Adult Family Home Application
RE-CERTIFICATION

Document Description	Managed Care Organization		Provider
	Not required during this review	Required during this review	Included
PROVIDER APPLICATION – PROVIDER INFORMATION	☐	☐	☐
HOME SAFETY- FIRE EXTINGUISHER TAGS/ FIRE EVACUATION PLAN / WELL WATER SAFETY	☐	☐	☐
AGENCY LICENSE, CERTIFICATE	☐	☐	☐
IRS FORM W-9 REQUEST FOR TAXPAYER IDENTIFICATION NUMBER AND CERTIFICATION	☐	☐	☐
CERTIFICATE OF INSURANCE	☐	☐	☐
TRAINING DOCUMENTATION AND PROCEDURES	☐	☐	☐
CAREGIVER BACKGROUND CHECKS/ DISCLOSURE **Within ten (10) days organization** will submit a **Staff Roster** of names, titles and dates of hire. Upon receipt of the staff roster, MCW will review and select 5-20 names including principals and owners. **A complete background check will consist of:** 1. Background Information Disclosure (BID) form DCF-82604. 2. Wisconsin Department of Justice (DOJ) Crime Information Bureau (CIB) response. 3. Department of Health Services (DHS) "Response to Caregiver Background Check" letter. 4. Driver's License Abstract *[Transportation Providers only].* Background check(s) must meet the standards set forth in the State of Wisconsin Caregiver Law, ss.50.065 and ss.146.40 Wis. Stats. and HFS 12 and HFS 13, Wis. Admin. Code *State of Wisconsin Caregiver Program.* Website: https://recordcheck.doj.wi.gov/	☐	☐	☐
MEDICAL EXAM/TB SKIN TEST	☐	☐	☐
PROVIDER CONFLICT OF INTEREST AND ACKNOWLEDGEMENT	☐	☐	☐

Adult Family Home Application Form
Re-Certification

Completion of this application form meets the requirements established by Wisconsin Medicaid Standards for Certified 1-2 Bed Adult Family Homes Articles. The standards are promulgated under the authority of ss. 46.031 and 46.036, Stats., which give the department authority to establish standards for the operation of one and two bed adult family homes. The personal information provided below may be used for secondary purposes [Privacy Law, s. 1504 (1) (m)]. The specification of a Social Security Number (SSN) is voluntary. If the SSN is not provided, it may cause delays in the processing of information.

COMPLETE APPLICATION IN FULL AND PROVIDE TO MY CHOICE WISCONSIN AFH CERTIFIER WITH COPIES OF ALL ITEMS LISTED IN RED AT THE TIME OF THEIR SITE INSPECTION. Any applicable recertification fee payable to My Choice Wisconsin must accompany this application. Please contact My Choice Wisconsin Provider Quality at 414-287-7600 with any questions.

Application Date_____ Date MCO Received_____

OPERATOR OF ADULT FAMILY HOME

**** Copies of /Medical Exam/TB Skin Test/ Background Disclosure Forms REQUIRED****

Name – First, Middle Initial, Last	**Social Security Number**	**Date of Birth**
Alias (List all known Alias or former names)		
Operator Home Address	**City / State**	**Zip Code**
Telephone Number	**Fax Number**	**Email**
Facility Name		
Facility Address	**City / State**	**Zip Code**
Facility Telephone Number	**Facility Fax Number**	
Operator Marital Status ☐Single ☐Married _____ ☐Widowed _____ ☐Divorced_____ Date Date Date		

ADDITIONAL OPERATOR OF ADULT FAMILY HOME

Name – First, Middle Initial, Last	**Social Security Number**	**Date of Birth**
Alias (List all known Alias or former names)		
Operator Home Address	**City / State**	**Zip Code**
Telephone Number	**Fax Number**	**Email**

EDUCATION	
Education- Operator 1	**Highest level completed** **____Elementary ___Highschool ___Tech/College ____Graduate / Doctorate**
Education – Operator 2	**Highest level completed** **____ Elementary ___ Highschool ___Tech/College ____Graduate / Doctorate**
Military Service – Operator 1 **___Yes ___No _____ Choose not to disclose**	**If yes, please provide date of service and discharge type** **Date of Service _____** **Discharge Type_____**
Military Service – Operator 1 **___Yes ___No _____ Choose not to disclose**	**If yes, please provide branch and discharge type** **Date of Service _____** **Discharge Type_____**
EMPLOYMENT- OPERATOR 1 List most recent full and part-time work including self-employment, seasonal, commissioned and child-care.	
Operator 1- Employer Name / Address / Telephone:	**Operator 1- Job Title / Date of Employment**
Operator 1- Work Schedule (Work-days and hours per day) **Monday_____ Tuesday _____ Wednesday_____ Thursday _____** **Friday _____ Saturday _____ Sunday _____**	
EMPLOYMENT- OPERATOR 2 List most recent full and part-time work including self-employment, seasonal, commissioned and child-care.	
Operator 1- Employer Name / Address / Telephone:	**Operator 1- Job Title / Date of Employment**
Operator 2- Work Schedule (Work-days and hours per day) **Monday_____ Tuesday _____ Wednesday_____ Thursday _____** **Friday _____ Saturday _____ Sunday _____**	

NON-RESIDENT INFORMATION OF PERSON(S) LIVING / FREQUENT VISITOR OR OVERNIGHT GUEST IN THE ADULT FAMILY HOME

Name – First, Middle Initial, Last	**Date of Birth**	**Social Security Number**	**Relationship to Provider**
Name – First, Middle Initial, Last	**Date of Birth**	**Social Security Number**	**Relationship to Provider**
Name – First, Middle Initial, Last	**Date of Birth**	**Social Security Number**	**Relationship to Provider**

STAFF WHO ARE ASSISTING YOU AT YOUR ADULT FAMILY HOME

**** Copies of /Medical Exam/TB Skin Test/ Background Disclosure Forms REQUIRED for Operator; Nonresidents living in the home and staff unless AFH is instructed otherwise. Background Disclosure Forms required for onsite inspection at all site visits.***

Name – First, Middle Initial, Last	**Date of Birth**	**Social Security Number**	**Circle one of the following:** Employee / Helper / Volunteer / Other
Alias (List all known Alias or former names)			
Name – First, Middle Initial, Last	**Date of Birth**	**Social Security Number**	**Circle one of the following:** Employee / Helper / Volunteer / Other
Alias (List all known Alias or former names)			
Name – First, Middle Initial, Last	**Date of Birth**	**Social Security Number**	**Circle one of the following:** Employee / Helper / Volunteer / Other
Alias (List all known Alias or former names)			
Name – First, Middle Initial, Last	**Date of Birth**	**Social Security Number**	**Circle one of the following:** Employee / Helper / Volunteer / Other
Alias (List all known Alias or former names)			
Name – First, Middle Initial, Last	**Date of Birth**	**Social Security Number**	**Circle one of the following:** Employee / Helper / Volunteer / Other
Alias (List all known Alias or former names)			

PLEASE ANSWER THE FOLLOWING QUESTIONS

1. Are there conceal carry weapons in the home? Yes _____ No _____

   If Yes, where are the weapons stored when not on the permit holder? _____

2. Are visitors allowed to bring conceal carry weapons into the home? Yes _____ No _____

   If **No**, do you have a notice posted prohibiting weapons on the property? Yes _____ No _____

3. The Adult Family Home where you provide care is: Owned by you _____ Rented by you _____

4. Do you or anyone else smoke in your home? ___Yes ___ No
   (In the State of Wisconsin, smoking is not allowed in 1-2 bed Adult Family Homes)

4. Is the Adult Family Home your primary residence? Yes _____ No _____

5. Type of Home? Ranch _____ Duplex _____ Townhouse _____ Apartment _____

   Other (please specify) _____

6. Total resident capacity: One bed _____ Two bed _____

7. Care provided for: All Female _____ All Male _____ Both _____
   Age Preference
   18-25_____ 26-65_____ 66-80_____ 80+_____ No Preference_____

8. Primary resident group(s) you will serve: (Please circle)

   ◯ AA – Advanced aged
   ◯ ALZ – Dementia / Alzheimer's
   ◯ DD – Developmental disabled
   ◯ MH–Emotionally disturbed / mental illness
   ◯ ADA – Alcohol / drugs
   ◯ PD-Physically disabled
   ◯ CC – Correctional clients
   ◯ TI- Terminally ill
   ◯ Hearing or Sight impaired
   ◯ TBI-Traumatic brain injury

9. Is the Adult Family Home handicap accessible with ramps: Yes _____ No _____

   How many ramps? _____

10. Please describe any special adaptations in the home (e.g. grab bars, roll-in shower, etc.)

    _____

    _____

11. Do you have pets in the home or frequent pet visitors? Yes _____ No _____

    If **Yes,** are there Dogs: Yes____ No____ Cats: Yes____ No____ or Ferrets: Yes____ No____
    Other_____

    If Yes to any of the above, I have attached a copy of current vaccination records.

Initial Here _____

12. I am required to have **FIRE EXTINGUSHERS (2A, 10B-C rating)** to be inspected every year by an authorized dealer or local fire department and **I have attached a copy of my current receipt or copy of tag(s) as proof of my Fire Extinguisher(s) inspection.** Initial Here _____

13. My Extinguishers are mounted near the kitchen, basement, and stairwell(s): Yes _____ No _____

14. **I have attached the required copy of my Adult Family Home Fire Evacuation Plan.**
Initial Here _____

15. I understand that **SMOKE DECTECTORS** are required to be tested monthly and documented tests must be kept in a Log which will be inspected. Initial Here _____

16. My Smoke Detectors are located near the kitchen, on the ceilings of living/family/dining rooms, basement, stairwell(s), and hallway between bedrooms: Yes _____ No _____

17. I understand that **FIRE DRILLS** are required to be done two times per year and documented in a Log which will be inspected. Initial Here _____

18. I understand that a working **CARBON MONOXIDE DETECTOR** is required on each floor level of my home. Initial Here _____

19. I understand that **PROPER VENTILATION** is required.
All shared/common rooms and each bedroom in my home has at least one window that is capable of being opened available for ventilation. Initial Here _____

20. I understand I must keep documentation of monthly smoke detector tests, bi-annual fire evacuation drills, and fire extinguisher inspection tags and they will be inspected. The emergency evacuation plan is posted and include a meeting location outside. Initial Here _____

21. I understand that I am required to have a current Program Statement (sample attached) which will be inspected. Initial Here _____

22. If my home is not on a municipal water supply, **I have attached well water testing results related to Coliform and Nitrate / E. coli, dated within previous year.**

Initial Here _____

PRIMARY CAREGIVER INFORMATION

23. Please describe your experience and training working with disabled, mental ill, or elderly residents.

_____

_____

_____

24. As the primary caregiver, I will do annual reviews and make any updates to my resident(s) Adult Family Home Service Plan with the Interdisciplinary Team (IDT). Initial Here _____

25. Are you currently employed outside of the home? Yes _____ No _____

If Yes, Name and address of employer: _____

Employer phone number: _____

Job Title: _____

What plans do you have for the supervision of resident(s) in your care while you are working?

_____

26. Are you currently certified / licensed by a regulatory agency? (CNA, Foster Care, RN, etc.)

Yes _____ No _____

If Yes, Type of license/certification: _____

Name of regulatory agency: _____

Effective date: _____

27. Financial Information: SPC 202.04 states: The sponsor may be requested to present evidence of having or having access to sufficient financial reserves to meet the needs of all residents and of all members of the household for whom the sponsor is financially responsible and to ensure the adequate functioning of the home for a period of at least 30 days without receiving payment for the care of any resident.

Annual Gross Household Income _____

Are your income taxes up-to-date? ___ Yes ___ No
Are your real estate taxes up-to-date? ___ Yes ___ No

____Yes ____ No I have enough cash reserves to ensure the adequate functioning of the home and to meet the needs of the residents and all household members for whom I am financially responsible, for a period of at least 30 days without receiving payment for the care of the resident.

28. Have you ever been revoked or denied a certification or license? (Foster Care, Daycare, Registered Nurse, CNA, etc.) Yes _____ No _____

If Yes, Type of license/certification: _____

Name, address and phone number of agency: _____

_____

Reason for denial or revocation: _____

If reinstated, please provide the date: _____

29. I understand that I must maintain a “Background Information Disclosure”, dated within the previous 4 years, filled out by every person living or working as staff in the household over the age of 12 (not including any My Choice Wisconsin members) which will be inspected. Initial Here _____

30. I understand, as the primary caregiver, that if I assist my resident(s) in taking prescription medication, I am required to have a completed **Caregiver Authorization to Administer Medication Form signed by the resident(s) physician.** Initial Here _____

This form is dated: _____

31. I understand that I must maintain "Medication Records" for members with prescription medication controlled or administered by the AFH operator. (See Standards, Article IX, Requirements for Resident Supports and Services, G, Prescription Medications, for all required content) which will be inspected. Initial Here _____

32. I understand that I must maintain "Monthly Medication Logs" and these are **not** required only if the member handles **ALL** aspects of the medications which will be inspected. Initial Here _____

33. I understand as caregivers, that my substitute(s) and I are required to complete 10 HOURS OF APPROVED TRAINING that is related to the health, safety, welfare, rights and treatment of my resident(s). **I have ATTACHED verification of my substitute(s) and my completed training hours.** Initial Here _____

34. I transport residents. Yes _____ No _____

35. List your Driver's License number and State where license was issued for all staff with driving responsibility:

_____

36. **I have attached proof of all applicable insurance and indemnification policies** (See your provider contract with My Choice Wisconsin for coverage requirements) Initial Here _____

37. **I have attached proof Department of the Treasury Internal Revenue Service form W9** Initial Here _____

38. I understand that I must maintain an "Agreement for Services" signed by Provider, Resident (or Guardian) and Care Manager that is less than one year old **(blank is enclosed)** which will be inspected. Initial Here _____

39. I understand that I must maintain a "Resident Rights Form" signed by Provider, Resident (or Guardian) and Care Manager that is less than one year old **(blank is enclosed)** which will be inspected. Initial Here _____

40. I understand that I must maintain Member's current Individualized Service Plan (I will call the member's Care Manager if I don't have a copy) which will be inspected. Initial Here _____

41. **RELEASE OF INFORMATION**

I hereby give permission to Care Wisconsin Inc. to contact the references provided and in addition to obtain any medical, psychiatric, financial, criminal, and employment information needed to process this application. Care Wisconsin is free to verify any information on the application form and contact other agencies such as Department of Health and Social Services, Human Services Departments and 51.42 Agencies.

In completing this application, we (I) understand there is no guarantee by Care Wisconsin that an adult will be placed in our (my) home. We (I) also understand that Care Wisconsin is free to consult persons or agencies named herein. The information contained in this questionnaire is true and correct to the best of our (my) knowledge.

Operator 1: _____
(Signature) (Date)

Operator 2: _____
(Signature) (Date)

42. **CONFLICT OF INTEREST STATEMENT**
AFH's operator must disclose if an operator, sponsor, guardian, employee, or the immediate family member of an employee, presents a conflict of interest barred by law. If a conflict not barred by law exists, consistent with the requirements in Articles VII.B., the sponsor will work with the certification agency to minimize the impact of the conflict.

Check all that apply

A. ☐ By my signature below, I affirm neither I, nor any immediate family members presents a conflict of interest barred by law.

B. ☐ By my signature below, I affirm that any and all conflicts of interests are reported to the placing agency, care management, affected residents and their guardians.

I have ATTACHED a copy of the Conflict of Interest Disclosure form

Operator 1: _____
(Signature) (Date)

Operator 2: _____
(Signature) (Date)

43. **ACKNOWLEDGEMENT**
I understand and acknowledge that My Choice Wisconsin is authorized to request any information that is appropriate and necessary for the proper administration of the Adult Family Home certification program. I authorize the release of information to any person, including employers, the District Attorney, law enforcement agencies, governmental agencies, or other persons and organizations.

I certify that all of the information I have listed in this application is truthful, accurate and correct to the best of my knowledge and that knowingly providing false information or omitting information may result in a fine (Chapter 946.32, Wis.Stats).

Signature: _____

Date signed: _____