1555 North RiverCenter Drive
Suite 206
Milwaukee, Wisconsin 53212

Main: 414-223-4847
Toll-free: 1-800-777-4376
www.iCareHealthPlan.org

INDEPENDENT CARE HEALTH PLAN

FIT AND QUALIFIED CERTIFICATION REQUEST OF 1-2 BED AFH

Name – Facility	**Name – Sponsor/Operator**	
Street Address		
City	**State**	**Zip Code**

- Completion of this form is required.
- Failure to complete this form completely and accurately may result in certification denial and/or delay in processing.
- Email or Fax this completed form with the items listed below to: NetDev@iCareHealthPlan.org or 414-272-5618.
- If you have questions regarding the completion of this form, please contact the Network Development Contract Specialist that you are assigned.

- **THE FOLLOWING ITEMS MUST BE SUBMITTED WITH THE APPLICATION FORM:**
  - Model Balance Sheet, or equivalent.
  - Copy of lease with acknowledgement of business operation, if applicable.

I . OWNERSHIP

1. The sponsor/operator owns the Building: ☐ Yes ☐ No

2. W-9 Type (check **one**)
   - ☐ Individual/Sole proprietor or single-member LLC
   - ☐ C Corporation
   - ☐ S Corporation
   - ☐ Partnership
   - ☐ Trust/estate
   - ☐ Limited liability company
   - ☐ Other – ***Specify*:**

3. If someone other than the sponsor/operator has ownership in the building, complete questions 4, 5 & 6 below in section I. If not, move to II. CREDITORS/1.

4. Owner of Building: Name –

   Address –

   City, State, Zip -

5. Owner Type (check **one**. Do not Check "Government – State" unless facility will be owned and operated by a State Agency.)

- ☐ Church
- ☐ Government – County
- ☐ Government – State
- ☐ Tribal
- ☐ Other – ***Specify:***

6. Copy of Lease with acknowledgement of business operation. ☐ Yes ☐ No

II. CREDITORS

1. List the names, principal business addresses, telephone numbers, and type and extent of obligation, in dollars, for all Creditors hold a security interest in the premises, whether the land or building. Include any Mortgage, Note, Deed or 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**
Telephone number	**Type of Obligation**	**Extent of Obligation**	

b.

Name – Individual, Partnership, Corporation, etc.			
Address – Street/PO Box	**City**	**State**	**Zip Code**
Telephone number	**Type of Obligation**	**Extent of Obligation**	

III. FIT AND QUALIFIED

The following information will be used to determine if the applicant meets the Fit and Qualified requirements under Wisconsin Medicaid Standards for Certified 1-2 Bed Adult Family Homes (AFH).

1. Do you presently have or intend to apply for another type of license, certification, or registration at this location?
   ☐ Current ☐ Future ☐ No *If "Current" or "Future," check below all that apply.*

   License or Certification Type

   - ☐ Adult family home (3-4 Bed)
   - ☐ Community-based residential facility
   - ☐ Other – ***Specify:***

IV. FINANCIAL INFORMATION

1. Has the sponsor/operator ever been adjudicated bankrupt? ☐ Yes ☐ No
   If "Yes," provide full details on a separate page, including dates, court, and the disposition of each matter.

2. Are there any unsatisfied judgments against the sponsor/operator? ☐ Yes ☐ No
If 'Yes" list all judgements on a separate page, listing names and addresses of creditors, amounts, and reasons for non-payment.

3. Does the sponsor/operator 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.

4. Are any liens filed against the sponsor/operator or the sponsor/operator's property? ☐ Yes ☐ No
If "Yes," indicate on a separate page who filed the lien(s), where filed, when filed, and amount of lien.

5. Operating Expenses – Complete the "Model Balance Sheet," or equivalent and return a copy with this form.

6. Evidence of 30-Days Projected Operating Funds in Reserve.

Total Monthly Expenses	$
Total Value of Monthly Public Contracts	$
TOTAL Operating Funds Needed in Reserve	$ 0

Submit copies of financial documents from other sources of funds or income that may be used to continue the operation of the facility for 30-days based on the above value. If using income from another individual, provide proof of income with certified documentation from the individual indicating permission to use in operating this facility.

NOTE: Child support may **not** be used as income to operate a facility.

Check all sources of funds or income that apply

- ☐ Savings or Other Financial Reserve
- ☐ Line of Credit
- ☐ Loan
- ☐ Outside Employment
- ☐ Other – ***Specify**:*

I attest to having a minimum of 30-days operating funds for each individual facility under this legal entity. Has available sufficient financial reserves to operate the home and meet the needs of all residents and household members for whom the sponsor is financially responsible for a period of at least 30-days.

☐ Yes ☐ No

7. Balance Sheet
   a. Calculate "current ratio" as a measure of financial strength based on values from your balance sheet. A generally acceptable ratio is 2: 1. The minimum acceptable ratio is 1: 1
   Your Current Ratio (Total Current Assets + Total Current Liabilities = Current Ratio): _____
   b. **Submit Model Balance Sheet or DQA form F-62674A, *Assisted Living Model Balance Sheet*.**

THE SPONSOR/OPERATOR IS RESPONSIBLE FOR NOTIFYING iCARE, IN WRITING, OF ANY CHANGES IN THE INFORMATION PROVIDED ON THIS APPLICATION.

SIGNATURE (in full) – Sponsor/Operator or Designee	**Date Signed**

Name – Sponsor/Operator or Designee (Print or Type)	**Title/Position**

By typing/signing your name above, you acknowledge that the information supplied in this form is true and accurate to the best of your knowledge.