Owner-Occupied AFH Application

Checklist

Please ensure you have completed all items on this checklist prior to submission.

All required items (on the application checklist below) must be submitted with this application to be considered. If all required items are not submitted at time of application, this application will be denied.

- ☐ **Owner-Occupied Adult Family Home Application**
- ☐ **Residential Summary Form**
- ☐ **Residential Program Statement**
- ☐ **Attestation Form**
- ☐ **W-9 Form**
- ☐ **Electronic Funds Transfer Form with a Voided Check**
- ☐ **Copy of Certification and/or License**
- ☐ **Copy of Certificate of Insurance**
  - **Homeowner's Insurance**
  - **Auto Insurance**
  - **General and Professional Liability Insurance (500,000/1,000,000)**
  - **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. (1801 Dolphin Drive, Waukesha, WI 53186) as the certificate holder.

COMMUNITY CARE, INC.

OWNER-OCCUPIED ADULT FAMILY HOME APPLICATION

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

I. Provider Contact Information

Provider Name: _____

E-Mail Address: _____

Adult Family Home Address

Street: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

Mailing Address - if different from above

Street: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

II. Services Offered

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

PROVIDER TYPE	
Residential Services: Licensed Adult Family Home	☐
Residential Services: Certified Adult Family Home	☐

Please attach a copy of the license or certification to the application.

III. Specialized Expertise Offered

Please check below any specialized expertise or unique services offered by your agency.

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

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. Client Data and Recordkeeping

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

_____

_____

_____

VI. General Information

Please indicate if you would like to have your home listed in Community Care's Public Provider Directory: ☐ YES ☐ NO

Does your agency perform Cultural Competency Training? ☐ YES ☐ NO

VII. Adult Family Home Information

Number of Certified/Licensed Beds: _____

Which Target Group(s) does your home serve? Please Check:
☐ **DD** (Developmentally Disabled) ☐ **PD** (Physically Disabled) ☐ **FE** (Frail Elderly)

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

List any fluent languages spoken (other than English): _____

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

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.

**Signature: _____

Print Name: _____

Date: _____

****Electronic signature is considered valid only when document is submitted by e-mail from the signer's e-mail 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.*

_____ _____

**Signature and Title Date

_____

Name of Agency (Service Provider)

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

RETURN YOUR APPLICATION WITH ALL REQUIRED DOCUMENTATION TO:

Email:

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