Total Estimated Project Cost	\$ _____	TOTAL FEES SUBMITTED	\$ _____

7. DESIGNER ATTESTATION AND INFORMATION

DESIGNER STATEMENT [Wis. Admin. Code §§ SPS 361.20, 361.31(1) and 361.40]: The designer indicated this form is responsible for preparing or supervising the preparation of the submitted plans, attests to the best of his/her knowledge that this submittal is accurate and complies with the applicable codes of the Department of Safety and Professional Services and the Department of Health Services. If a building, following construction of this project, contains more than 50,000 cubic feet in volume, plans are required to be prepared, signed, sealed, and dated by a Wisconsin-registered engineer, architect, or designer [§ SPS 361.31(1)1]. Signature and seals affixed to the plans shall be original.

DESIGNER 1 | **Type of Designer:** Building HVAC Lighting Fire Protection Component Work Other

Name – Design Firm _____ Design Firm Project No. _____

Name – Supervising Professional _____ Telephone No. _____ Email Address (**MANDATORY. Print clearly or type.**) _____

Mailing Address – Street or P.O. Box _____ City _____ State _____ Zip Code _____

SIGNATURE – Designer _____ Date Signed _____ Name – Designer (*Print or type.*) _____ Reg. No. – Designer _____

DESIGNER 2 | **Type of Designer:** Building HVAC Lighting Fire Protection Component Work Other

Name – Design Firm _____ Design Firm Project No. _____

Name – Supervising Professional _____ Telephone No. _____ Email Address (**MANDATORY. Print clearly or type.**) _____

Mailing Address – Street or P.O. Box _____ City _____ State _____ Zip Code _____

SIGNATURE – Designer _____ Date Signed _____ Name – Designer (*Print or type.*) _____ Reg. No. – Designer _____

8. SUPERVISING PROFESSIONAL ATTESTATION AND INFORMATION

SUPERVISING PROFESSIONAL STATEMENT: If building will be 50,000 cubic feet or greater, I have been retained by the owner as the supervising professional, per Wis. Admin. Code § SPS 361.40, for the supervision of on-site observations to determine if construction is in substantial compliance with approved plans and specifications. Upon completion of construction, I shall file a written statement with the department and municipality certifying that, to the best of my knowledge and belief, construction has or has not been performed in substantial compliance with approved plans and specifications. In the event that I am no longer associated with this project, I shall file a compliance statement notifying the department, as such, and indicating the current status of compliance.

SUPERVISING PRO 1 | **Type of SP:** Building Fire Protection HVAC Lighting Structural Other

Name – Firm or Company _____ Registration No. _____

Telephone No. _____ Email Address **(MANDATORY)** *(Print clearly or type.)* _____

SIGNATURE – Supervising Professional 1 | Date Signed *(MM/dd/yyyy)* _____ | Name – Building *(Print clearly or type.)* _____

SUPERVISING PRO 2 | **Type of SP:** Building Fire Protection HVAC Lighting Structural Other

Name – Firm or Company _____ Registration No. _____

Telephone No. _____ Email Address **(MANDATORY)** *(Print clearly or type.)* _____

SIGNATURE – Supervising Professional 2 | Date Signed *(MM/dd/yyyy)* _____ | Name – Building *(Print clearly or type.)* _____

9. COMPONENT DESIGNER ATTESTATION AND INFORMATION

COMPONENT DESIGNER. The Department of Health Services requires that the project designer review individual component submittals for compliance with the general design concept. The project designer and Department of Health Services shall rely on the seal of the component designers for compliance with the codes as they apply to their designs.

COMPONENT DESIGNER 1 | **Type of CD:** Structural Footing and Foundation

SIGNATURE – Component Designer 1 | Date Signed *(MM/dd/yyyy)* _____ | Name – Component Designer 1 *(Print clearly or type.)* _____

COMPONENT DESIGNER 2 | **Type of CD:** Building Fire Protection HVAC Lighting Structural Other

SIGNATURE – Component Designer 2 | Date Signed *(MM/dd/yyyy)* _____ | Name – Component Designer 2 *(Print clearly or type.)* _____

10. OWNER ATTESTATION AND INFORMATION

OWNER STATEMENT: I request that plans be reviewed for compliance with applicable code requirements set forth in Wis. Admin. Code chs. SPS 360-366 of the rules of the Department of Safety and Professional Services and in chs. DHS 83-134 of the Department of Health Services. I recognize that I am responsible for compliance with all code requirements and any conditions of approval. If a building is 50,000 cubic feet in total volume or greater, I will retain a supervising professional as required by § SPS 361.31 throughout construction to project completion and am responsible for ensuring the filing of a Compliance Statement by the supervising professional prior to occupancy. I understand that plans are required to be prepared, signed, sealed, and dated by a Wisconsin registered engineer or architect (§ SPS 361.13) and that signatures and seals affixed to the plans shall be original.

Name – Owner / Entity _____

Mailing Address – Owner / Entity (Street or P.O. Box) _____ City _____ State _____ Zip Code _____

Name and Title – Contact Person _____ Telephone No. _____ Email Address _____

SIGNATURE – Owner (or Authorized Representative) _____ Date Signed _____

If signature is provided by an authorized representative, provide name and title: Name – Authorized Representative _____ Title – Authorized Representative _____