Adult Family Home Certification Application
Community Care Home

Please print neatly and fill out each section using N/A if not applicable

Identifying Information

Provider/Business Name:		Name of AFH:
Business Mailing Address:		AFH Physical Address & County:
Business Phone:	Business Fax:	AFH Phone:
Business Contact Name: Phone: Email:		AFH Contact Name & Phone and/or Email:
Location to mail certification related notices (renewal notice, certificate) **Check one:** ☐Business ☐AFH		

Does GPS find your home? ☐ Yes ☐No Color of Home: Outside covering: ☐Siding ☐Brick
Located on what side of the road-check one: ☐North ☐South ☐East ☐West
Directions to Home:

Facility

Does your home have a Behavioral Safe Room or other special features? ☐ Yes ☐ No		
If Yes, please explain:		
Location Description ☐City ☐Rural ☐Farm	Nearest Town:	How is water supplied to your home? ☐Public Water Supply ☐Private Well (Testing Required)
Type of House: ☐ 1 story ☐ 2 story ☐ w/basement ☐ Other: ☐ Apartment: ☐ first floor ☐ second floor ☐ Mobile Home		
How many rooms in the home? (include bed, bath and laundry rooms)	Is your home wheelchair accessible? ☐Yes ☐No	

Number of Bedrooms			Number of Bathrooms		
First Floor	Second Floor	Other	First Floor	Second Floor	Other
Describe any other special adaptations in your home (ramps, etc.)					

Are there pets in the home? ☐Yes ☐No	Do you allow members to have pets in the home? ☐Yes ☐No	Type of Pet	Expiration Date of Vaccination
		1.	
		2.	
		3.	

Please provide the following information for any individuals 18 years of age or older who live in the facility and are not a member/resident.

Last Name, First, MI	Relationship to Applicant	D.O.B

Preferences

Do you want to be certified for one or two adults? ☐One ☐Two	Would you prefer to work with adults who are: ☐Male ☐Female ☐No Preference
What age group would you prefer to work with? ☐18-25 ☐25-65 ☐65 & older ☐No preference	What populations would you prefer to provide care for? ☐Developmentally Disabled ☐Physically Disabled ☐Elderly ☐Mental Illness Specialty:

Insurance Liability Insurance

1. Vehicle. Applicants who transport members in their vehicles shall have a valid driver's license and shall provide Inclusa with documentation of minimum liability insurance coverage of $1 Million. Inclusa expects that providers will follow proper protocol to ensure that all drivers have gone through a driver's license check and that adequate insurance coverage is in place.
2. General Liability. Applicants shall provide Inclusa with documentation of sufficient minimum facility liability insurance coverage of $1 Million + $1 Million umbrella.
3. Professional. Applicants shall provide Inclusa with documentation of sufficient minimum professional liability insurance coverage of $ 1 Million to ensure protection.

PLEASE PROVIDE A DECLARATION PAGE OF YOUR INSURANCE POLICIES

Experience

1. Do you operate any other residential facilities that serve adults? ☐Yes ☐No
   If yes, please identify the licensing or certifying agency and type of license or certificate, **copy required**:
   ____
2. Have you ever been denied licensure or certification of any kind to provide care or services to persons or, has such a licensure or certification ever been revoked or suspended? ☐Yes ☐No
   If yes, please identify the licensing or certifying agency and type of license or certificate:
   ____
3. Does staff in this home have or will receive any specialized training? Please explain:________________________________
   ____
4. Will staff hold any licensure? Please explain:
   ____
   ____

Financial

The sponsor may be requested to present evidence of 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.
Please check all other sources of income that could be utilized:

☐Savings ☐Line of Credit ☐Loan ☐Purchase Contract ☐Other Assets

Training

While Inclusa recognizes that most agencies follow a higher standard for their 1-2 bed Adult Family Homes, Inclusa expects that at a minimum, facilities meet the Wisconsin Medicaid Standards for Certified 1-2 bed Adult Family Homes.

If this is your first Adult Family Home, please provide references:

Name:		Relationship:	
Address:	City:	State:	Zip Code:
Phone:	Email:		
Name:		Relationship:	
Address:	City:	State:	Zip Code:
Phone:	Email:		
Name:		Relationship:	
Address:	City:	State:	Zip Code:
Phone:	Email:		

The Applicant is responsible for notifying Inclusa in writing, of any changes in the information provided in the application.

I understand there is no guarantee by the certifying agency that a member will be placed in my home.

The certifying agency is free to verify any information on the application form and to contact other agencies such as the Department of Health and Family Services, Human Services Departments and 51.42 Agencies.

I understand that the information disclosed will be used for the sole purpose of investigating my application for my Adult Family Home certification.

The information contained in this application is true, correct and complete to the best of my knowledge.

Applicant or Designee: ____ ______________________________
Signature Date

Further, I attest that I have read and will comply with all applicable requirements as stated in the Wisconsin Medicaid Standards for Certified 1-2 Bed Adult Family homes. http://www.dhs.wisconsin.gov/publications/P0/P00638.pdf

Applicant or Designee: ____ ______________________________
Signature Date

Send your completed Adult Family Home Certification Application to:

Submission Options:

Email: shelli.rogge@inclusa.org
Fax: (715) 514-3147
Mail: Shelli Rogge
Inclusa
3203 Stein Blvd., Suite 1
Eau Claire, WI 54701