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| **DEPARTMENT OF HEALTH SERVICES**  Division of Quality Assurance  F-03267 (01/2024) | | | | | | **STATE OF WISCONSIN**  Adult Day Care Center Certification  Page 1 of 16 | | | | | | | | |
| **ADULT DAY CARE CENTER (ADCC)**  **CERTIFICATION APPLICATION** | | | | | | | | | | | | | | |
| Completion of this form is required by Wis. Stat. § 49.45(47)(b) and Wis. Admin. Code § DHS 105.14(2)(a). Adult day care centers (ADCC) serving publicly funded clients must meet state certification requirements in order to receive funds for the cost of care for these participants. Failure to complete this form completely and accurately may result in a delay in processing and/or denial of certification.  Send the completed form with the items listed in Step 2 below to: **Division of Quality Assurance**  **BHS Licensing and Certification Section**  **PO Box 2969**  **Madison, WI 53701-2969**  If you have questions regarding the completion of this form, call **608-266-7297** or email [DHSDQALCCS@dhs.wisconsin.gov](mailto:DHSDQALCCS@dhs.wisconsin.gov). | | | | | | | | | | | | | | |
| **APPLICATION PROCESS**  **Step 1 Background Check** —Background checks are conducted by the Office of Caregiver Quality.  **Step 2** **Complete Application** — A fully completed application is received and reviewed by the department. Incomplete applications will be returned to the applicant without processing.  **Step 3** **Initial Visit** — An initial visit is completed by department staff to determine compliance with all regulatory requirements for program certification, including the federal Home and Community-Based Services (HCBS) settings rule.   |  |  |  |  | | --- | --- | --- | --- | | **STEP 1 – BACKGROUND CHECK** | | | | | **DO NOT SUBMIT BACKGROUND MATERIALS WITH THIS CERTIFICATION APPLICATION.**  Submit DHS forms F-82064, Background Information Disclosure (BID), and F-82069, BID Appendix, with required fees to the Office of Caregiver Quality. Refer to [www.dhs.wisconsin.gov/caregiver/entity-cbc.htm](http://www.dhs.wisconsin.gov/caregiver/entity-cbc.htm). Background checks are completed by the Office of Caregiver Quality for the operator and all non-client household members age 10 and older. (Wis. Stat. § 50.065(2)(am))  To facilitate the coordination of information between the Office of Caregiver Quality and licensing associates, provide the name(s) of all persons whose background checks were submitted for this application. (Attach an additional list if necessary.) | | | | | Name |  | Name |  | | | | | | | | | | | | | | | |
| **STEP 2 – COMPLETE APPLICATION** | | | | | | | | | | | | | | |
| The following items must be included with this completed and signed application form. | | | | | | | | | | | | | | |
|  | 1. | Non-refundable certification fee of $127.00 | | | | | | | | | | | | |
|  | 2. | Program description (Wis. Admin. Code § DHS 105.14(2)(b)1.a-k), (intended to be provided to each caregiver and any other person upon request). The program description needs to contain all of the following: | | | | | | | | | | | | |
|  | 2.1 Operator name [Wis. Admin. Code § DHS 105.14(2)(b)1.a.] | | | | | | | | | | | | |
|  | 2.2 Program director name [Wis. Admin. Code § DHS 105.14(2)(b)1.a.] | | | | | | | | | | | | |
|  | 2.3 Program capacity DHS [Wis. Admin. Code § DHS 105.14(2)(b)1.b.]. This capacity needs to reflect the qualifying square footage under Wis. Admin. Code § DHS 105.14(8)(a)2, as discussed above | | | | | | | | | | | | |
|  | 2.4 Program goals and description [Wis. Admin. Code § DHS 105.14(2)(b)1.c.] | | | | | | | | | | | | |
|  | 2.5 Hours of Operation [Wis. Admin. Code § DHS 105.14(2)(b)1.d.] | | | | | | | | | | | | |
|  | 2.6 Program Limitations [Wis. Admin. Code § DHS 105.14(2)(b)1.e.] | | | | | | | | | | | | |
|  | 2.7 Fee schedule [Wis. Admin. Code § DHS 105.14(2)(b)1.f.] | | | | | | | | | | | | |
|  | 2.8 Procedure for informing of changes [Wis. Admin. Code § DHS 105.14(2)(b)1.g.] | | | | | | | | | | | | |
|  | 2.9 Procedures for incident reporting [Wis. Admin. Code § DHS 105.14(2)(b)1.h.] | | | | | | | | | | | | |
|  | 2.10 Participant group and explanation (if more than one group) [Wis. Admin. Code § DHS 105.14(2)(b)1.i.] | | | | | | | | | | | | |
|  | 2.11 Grievance procedure [Wis. Admin. Code § DHS 105.14(2)(b)1.j.] | | | | | | | | | | | | |
|  | 2.12 Criteria for involuntary discharge [Wis. Admin. Code § DHS 105.14(2)(b)1.k.] | | | | | | | | | | | | |
|  | 3. | Evidence that the Program Director has either an associate degree or higher from an accredited college in a health care related field OR at least 2 years' experience working in a health care related field which served a population similar to the participant group of the ADCC [Wis. Admin. Code § DHS 105.14(3)(b)] | | | | | | | | | | | | |
|  | 4. | DQA form F-26274A, Model Balance Sheet, [Wis. Admin. Code § DHS 105.14(2)(a)2.e] | | | | | | | | | | | | |
|  | 5. | Evidence of financial ability to operate for 60 days [Wis. Admin. Code § DHS 105.14(2)(a)2.f] | | | | | | | | | | | | |
|  | 6. | Proof of transportation liability insurance, if applicable [Wis. Admin. Code § DHS 105.14(2)(a)2.g] | | | | | | | | | | | | |
|  | 7. | Well water test results, if applicable [Wis. Admin. Code § DHS 105.14(8)(b)2] | | | | | | | | | | | | |
|  | 8. | Fire inspection report [Wis. Admin. Code § DHS 105.14(9)(b)] | | | | | | | | | | | | |
|  | 9. | Facility: “A clearly labeled floorplan showing all measurements, and clearly labeled areas that qualify as participant square footage under Wis. Admin. Code § 105.14(8)(a)2, which requires 50 sq. ft. per participant, ‘not including passageways, bathrooms, lockers, office, storage areas, staff room, furnace rooms, and parts of rooms occupied by stationary equipment.’” | | | | | | | | | | | | |
|  | 10. | Pet Vaccination Records, if applicable [Wis. Admin. Code § DHS 105.14(8)(a)(8)] | | | | | | | | | | | | |
|  | 11. | Program evaluation plan [Wis. Admin. Code § DHS 105.14(2)(a)2.i] | | | | | | | | | | | | |
| **General Information** | | | | | | | | | | | | | | |
| Name — Program | | | | | | | | | | | | | | |
| Street Address — Program | | | | | City | | | State | | Zip Code | | | County | |
| Phone — Program | | | Fax — Program | | | | Email — Program | | | | | | | |
| Name — Program Director | | | | | | | | | | | Date of Birth — Program Director | | | |
| **Designated Mail Recipient** | | | | | | | | | | | | | | |
| **The individual named below will be the main point of contact for all communication from the bureau, including certification renewal.** | | | | | | | | | | | | | | |
| Name — Designated Mail Recipient | | | | Title | | | | | Email | | | | | |
| Mailing Address — Street or PO Box | | | | | | | City | | | | | State | | Zip Code |
| **Program Information** | | | | | | | | | | | | | | |
| The ADCC is located in: | | | | | | | | | | | | | | |
| Private Family Home  Multi-Use Facility (Nursing home, community based residential facility, residential care apartment complex or  pre-vocational program)  Other — Please describe: | | | | | | | | | | | | | | |

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| **Owner/Operator/Certificate Holder Information** | | | | | | | | | | | | | | | | | |
| Name — Corporation/Legal Entity (if applicable) | | | | | | | | | | | FEIN (Federal Employer Identification No.) | | | | | | |
| Name — Certificate Holder or Corporate Representative | | | | | | | | | | | Date of Birth — Certificate Holder or Corporate Rep. | | | | | | |
| Address — Certificate Holder/Corporate Representative | | | | | | | | | City | | | | | | State | | Zip Code |
| Phone | | | | Fax | | | | | Email | | | | | | | | |
| Provide the name(s) of any other facilities associated with this certificate holder or corporate entity. Attach an additional list if needed. | | | | | | | | | | | | | | | | | |
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| **Participant Information** | | | | | | | | | | | | | | | | | |
| **Total Number of ADCC Participants Served:** | | | | | | |  | | | | | | | | | | |
| Check only the box(es) indicating the **primary** participant group(s) you will serve. | | | | | | | | | | | | | | | | | |
| AA — Advanced Age  DD — Developmentally Disabled (Intellectually Impaired)  PD — Physically Disabled | | | | | | | | | | ALZ — Irreversible Dementia/Alzheimer’s  MH — Emotionally Disturbed/Mental Illness  TBI — Traumatic Brain Injury | | | | | | | |
| Will you accept public funding?  Yes  No | | | | | | | | | | | | | | | | | |
| **FIT AND QUALIFIED (Required by Wis. Stat. § 50.03(3)(b) and Wis. Admin Code § DHS 105.14(2)(c)(1-4))** | | | | | | | | | | | | | | | | | |
| **Ownership** | | | | | | | | | | | | | | | | | |
| Provide the following information, if applicable:   * List all names, principal business addresses, and the percentage and type of ownership interest of all persons or business entities having any ownership interest in the facility, whether direct or indirect, and whether the interest is in the profits, land or building, including owners of any business that owns any part of the land or building. * If a partnership, list each partner. * If a corporation, list each officer and director of the corporation. * If any person or business entity named is a bank, credit union, savings and loan association, investment association, or insurance corporation, it is sufficient to name the entity involved without providing information regarding the officers and directors of the entity. | | | | | | | | | | | | | | | | | |
| 1. The **certificate holder** owns the: *(Check all that apply)*  Operations  Building  Land | | | | | | | | | | | | | | | | | |
| 1. **Certificate Holder** Type *(Check* ***one.*** *Do not check “Government – State” unless facility will be owned and operated by a state agency.)* | | | | | | | | | | | | | | | | | |
| Church  Corporation For-Profit  Corporation Non-Profit | | | | | | Government – County  Government – State  Government – Other  Tribal | | | | | | | Limited Liability Corporation (LLC)  Partnership  Proprietorship (individual) | | | | |
|  | | | | | |  | | | | | | | Other – *Specify:* | | | | |
| 1. List the interested parties relative to the entity named as **certificate holder** *[Wis. Stat. § 50.03(3)].* Attach additional pages, if needed. | | | | | | | | | | | | | | | | | |
| a. | | Name — Interested Party | | | | | | Title | | | | | | Percentage of Financial Interest | | | |
|  | | Address – Street/PO Box | | | | | | City | | | | | | State | | Zip Code | |
| b. | | Name — Interested Party | | | | | | Title | | | | | | Percentage of Financial Interest | | | |
|  | | Address — Street/PO Box | | | | | | City | | | | | | State | | Zip Code | |
| **Creditors** | | | | | | | | | | | | | | | | | |
| 1. List the names, principal business addresses, phone numbers, and type and extent of obligation, in dollars, for all creditors holding a security interest in the premises, whether the land or building. Include any mortgage, note, deed of trust, or other obligation secured in whole or in part by the land on which, or building in which, the facility is located. Attach additional pages, if necessary. | | | | | | | | | | | | | | | | | |
| a. | | Name — Individual, Partnership, Corporation, Etc. | | | | | | | | | | | | | | | |
|  | | Address — Street/PO Box | | | | | | City | | | | | | State | | Zip Code | |
|  | | Phone No. | | | Type of Obligation | | | | | | | Extent of Obligation | | | | | |
| b. | | Name — Individual, Partnership, Corporation, Etc. | | | | | | | | | | | | | | | |
|  | | Address — Street/PO Box | | | | | | City | | | | | | State | | Zip Code | |
|  | | Phone No. | | | Type of Obligation | | | | | | | Extent of Obligation | | | | | |
| 1. List the names, principal business addresses, phone numbers, and type and extent of agreement, in dollars, for all persons and business entities holding any lease or sublease for the land where the building is located. Attach additional pages, if necessary. | | | | | | | | | | | | | | | | | |
| a. | | Name — Individual, Partnership, Corporation, Etc. | | | | | | | | | | | | | | | |
|  | | Address — Street/PO Box | | | | | | City | | | | | | State | | Zip Code | |
|  | | Phone No. | | | Type of Obligation | | | | | | | Extent of Obligation | | | | | |
| b. | | Name — Individual, Partnership, Corporation, Etc. | | | | | | | | | | | | | | | |
|  | | Address — Street/PO Box | | | | | | City | | | | | | State | | Zip Code | |
|  | | Phone No. | | | Type of Obligation | | | | | | | Extent of Obligation | | | | | |
| **Fit and Qualified** | | | | | | | | | | | | | | | | | |
| The following information will be used to determine if the applicant meets the fit and qualified requirements under Wis. Stat. ch. 50 and Wis. Admin. Code chs. DHS 83, DHS 88 and DHS 105.14, as applicable. | | | | | | | | | | | | | | | | | |
| 1. Have you ever applied for licensure or certification for a residential facility, health care facility, or a day care program for adults or children and been denied licensure or certification? [Wis. Admin. Code § DHS 105.14(2)(c)2] | | | | | | | | | | | | | | | | | |
|  | Yes  No | | *If “yes,” explain and provide relevant information.* | | | | | | | | | | | | | | |
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| 2. Have you ever operated a residential facility, health care facility, or a day care program for adults or children in Wisconsin or in any other state? [Wis. Admin. Code § DHS 105.14(2)(c)2] | | | | | | | | | | | | | | | | | |
|  | Yes  No | | *If “yes,” provide the name, address, and phone number of the facility/program.* | | | | | | | | | | | | | | |
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| 3. | Was the facility/program licensed, certified, or otherwise regulated by any government or private agency? [Wis. Admin. Code § DHS 105.14(2)(c)2] | | | | | | | | | | | | | | | | |
|  | Yes  No | | *If “yes,” provide the name, address, and phone number of the agency.* | | | | | | | | | | | | | | |
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| 4. | Have you ever had any license, certification, or governmental approval to operate a facility/program revoked, suspended, or not renewed in Wisconsin or any other state? [Wis. Admin. Code § DHS 105.14(2)(c)2] | | | | | | | | | | | | | | | | |
|  | Yes  No | | *If “yes,” specify the type of license, certification, or approval affected; in which state the action occurred; which agency took the enforcement action; and the name, address, phone number, and type of facility/program that was affected.* | | | | | | | | | | | | | | |
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| 5. | Has the applicant ever been arrested or convicted for a crime involving abuse, neglect, or mistreatment of a person or misappropriation of property of a person? [Wis. Admin. Code § DHS 105.14(2)(c)3.a] | | | | | | | | | | | | | | | | |
|  | Yes  No | | *If “yes,” please explain and provide relevant information.* | | | | | | | | | | | | | | |
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| 6. | Has the applicant ever been arrested or convicted for a crime subject to elder abuse reporting under Wis. Stat. § 46.90? [Wis. Admin. Code § DHS 105.14(2)(c)3.b] | | | | | | | | | | | | | | | | |
|  | Yes  No | | *If “yes,” please explain and provide relevant information.* | | | | | | | | | | | | | | |
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| 7. | Has the applicant ever been arrested or convicted for a crime related to the manufacture, distribution, use, or dispending of a controlled substance? [Wis. Admin. Code § DHS 105.14(2)(c)3.c] | | | | | | | | | | | | | | | | |
|  | Yes  No | | *If “yes,” please explain and provide relevant information.* | | | | | | | | | | | | | | |
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| 8. | Has the applicant ever been arrested or convicted of fraud or substantial or repeated violations of applicable laws and rules in the operation of any health care center or in the care of dependent persons? [Wis. Admin. Code § DHS 105.14(2)(c)3.d] | | | | | | | | | | | | | | | | |
|  | Yes  No | | *If “yes,” please explain and provide relevant information.* | | | | | | | | | | | | | | |
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| 9. | Has the applicant ever been arrested or convicted for a charge which substantially relates to the care of adults or minors, to the funds or property of adults or minors, or to the operation of a residential or health care center? [Wis. Admin. Code § DHS 105.14(2)(c)3.e] | | | | | | | | | | | | | | | | |
|  | Yes  No | | *If “yes,” please explain and provide relevant information.* | | | | | | | | | | | | | | |
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| **Financial Information** | | | | | | | | | | | | | | | | | |

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| 1. Has the licensee ever been adjudicated bankrupt? | | |
|  | Yes  No | *If “yes,” provide full details on a separate page, including dates, court, and the disposition of each matter.* |
| 1. Are there any unsatisfied judgments against the licensee? | | |
|  | Yes  No | *If “yes,” list all judgments on a separate page, listing names and addresses of creditors, amounts, and reasons for non-payment.* |
| 1. Does the licensee owe any debts that are 90 days or more past due? | | |
|  | Yes  No | *If “yes,” list all debts 90 days past due on a separate page, listing the names and addresses of creditors, amounts, and reasons for non-payment.* |
| 1. Are any liens filed against the licensee or the licensee’s property? | | |
|  | Yes  No | *If “yes,” indicate on a separate page who filed the lien(s), where filed, when filed, and amount of lien.* |

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|  | Evidence of 60 Days Projected Operating Funds in Reserve  Check all sources of funds or income that apply. Provide documentation supporting proof of funds. | |
|  | Savings or Other Financial Reserve  Line of Credit  Loan  Outside Employment | |
|  | Other - *Specify:* |
|  | **I attest to having a minimum of 60 days operating funds for each additional licensed facility under this legal entity.** | |
| **ATTESTATIONS OF COMPLIANCE WITH Wis. Admin Code § DHS 105.14** | | |
| Prior or to a surveyor coming to the adult day care center to inspect the building, applicant must ensure that each item identified below is in compliance with Wisconsin Admin. Code § DHS 105.14.  **Disclaimer:** The statements in this form paraphrase the Adult Day Care Center Certification regulatory requirements. This list should not be considered all-inclusive. The applicant is responsible for knowing and meeting all regulations.  By checking the boxes below, the applicant is attesting that this ADCC program is in substantial compliance and ready for an initial review of regulatory compliance. | | |

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| **Compliance Status** |
| *Check each statement below when compliance is met.* |

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|  | 1. The premises and furnishings are clean, comfortable, and in good repair. *[Wis. Admin. Code § DHS 105.14(8)(a)7.]* | |
|  | 1. Toilet rooms and fixtures function properly and are maintained in a sanitary and odor-free condition.  *[Wis. Admin. Code § DHS 105.14(8)(a)6.]* | |
|  | 1. The center has a phone on the premises, which is immediately accessible during hours of operation.  *[Wis. Admin. Code § DHS 105.14(8)(a)4.]* | |
|  | 1. Stairs, walks, and ramps are maintained in a safe condition. *[Wis. Admin. Code § DHS 105.14(8)(d)]* | |
|  | 1. Pets *(Check* ***only one*** *of the two following boxes.)*   I will not have any pets at the facility.  ***OR***  An animal will be on the premises that is tolerant of participants and staff and vaccinated against diseases including rabies, if indicated. *[Wis. Admin. Code § DHS 105.14(8)(a)8.]* | |
|  | 1. The temperature of all water heaters connected to sinks, showers and tubs used by participants is set to at least 140 degrees F. The temperature of hot water at plumbing fixtures used by participants does not exceed the range of 110 to 115 degrees F. *[Wis. Admin. Code § DHS 105.14(8)(b)3.]* | |
|  | 1. The ADCC has a written plan for responding to fires, tornadoes, missing participants, injuries, and staff absenteeism. The evacuation plan is posted. *[Wis. Admin. Code § DHS 105.14(9)(a)]* | |
|  | 1. There is at least one 2A, 10-B-C fire extinguisher per 1,500 sq. ft. of space. *[Wis. Admin. Code § DHS 105.14(9)(b)2.]* | |
|  | 1. If only one fire extinguisher is necessary in the building, it is to be located near the cooking area. *[Wis. Admin. Code § DHS 105.14(9)(b)2.]* | |
|  | 1. Each fire extinguisher has been inspected by a qualified person within the past year and bears a label indicating its condition and date of the last inspection. *[Wis. Admin. Code § DHS 105.14(9)(b)3.]* | |
|  | 1. The ADCC has working smoke detectors in each activity room and hallway which will be tested monthly, unless the fire department has indicated otherwise in writing. A copy of that document has been submitted with this compliance form. *[Wis. Admin. Code § DHS 105.14(9)(b)4.]* | |
|  | 1. The ADCC is designed in such a way that it is accessible and functional in meeting the identified needs of the participant group it serves. *[Wis. Admin. Code § DHS 105.14(8)(a)3.]* | |
|  | 1. The ADCC program provides at least 50 sq. ft. of usable floor space for each participant exclusive of passageways, bathrooms, lockers, office, storage areas, staff room, furnace rooms, and parts of rooms occupied by stationary equipment. *[Wis. Admin. Code § DHS 105.14(8)(a)2.]* | |
|  | 1. The ADCC has provided sufficient furniture and equipment for use by participants that provides comfort and safety and is appropriate for the participant group it serves. *[Wis. Admin. Code § DHS 105.14(8)(c)1.]* | |
|  | 1. Heat is maintained at no less than 70° F. *[Wis. Admin. Code § DHS 105.14(8)(a)5.]* | |
|  | 1. The ADCC has obtained department approval for delayed egress locks. *[Wis. Admin. Code § DHS 105.14(8)(e)]*   Applicable  Not applicable | |
|  | 1. The ADCC has a written policy for medication management. The caregiver administering medications shall be 18 years of age or older. Medication administration by routes to include: injectable, nebulizers, stomal and enteral medications, and medications, treatments or preparations delivered vaginally or rectally shall be administered by a registered nurse or by a licensed practical nurse within the scope of their license, or may be delegated to a non−licensed caregiver pursuant to s. N 6.03 (3). *[Wis. Admin. Code § DHS 105.14(7)(d)].* | |
| **ADCC Located in a Multi-Use Facility** (e.g., Nursing Home, Community-Based Residential Facility (CBRF), Residential Care Apartment Complex (RCAC), or pre-vocational program) | | |
|  | 1. Not applicable — the ADCC is not located in a multi-use facility.   ***OR***  Applicable — the ADCC is located in a multi-use facility. **If this section of the rule applies, the ADCC meets ALL the following requirements:** *[Wis. Admin. Code § DHS 105.14(10)(a)]* | |
|  | 1. ***Exterior*.**  a. Access to the ADCC shall be distinct and have separate entrance and exit doors so each participant and staff are not walking through the living or program areas of others. A multi-use facility may have a shared lobby leading to a distinct entrance door for the ADCC.  b. The ADCC shall have a separate door to the outside so each participant and staff are not walking through the living or program areas of others. | |
|  | 2. ***Interior.***  a. The ADCC shall be separate from living areas, shall be in addition to space required for other programs, and shall meet the requirements of Wis. Admin. Code*§ DHS 105.14(8)(a)2.*  b. Spaces designated for program activities, dining, toileting, exercise and ambulation are distinctly part of the adult day care area and limited to use by an ADCC participant. An ADCC participant may be provided personal care or therapy in space also used by residents or attendees of a multi-use facility provided that the ADCC services are scheduled at different times from any other occupants. | |
|  | 3. ***Staffing*.**  The ADCC shall have distinct and separate caregivers. No caregiver may be concurrently assigned to the ADCC and another program. All staff assigned to the ADCC shall meet requirements for orientation and training under Wis. Admin. Code *§ DHS 105.14(4).* | |
|  | 4. ***Activities*.** The ADCC activity program shall be programmatically distinct from the weekly or monthly calendar of activities planned for residents or attendees of a multi-use facility, but may include special events provided on a non-routine basis. | |
| **ADCC Located in a Private Family Home** | | |
|  | | 19.Not applicable — the ADCC is not located in a private family home.  ***OR***  Applicable — the ADCC is located in a private family home.  If ADCC participants and other occupants are intermixed in a private family home and the common dining and living space is available to ADCC participants and other occupants, the common dining and living space shall be determined by the total capacity of the building as described in Wis. Admin. Code§ DHS 105.14(8)(a)2. |
| **HOME AND COMMUNITY BASED SERVICE (HCBS) REVIEW BENCHMARK CHECKLIST** | | |

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| **The Home and Community-Based Services (HCBS) settings rule was published in 2014 by the Centers for Medicare & Medicaid Services (CMS). The federal requirements define the qualities of settings eligible for reimbursement for Medicaid home and community-based services. Under the requirements, DHS must ensure that settings in which HCBS are provided meet and remain in compliance with the settings rule requirements Additional information can be found at:** [**https://www.dhs.wisconsin.gov/hcbs/nonresidential.htm**](https://www.dhs.wisconsin.gov/hcbs/nonresidential.htm)**. You may also want to review the Adult Day Care Center HCBS Reviewer Guidelines, F-03124B.** |

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| **HCBS Benchmark** | **Documented Evidence or Interview** | **Meets Benchmark** |
| **1A**. Setting has at least two of the following at or near the setting:   * Sidewalks * Pedestrian roads * Signage * Curb cuts and * Accessible ramps (or equivalent)   If not, setting has a plan in place and implements the plan to access the broader community. |  | Yes  No, Explain: |
| **1B**. Setting has access to a variety of community-based activities that provide a measure of psycho-social value to individuals. Examples of where such activities can take place may include, but are not limited to:   * Parks * Schools and/or colleges/universities * Library * Community center * Job center * Restaurants * Stores   If not, setting has a plan in place and implements the plan to access the broader community. |  | Yes  No, Explain: |
| **2A.** Setting provides daily interaction with people from the broader community who do not receive HCBS services and are not paid to provide support. |  | Yes  No, Explain: |
| **2B.** People receiving HCBS have opportunities for individualized or small group activities in and outside the setting with people without disabilities in addition to congregate activities. |  | Yes  No, Explain: |
| **3A.** People may choose to receive their medical treatments in the same places as other without disabilities and are not mandated to use services that may be provided by the setting. |  | Yes  No, Explain: |
| **4A.** Setting provides people the same degree of access to the community as people not receiving HCBS, including staff and volunteers. |  | Yes  No, Explain: |
| **5A.** Setting offers opportunities to experience activities that promote new learning related to areas of interest identified by person. |  | Yes  No, Explain: |
| **5B.** Setting allows people receiving HCBS to request time off for any reason including illness. |  | Yes  No, Explain: |
| **6A.** Settings does not have rules to restrict freedom of movement inside or outside the setting that can be considered different than people not receiving HCBS. Any restrictions must be documented in the individual’s person-centered assessment, plan, and behavior support plan. |  | Yes  No, Explain: |
| **7A.** The setting provides or supports access to accessible public transportation to and from facility to the broader community. If public transportation is not available, the setting provides and posts information, in a convenient location, about resources to access the broader community. |  | Yes  No, Explain: |
| **7B.** The setting provides transportation for individuals receiving HCBS to the broader community when requested, within reason, or provides and posts information, in a convenient location, about transportation options to individuals if setting does not provide transportation. |  | Yes  No, Explain: |
| **8A.** Setting provides tasks and activities both inside and outside the setting that are comparable to tasks and activities for people of similar ages who do not receive HCBS. |  | Yes  No, Explain: |
| **8B.** Individuals are able to decline to participate in activities. |  | Yes  No, Explain: |
| **9A.** Setting provides:   * A secure place for people to store their personal belongings * Opportunity for people to choose where they keep their monetary resources in the same ways as people not receiving HCBS, **and** * Decision making opportunities for spending one’s own money onsite or in the community.   This may include provision of vending machines, a cafeteria, access to restaurants and/or shopping opportunities. |  | Yes  No, Explain: |
| **10A.** Setting adapts activities and schedules to the person’s needs and preferences upon request. This includes:   * Offering both community-based and facility-based options at various times throughout the day to allow flexibility for people receiving HCBS to choose where their services take place. * Using adaptive aids and technology to assist in activity participation, **and**   Other accommodations to meet the individual’s needs within the scope of the setting’s responsibilities. |  | Yes  No, Explain: |
| **11A.** Setting has practices, procedures, and policies to ensure:   * All information about individuals receiving waiver funded HCBS services is kept private and confidential * Individuals have privacy when receiving assistance with personal cares; **and** * Staff receive training on confidentiality upon hire and annually thereafter. |  | Yes  No, Explain: |
| **12A.** Setting ensures staff remain discreet and respectful at all times, including:   * Addressing individuals in the manner in which they would like to be addressed * Using a person’s preferred name, nickname or title * Not talking about a person receiving HCBS in the presence of others and * Not discussing individuals as if he/ she were not present |  | Yes  No, Explain: |
| **13A**. Settings using restraints or restrictive measures must:   * Have a policy that matches state restrictive measures policies * Use them in accordance with Wisconsin policies * Use them only as approved by DHS and if not approved, does not use **and** * Report emergency use of restrictive measures to the waiver agency as an incident.   Settings that do not use restraints or restrictive measures are exempt from meeting this benchmark. |  | Yes  No, Explain: |
| **14A.** Setting has practices and policies in place to ensure that staff respond to people’s needs and preferences, as identified in their person-centered assessment and plan, in a timely manner. |  | Yes  No, Explain: |
| **15A.** Setting ensures person-centered behavior support plans are implemented in such a way as to not impede the rights of other individuals or restrict others from setting activities. |  | Yes  No, Explain: |
| **16A.** Setting ensures that people who receive HCBS make meaningful choices in their daily activities, which align with their personal goals, interests, and needs.  Meaningful choices may be made in a variety of ways including:   * Person-centered assessments, * Formal interviews or * Informal discussion with person, **and** * Consideration of input from legal decision maker or others as identified by the individual. |  | Yes  No, Explain: |
| **17A.** Setting offers a variety of places in the physical environment to meet an individual’s goals and needs. Activities cannot take place in the same room, but rather in a variety of at least two distinct areas, with at least one allowing for privacy. Options include:   * Indoor or outdoor gathering spaces, * Large or small group activity areas, * Private space **or** * Quiet areas |  | Yes  No, Explain: |
| **18A**. Setting offers:   * An array of comparable tasks and activities * The flexibility to adjust as needed * Comparable assessment tools **and** * Communication approaches for people of similar age, skills, and abilities |  | Yes  No, Explain: |
| **19A.** Setting provides and posts information about:   * Individual rights * How to make a request for additional services, accommodations, or changes to their person-centered, setting-specific assessment and plan. * Competitive Integrated Employment.   <https://dwd.wisconsin.gov/dwd/publications/dvr/pdf/dvr-19024-p.pdf> |  | Yes  No, Explain: |
| **20A.** Setting is accessible per the Americans with Disabilities Act (ADA). If ADA allows exceptions, setting must have a reasonable accommodations policy. |  | Yes  No, Explain: |
| **21A.** Setting ensures that people who receive HCBS have access to a dignified, age-appropriate dining experience. This includes:   * A meal setting where people can move about, talk to others and be comfortable. * A dignified approach to assistance with pace, food sequence and refusal of food items when setting assists people to eat. * Use of appropriate clothing protection, if needed. * Allowing consumption of snacks and meals for people receiving HCBS like others in a similar setting. And * Opportunities for private dining if requested. |  | Yes  No, Explain: |
| **21B.** Settings must arrange for or provide meals, including alternative choices, if requested. |  | Yes  No, Explain: |
| **22A.** The setting will:   * Not restrict social interactions or set time limits on who people can talk to and spend time with in or outside the setting. * Allow people to spend as much of their free time as they like with whomever they choose. |  | Yes  No, Explain: |
| **23A.** Setting provides informed choice opportunities for people receiving HCBS to practice decision making and to be as autonomous as possible. |  | Yes  No, Explain: |
| **24A.** Setting allows flexibility for people receiving HCBS to choose with which staff they would like to work, within reason, that doesn't negatively impact the quality of services being provided to others in the setting. |  | Yes  No, Explain: |
| **25A.** Setting offers people opportunities to:   * Make their own schedules **and** * Update and change their daily schedules upon request and at the person’s six- month review.   Setting must document these choices and options for each person. |  | Yes  No, Explain: |
| **26A.** Setting has documented policies, procedures, and practices to ensure the person receiving HCBS is supported and involved in developing person-centered, setting-specific assessments and plans to support their needs and preferences |  | Yes  No, Explain: |
| **27A.** Setting has policies, procedures, and practices in place to ensure that staff is trained upon hire and annually in:   * Person-centered assessment and planning strategies * Individual and human rights, including how to support people to assert their rights and file grievances * Working with the target population * Using individualized communication styles **and** utilization of assistive technology |  | Yes  No, Explain: |
| **28A.** The setting allows prospective participants the opportunity to tour the setting. |  | Yes  No, Explain: |
| **Heightened Scrutiny Criteria** | | |
| Is the setting:   * In a publicly or privately owned facility providing inpatient care (such as a skilled nursing facility)? * On the grounds of, or adjacent to, a public institution? * Isolated from the broader community?   Definitions found at: <https://www.dhs.wisconsin.gov/hcbs/heightened-scrutiny.htm> |  | No  Yes, Explain: |

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| **Attestation** | | |
| The signatory of this document is duly authorized by the applicant/certificate holder to sign this agreement on its behalf. The applicant/certificate holder hereby accepts responsibility for knowing and ensuring compliance with all certification and operational requirements for this program. | | |
| **I attest, under penalty of law, that the information provided above is truthful and accurate to the best of my knowledge.**  **I understand that knowingly providing false information or omitting information may result in denial of licensure, a fine of up to $10,000, or imprisonment not to exceed six years or both (Wis. Stat. § 946.32).** | | |
| **SIGNATURE** (In full) — Applicant or Designee (must be owner or board member) | | Date Signed |
| **Name — Applicant or Designee (Print or type.)** | Title — Applicant or Designee (must be owner or board member) | |