Owner-Occupied AFH Application

Checklist

The items below must be completed *prior to submission* and included with this application to be considered. If all items are not received at time of application, this application will not be accepted.

- ☐ Owner-Occupied Adult Family Home Application
- ☐ Attestation Form (**Word** or **PDF** format)
- ☐ Wisconsin Medicaid Approval Letter(s) for each service/location
- ☐ **W-9 Form**
- ☐ Copy of any applicable Certifications and/or Licenses
- ☐ Certificate of Liability Insurance (COI)
  - Homeowner's Insurance (either policy declaration or COI)
  - Auto Insurance (either policy declaration or COI)
  - General and Professional Liability ($500,000/$1,000,000 limits)
  - Worker's Compensation & Employer's Liability (if applicable per state requirements)

  Please contact your insurance agent to obtain a 'Certificate of Insurance' form naming Community Care, Inc. as a certificate holder (1801 Dolphin Drive, Waukesha, WI 53186)
- ☐ Program Statement - required for all licensed/certified providers
- ☐ Residential Summary Form - required for all residential facilities (**Word** or **PDF** format)

Return your application with ALL REQUIRED documentation to:

Email (preferred method):
ContractInquiries@communitycareinc.org

Mail to:
Community Care, Inc.
Provider Management Department
1801 Dolphin Drive
Waukesha, WI 53186

Fax to:
(262) 446-6707

For questions please contact our Provider Hotline at 866-937-2783, option 2

COMMUNITY CARE, INC.
OWNER-OCCUPIED ADULT FAMILY HOME APPLICATION

(To be completed by owner-occupied Adult Family Homes only)

I. PROVIDER CONTACT INFORMATION – *Please Type or Print*

Provider Name: _____

Adult Family Home Address:

Street: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Mailing Address (cannot be a P.O. Box) **Same as Address Above** ☐

Street: _____

City: _____ State: _____ Zip:

Phone: _____ Fax: _____

Tax Id: _____ NPI # _____

Medicaid #: _____ Medicare # _____

Contact Name: _____ Title: _____

Contact E-Mail: _____ Phone: _____

Contract Signer: _____

Signer's Title _____

Website: _____

II. GENERAL INFORMATION

OWNERSHIP INFORMATION

☐ The organization is minority-owned.
☐ The organization is woman-owned.
☐ The organization is disabled veteran-owned.
☐ The organization is a small business.

OWNERSHIP RACE/ETHNICITY (*Optional-If information is provided, it will be included in our Provider Directory*)

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Hispanic or Latino
☐ Middle Eastern or North African
☐ Native Hawaiian or Pacific Islander
☐ White
☐ Prefer not to answer

Do you currently have or have you previously had a contract with CCI?
☐ Yes ☐ No Please explain: _____

Do you have an affiliation with another Legal Entity currently contracted with CCI?
☐ Yes ☐ No What is the affiliation: _____

Target Group(s): *Please select the population(s) you serve*

Physically Disabled (PD)	☐	Frail Elderly (FE)	☐
Intellectually/Developmentally Disabled (IDD)	☐	All (PD, IDD, FE)	☐

Do you wish to be published in Community Care's public provider directory? ☐ Yes ☐ No

III. SPECIALIZED EXPERTISE OFFERED

Please check below any specialized expertise or unique services offered.

	Advanced Aged		Correctional Clients		Vent Care
	Intellectually/Developmentally Disabled		Irreversible Dementia/Alzheimer's		Wound Care
	Physically Disabled		Traumatic Brain Injury		Memory Care
	Alcohol/Drug Dependent		Bariatric – 500 lbs. or more		Bathing Services
	Emotionally Disturbed/Mental Illness		Bariatric – under 500 lbs.		Diabetic Expertise
	Terminally Ill		RN on staff		

IV. LENGTH OF TIME AS AN ADULT FAMILY HOME

Please indicate the length of time your home has been providing adult family home services.

_____ **Years** _____ **Months**

V. CULTURAL COMPETENCIES

Please indicate the cultural composition of your organization by checking all that apply:

Does your agency perform Cultural Competency Training? ☐ Yes ☐ No

Has your agency implemented National Standards for Culturally and Linguistically Appropriate Services (CLAS)? https://thinkculturalhealth.hhs.gov/clas ☐ Yes ☐ No

VI. CLIENT DATA AND RECORDKEEPING

Is the adult family home location HIPAA compliant? ☐ Yes ☐ No
If no, please explain:

VII. ADULT FAMILY HOME INFORMATION

Please select the appropriate Residential Service provided at your Adult Family Home by placing a check mark next to the corresponding service.

Residential Services: Licensed Adult Family Home ☐ Number of Licensed Beds:
Residential Services: Certified Adult Family Home ☐ Number of Certified Beds:

Does your home have private or shared bedrooms? ☐ Private ☐ Shared ☐ Both

If you are a certified 1-2 bed adult family home, have you submitted Background Information Disclosure (BID) forms to your certifying agency for all persons over 18 living in your home and for all your substitute caregivers? ☐ Yes ☐ No

Does owner/operator have any criminal charges pending against them or were they ever convicted of any crime anywhere, including in federal, state, local, military and tribal courts? ☐ Yes ☐ No
If yes, please explain: _____

Did you receive approval on all background checks submitted? ☐ Yes ☐ No

VIII. ADULT FAMILY HOME ACCESSIBILITY AND AVAILABILITY

Does your home have wheelchair accessible entrance(s) to grade? ☐ Yes ☐ No
If yes, how many ramped entrances on home: One ☐ Two ☐

Does your home have handicapped accessible bathrooms (meaning bathroom space to accommodate person in wheelchair) ☐ Yes ☐ No If yes, How many: _____

Does your home have a roll-in shower? ☐ Yes ☐ No

Is Sign Language used in the home? ☐ Yes ☐ No

Does anyone smoke in the home? ☐ Yes ☐ No

Are members allowed to smoke? ☐ Yes ☐ No If yes, where (inside, outside, etc.)? _____

Does your home have any pets? ☐ Yes ☐ No If yes, please list type and number of pets: _____

IX. CONTRACTING REQUIREMENT

All providers must check the following box stating that they have read & understand the following statement.

Community Care Inc. will not contract directly with a program member's relative for the purpose of providing care to the member. *("Relative" means a spouse, parent, step-parent, child, step-child, sibling, grandchild, grandparent, aunt, uncle, niece or nephew, including in-laws)*

☐ I have read and understand.

X. INELIGIBLE ORGANIZATIONS

The MCO shall exclude from participation all organizations which could be included in any of the following categories (references to the Act in this section refer to the Social Security Act):

1. **Ineligibility**
   Entities which could be excluded under Section 1128(b)(8) of the Social Security Act are entities in which a person who is an officer, director, agent or managing employee of the entity, or a person who has a direct or indirect ownership or control interest of 5% or more in the entity, or a person with beneficial ownership or control interest of 5% or more in the entity has:

   a. Been convicted of the following crimes:

      i. Program related crimes, i.e., any criminal offense related to the delivery of an item or service under Medicare or Medicaid (see Section 1128(a)(1) of the Act);
      ii. Patient abuse, i.e., criminal offense relating to abuse or neglect of patients in connection with the delivery of health care (see Section 1128(a)(2) of the Act);
      iii. Fraud, i.e., a State or Federal crime involving fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct in connection with the delivery of health care or involving an act or omission in a program operated by or financed in whole or part by Federal, State or local government (see Section 1128(b)(1) of the Act);
      iv. Obstruction of an investigation, i.e., conviction under State or Federal law of interference or obstruction of any investigation into any criminal offense described directly above (see Section 1128(b)(2) of the Act); or,
      v. Offenses relating to controlled substances, i.e., conviction of a State of Federal crime relating to the manufacture, distribution, prescription or dispensing of a controlled substance (see Section 1128(b)(3) of the Act).

   b. Been Excluded from Participation in Medicare or a State Health Care Program. A State health care program means a Medicaid program or any State program receiving funds under title V or title XX of the Act. (See Section 1128(b)(8)(iii) of the Act).

   c. Been Assessed a Civil Monetary Penalty under Section 1128A of the Act. Civil monetary penalties can be imposed on individual providers, as well as on provider organizations, agencies, or other entities by the DHS Office of Inspector General. Section 11238A authorizes their use in case of false or fraudulent submittal of claims for payment, and certain other violations of payment practice standards. (See Section 1128(b)(8)(B)(ii) of the Act).

FINANCIAL INFORMATION

According to § 131 of the IRS tax code, certain foster care payments are not taxable as income. The purpose of this form is to assist Community Care, Inc. in determining whether this is the case. If it appears that you qualify, you have the option of requesting that a 1099, or equivalent form, not be prepared at year end by Community Care, Inc. for you. However, you are responsible for determining whether payments made to you are taxable or not, and paying the taxes on that income if it is taxable. Community Care, Inc. will not be held responsible for any taxes, interest or penalties on income paid to you.

Please answer all of the questions noted below or the form will be returned to you. If you do not complete this form or if Community Care does not receive this form, you may be issued a 1099 at year-end. Even if you are issued a 1099 form, it is up to you and your tax advisor to determine if the amount needs to be claimed as taxable income.

Social Security Number: _____ Tax ID (if applicable) _____

1. Are you operating your Adult Family Home as a: (Check One)
   - ☐ NON-TAXABLE Cost Reimbursement Model (1099 Form will NOT be issued)
   - ☐ TAXABLE Business Model (1099 Form WILL be issued)
2. Are you subject to back-up withholding?
   - ☐ Yes
   - ☐ No
3. How your business is organized:
   - ☐ Individual/Sole Proprietor
   - ☐ Corporation
   - ☐ Partnership
   - ☐ Other, please specify: _____
4. Is the Adult Family Home also your primary home?
   - ☐ Yes
   - ☐ No
5. Number of adult clients, please specify number: _____
6. Does your home currently provide Respite Care? ☐ Yes ☐ No
7. If **NO**, are you interested in providing Respite Care? ☐ Yes ☐ No
8. All payments for Respite Care are taxable and Community Care will send you 1099 Form if you decide to provide respite to our members. ☐ I have read and understand.

I have read and understand the information on this sheet. To the best of my knowledge, the answers that I have provided above are true and correct. I understand that I, solely, am responsible for determining the taxability and reporting of income. Community Care, Inc. will not be held responsible for any taxes, interest or penalties on income paid to me.

Print Name: _____

Signature: _____

Date: _____

- Electronic signature is considered valid only when document is submitted by e-mail from the signer's email address.
- If mailing or faxing application, signature must be handwritten.

COMMUNITY CARE, INC.
PROVIDER ASSURANCES AND CERTIFICATIONS

I _____ agree that all information included in this application is true and correct and that the provider understands and agrees to the application information and requirements. Provider further acknowledges that the information in this application is subject to periodic verification without notice and that any misrepresentation on this form may result in disqualification from receiving public (CMO) funds and legal action or fiscal sanctions may be taken as determined appropriate by Community Care, Inc. or its designated representative(s). Provider understands that completion of provider application does not guarantee network admission and/or subsequent contract with the CMO.

I _____ constitute as the Provider to allow authorized representatives of Community Care, Inc. funding sources to have access to all records necessary to confirm the provision of services by the Provider. Failure on the part of the Provider to comply with program requirements or not have sufficient documentation to verify provision of the services billed may result in withholding or forfeiture of any payments. At a minimum, the Providers must have client records that include: names and address, the type and dates of service provided, the number of units of service provided, and documentation that service was provided.

*The applicant certifies to the best of its knowledge and belief, that it is not an **"Ineligible Organization"** as defined in section X. of this application. The applicant further certifies to the best of its knowledge and belief, that it and its principals: (1) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or agency; (2) have not within a three-year period preceding this application been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property; (3) are not presently indicted for or otherwise criminally charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in (2) of this certification; and , (4) have not within a three-year period preceding this application had one or more public transactions (Federal, State or local) terminated for cause or default*

_____ _____

Authorized Signature and Title Date

_____

Name of Business

- Electronic signature is considered valid only when document is submitted by e-mail from the signer's email address.
- If mailing or faxing application, signature must be handwritten.