My Choice Family Care
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 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.

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**
Address	**City / State**	**Zip Code**
Telephone Number	**Fax Number**	**Email**
Facility Name		
Facility Address	**City / State**	**Zip Code**
Facility Telephone Number	**Facility Fax Number**	

NON-RESIDENT INFORMATION OF PERSON(S) LIVING 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 at initial certification 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
Name – First, Middle Initial, Last	**Date of Birth**	**Social Security Number**	**Circle one of the following:** Employee / Helper / Volunteer / Other
Name – First, Middle Initial, Last	**Date of Birth**	**Social Security Number**	**Circle one of the following:** Employee / Helper / Volunteer / Other
Name – First, Middle Initial, Last	**Date of Birth**	**Social Security Number**	**Circle one of the following:** Employee / Helper / Volunteer / Other
Name – First, Middle Initial, Last	**Date of Birth**	**Social Security Number**	**Circle one of the following:** Employee / Helper / Volunteer / Other

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. 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 _____

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? Yes _____ No _____

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

If Yes to any of the above, I have attached a copy of current record of rabies vaccination.
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, 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. 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: _____

28. 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 _____

29. 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: _____

30. 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 _____

31. 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 _____

32. I understand as caregivers, that my substitute(s) and I are required to complete 8 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 _____

33. I transport residents. Yes _____ No _____

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

_____

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

36. 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 _____

37. 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 _____

38. 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 _____

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: _____