KENOSHA COUNTY DEPARTMENT OF HUMAN SERVICES
Division Of Aging, Disability & Behavioral Health Services
Residential Services Application

This application information is provided by the Kenosha County Department of Human Services (KCDHS), Division of Aging, Disability & Behavioral Health Services (DADBHS), for non-competitive applications from organizations that are interested in providing Residential Services as listed below. Applying does not guarantee placements, contracts, nor a specific level of funding.

RESIDENTIAL SERVICES

Community Based Residential Facility (CBRF)

Adult Family Home (AFH)

Residential Care Apartment Complex (RCAC)

The Division will administer any contracts resulting from this application. **Completed applications must include all required information described within or as requested by KCDHS DADBHS.**

POINT OF CONTACT	Jeni Parkinson, Behavioral Health Manager: jeni.parkinson@kenoshacounty.org / (262)605-6686
MAIL/DELIVER TO:	Division of Aging, Disability & Behavioral Health Services ATTN: Residential Services Application 8600 Sheridan Road, Suite 500 Kenosha, WI 53143-6507
EMAIL SUBMISSION TO:	jeni.parkinson@kenoshacounty.org

Kenosha County Department of Human Services
Mission Statement

Encompassing the following Divisions:

- Aging, Disability & Behavioral Health Services
- Brookside Care Center
- Children & Family Services
- Public Health
- Veterans
- Workforce Development

To develop, coordinate, and administer a comprehensive network of services to children, youth, families, the elderly, and individuals striving to cope with developmental disabilities, mental illness, and alcohol and drug problems; to preserve and strengthen families, while protecting children from high-risk or abusive situations; to empower individuals and families to become law-abiding and economically self-sufficient; to assure the delivery of public health services necessary to prevent disease; to protect, promote, and preserve a healthy citizenry and environment; to advise and assist military veterans; to provide high quality nursing home services to the elderly and medically disabled; to advocate on behalf of these constituencies on the local, state, and national level.

Kenosha County Human Services websites:
http://www.kenoshacounty.org/index.aspx?nid=151
https://www.kenoshacounty.org/151/Doing-Business-w-DHS

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I GENERAL REQUIREMENTS

A. It is the intent of Kenosha County Department of Human Services, (KCDHS) to execute a one-year contract if a contract results from this application. Contract renewals are determined solely by Kenosha County subject to applicable requirements and department authorizations, and are contingent on availability of funds, satisfactory contract performance, and negotiation of renewal rates.

B. Any rates submitted in applications are subject to approval by KCDHS, Division of Aging, Disability & Behavioral Health Services (DADBHS), and are contingent upon final KCDHS budget approvals.

C. Approval of providers will be based on information submitted in vendor's application, including any references and any oral interviews or site visits as applicable. Failure to respond to all elements of the program specifications and requirements may result in disqualification.

D. Applications should be typed & organized, and clearly, completely & concisely written.

E. KCDHS reserves the right to request additional documentation or information if necessary to adequately review applications.

F. KCDHS does not reimburse costs incurred in application preparation.

G. KCDHS allows for a maximum of 10% administrative cost (10% of total program costs, i.e., net of profit & administrative cost).

H. KCDHS reserves the right to negotiate changes in both reporting and billing requirements.

I. KCDHS expects providers to make every reasonable effort to control service rates and maximize revenue, billed through such methods as third-party payments and MA billing, when there is a correlated Medicaid benefit.

J. As a Federal/State/County funded program, be aware that regulations may change during program operation and the program design may be affected resulting in modification by KCDHS.

K. Kenosha County reserves the right to reject any or all applications received, to negotiate with all qualified sources, to cancel in part or in its entirety the application process, to extend the due date or to re-issue any or all parts of the application process information, if it is in the best interest of KCDHS.

L. All material submitted by Applicant/agencies become the property of Kenosha County upon submission, and therefore public information, following completion of all application process activities and are subject to requirements of Wisconsin open records laws.

II SPECIAL REQUIREMENTS

A. Data Reporting Requirements - Data reporting requirements serve three purposes:

1) meet Federal and State reporting requirements,

2) provide information for program monitoring and management and

3) provide for component and program evaluation.

KCDHS reserves the right to specify its individual reporting requirements.

B. Performance Measures and Reporting – Contracted agencies are required to comply with performance reporting requirements and methods as defined by the Department of Human Services and any other governing authorities. Requirements may include submitting reports, and attending meetings with KCDHS representatives to review services, to assess progress and performance, to identify barriers, and to determine if any corrective action measures are necessary. It is the responsibility of the service provider to provide corrective action plans and reports if requested.

III INSTRUCTIONS

A. **A complete application must include all applicable information as defined in #1-26. See Attachment A for required items for each service type.** If you believe you have a valid reason for excluding an item listed in #1-26, and it is required of your service type as per Attachment A, a written explanation must be included.

1. Application Signature Sheet/Checklist (Attachment A) – complete and use as top page.
2. Assurances (Attachment B) – complete and return.
3. Residential Services Checklist (Attachment C) - complete and return.
4. References Information (Attachment D) – complete and return.
5. Resident Satisfaction Summary Report – Provide a summary of the satisfaction survey results obtained from residents or their guardians from the past year.
6. Incident Report Form and Written Protocol – written policies/procedures, along with a blank incident report form that the agency uses to document injuries, falls, medication errors, etc.
7. Facility-Specific Activity Calendar – copies of activity calendar by facility, and what can typically be expected.
8. Facility-Specific Menu – copies of and menu by facility, and what can typically be expected.
9. County Employee Disclosure – list of all Kenosha County employees or former employees to whom the agency paid a wage, a salary or independent consultant fee during the preceding one- and one-half years. If none, include statement.
10. Licenses, Accreditations, and Certifications – current licenses, accreditations or certifications held or required for staff and/or the organization.
11. BQA Information – report of any citations, violations, and deficiencies as noted by the Bureau of Quality Assurance (BQA) and the corrective action plans (or any other response) submitted to the licensing authority.
12. Evidence of Current Insurance Coverage – a current certificate of insurance. All vendors contracting with KCDHS will be required to submit a contract compliant certificate of insurance before a contract is legally authorized.
13. Excerpts of Personnel Policies – agency's personnel policies that define EEO/AA plan, benefit package (holidays, vacation, etc.), hiring procedures & training program, and Caregiver Background Checks procedure.
14. Caregiver Criminal Background Check – applicant shall ensure that caregiver criminal history and patient abuse record search policies are in place, including use of certified nursing assistant registry per 50.0654 and 146.40(4)g Wis. Stats., and criminal history and child abuse record search 48.685 Wis. Stats., and WI Administrative Code Chapter HFS 13.
15. Organizational Chart – organizational chart of the agency.
16. Annual Report – agency's latest annual report.
17. Audit/Fiscal Report – last completed fiscal year audit, completed by independent auditor.
18. Admission Policy/Procedures & Forms – admission forms and the general written admission policies/procedures.
19. Assessment Forms – blank forms of assessment that the agency uses to collect demographic, financial, health, behavioral, personal inventory, etc. related to assessing a new/prospective resident.

20. Program Statement – Submit a Program Statement for each facility that clearly details the target group to be served, the number of beds and the program philosophy.
21. Agency Statement – Describe agency and any subsidiaries, preferences, and specialty services designed to meet the needs of target populations(s) you plan/desire to serve.
22. Master Schedule – Provide a weekly schedule by facility, identifying the hours worked by each staff position.
23. Staff Hiring/Qualifications/Training Procedures – Include written hiring practices, job qualifications, duties, and general training routine for new hires. Describe qualifications and experience of current staff and how supervision is provided.
24. Board of Directors (as applicable) – list of current Board of Directors and/or owners identified by name with middle initial, Board office, address, employer and occupation, and statement that Board members shall be 18 years of age or older.
25. Evidence of Board Approval (as applicable) documentation stating that the agency's governing board has given its approval for the submittal of the application.
26. Budget Worksheets further defined below.

KCDHS reserves the right to request additional documentation or information if necessary to adequately review applications.

B. Program Budget Guidelines

Applicant must comply with applicable Allowable Cost Policy Manual latest revision (DCF).

Local policy does not allow:

- Any charges for program costs not directly applicable to the funded program.
- Any charges or costs deemed unreasonable or excessive to the operations of the program or service.

Profit will be restricted to the limitations imposed by the Wisconsin DHFS Allowable Cost Policy (noted above).

1. KCDHS may, in the negotiation of a contract budget, disallow certain proposed cost items, reduce certain proposed cost items, and/or realign or increase proposed cost items.
2. The budget proposed by the provider for the selected programs shall include all costs associated with the operation of this component.
3. Use the Residential Budget Worksheet format to present your budget information.

C. Residential Budget Worksheets

Please email your completed budget worksheets to marcy.gilbertson@kenoshacounty.org Return one copy of the Residential Budget Worksheets with your application, (one set is five tabs or worksheet pages).

- The Residential Budget Worksheet is an EXCEL file with five separate worksheets.
- Begin on worksheet one. Enter information in designated blue areas on all worksheets.
- Once entered, the information will automatically copy to other worksheets.
- The yellow and gray areas of the worksheets are calculations and should be verified for accuracy.

If you have any questions regarding the budget worksheets, please contact Marcy Gilbertson, Fiscal Manager Kenosha County Department of Human Services at (262) 605-6682 or marcy.gilbertson@kenoshacounty.org

D. Completing the Residential Budget Worksheet Excel File Information

1. *Budget Worksheet #1 – FTE & Salary Allocation* - Complete the blue shaded section that summarizes the percent of personnel time allocated to complete each program:
   a. Insert a Program Name as the column heading. Distribute the percentage of each individual's time across: (1) Direct Staff FTE and (2) Admin/Clerical/Supervision.
   b. To ensure unit rates are based on consistent information, the following explanation is offered to assist in distinguishing between the direct staff and the Administration/Clerical/Supervision columns. Direct Staff includes personnel who have face-to-face client contact or are involved in any other program-related activity that relates to the client served. Admin /Clerical/Supervision includes the support staff (secretarial, receptionist, etc.,) supervision of direct staff, and administration of overall agency business. The personnel listed in this column would not have direct contact with client served.
   c. Insert each employee's position title, annual salary and full-time equivalents in the applicable columns of the budget grid. (One Full-Time Equivalent is equal to 2,080 hours of work per year.)
2. *Budget Worksheet #2 – Fringe Benefit Computation* – Complete the blue sections. Remember to include an explanation of other benefits listed.
3. *Budget Worksheet #3 – Total Agency Budget by Program (Expense Summary) Complete* Worksheet #3, which summarizes all expenses.
   a. In the operating expense section insert the expense figures that are applicable to your program application and agency.
   b. Insert your applicable administrative allocation rate in box in lower left-hand corner. Indicate the basis by which administrative costs are allocated to the proposed program budget under budget narrative in worksheet #5.
4. *Budget Worksheet #4 – Detail of Other Expenditures*

   Use to explain amounts on Worksheet #3-line items: "Equipment purchases > $500 related to room & board, Equipment purchases > $500 not related to room & Board, Other allowable costs related to room & board and Other allowable costs not related to room & board."
5. *Budget Worksheet #5 - Budget Narrative*

   Provide information for reviewers to determine the reasonableness of the costs included in the budget. For example, indicate which salaries are higher due to staff education or experience levels. If current KCFHS provider, comment on significant increases or decreases of line-item expenses from previous year. If administration allocation is included in Budget Worksheet # 3, indicate the basis by which these costs are allocated to this application.

IV APPLICATION REVIEW PROCESS

The review process is based on information submitted to address the application requirements. KCDHS reserves the right to include site visits and oral interviews in the review process for any submitted application. The application review and approval process are completed by KCDHS management that includes program and fiscal representatives from the Division of Aging, Disability & Behavioral Health Services.

Completing an application is neither a guarantee of placements, nor does it guarantee a contract with any division of the Kenosha County Department of Human Services. KCDHS reserves the right to maintain discretionary use of provider services deemed most advantageous to the consumer and the Department.

V PROGRAM/SERVICE DESCRIPTION AND SPECIFICATIONS

A. SERVICE DESCRIPTION & ACTIVITIES

1. Applicant must be licensed or certified through WI s. 50.01 DHS 83, DHS 88, or DHS 89, and are expected to deliver continuous care and supervision in a community-based setting to individuals with Kenosha County Division of Aging, Disability, and Behavioral Health Services (DADBHS) authorizations.
2. Specific care will include but is not limited to:
    - Supervision of placed residents to ensure personal safety,
    - Ensuring personal cares are met through prompting and/or guidance,
    - Symptom monitoring,
    - Medication facilitation, and
    - Transportation to medical or legal appointments.
3. Applicant will work in collaboration with case management staff associated with DADBHS and will communicate regarding admission and discharges to the facility, creating or updating a residential placement service plan, any changes in a resident's condition, especially if dangerous behaviors are present, changes in a resident's medication, or any other information requested.
4. Referrals will be received from DADBHS affiliated case managers. The residential facility will conduct a comprehensive assessment of a potential resident's needs and preferences, and carefully consider its ability to meet those needs and preferences prior to placement. The assessment will gather physical, cognitive, emotional, social, and spiritual information to determine the needs, strengths, and preferences of potential residents. Resident life history information will also be gathered and recorded, including information about personal interests and routines. The assessment can include input from the resident, family, case managers, and physicians. The complete written assessment report shall be retained in the resident's record. Prior to admission, the residential facility will provide the opportunity for potential new residents, families, and case managers to observe, experience, and evaluate everyday activities.
5. Goals – To maintain mental and physical health stability in the community and increase independent living skills to support the individual's transition to the most independent, least restrictive, living environment possible.
6. Personnel – Applicant shall be staffed in accordance with the facility's licensing regulations and as needed to meet a resident's individual needs as outlined in the service plan. Enhanced staffing for individual residents must be discussed and approved by DADBHS administration (DADBHS Director, Behavioral Health Manager, and Quality Analyst) in advance.

B. PERFORMANCE REQUIREMENTS AND REPORTING METHODS

The performance requirements and reporting methods below are designed to reflect the targeted outcomes and measures for the services of this contract. DADBHS reserves the right to modify performance requirements and reporting methods as necessary to achieve service goals. Reporting is required to be submitted to DADBHS administration on the timelines specified below.

Desired Outcomes(s)	Measures(s)
All Community Based Residential Facilities and Adult Family Homes shall be in compliance with all requirements and standards set forth in DHS 83 and DHS 88 respectively.	• The residential facility notifies DADBHS' Behavioral Health Manager when a state inspection has occurred. • The residential facility submits a copy of the WI. Division of Quality Assurance (DQA) Survey Report to the Behavioral Health manager. • The residential facility corrects any sanction, penalty, or deficiency imposed by DQA. • The residential facility submits a copy of any required Plan of Correction to the Behavioral Health Manager.
All residents placed in a residential placement facility will have a service plan outlining their individual needs.	• Service plans will be completed in accordance with pertinent state statutes. • All initial or updated service plans will be submitted to the appropriate case manager and the Kenosha County Behavioral Health Manager within 30 days of completion.
The residential facility will report ongoing progress on the resident's recovery, including progress on resident's life skills and ability to live independently, and any complaints or grievance residents may have against the facility.	• Medication compliance through the Medication Administration Record, Incident reports, and physician visit summary summaries. • Written living skills assessments when requested by the DADBHS affiliated case manager. • Assist resident in writing a written compliant if requested or send a summary of the resident satisfaction evaluation results to the case manager and Behavioral Health Manager.
Resident personal expense funds will be used to meet the individual's personal needs.	• Quarterly statements of each resident's personal needs funds will be submitted to the Behavioral Health Manager.
Residential placement facility staff shall be knowledgeable about severe and persistent mental health diagnoses and able to offer appropriate care.	• Annually, applicant shall submit proof of staff training on severe and persistent mental health diagnosis.

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ATTACHMENT A – SIGNATURE SHEET & CHECKLIST

COMPLETE, SIGN, AND ATTACH AS COVER PAGE

Refer to page one for mailing/delivery information.

Business / Agency Name _____ Years in Business_____

Business Address _____ City/State/Zip _____

Billing Address _____ City/State/Zip _____

Director/Owner_____Telephone Number_____Email: _____

Operations Contact _____Telephone Number_____Email: _____

Application Contact _____Telephone Number_____Email: _____

Check ALL boxes below that apply.

Residential Service Area

☐ AFH: 1-2 Beds Certified ☐ 3-4 Beds Licensed by State ☐ CBRF ☐ RCAC

☐ AFH: 1-2 Beds Certified Owner Occupied Home ☐ 3-4 Beds Licensed by State Owner Occupied Home

Population Served

☐ AODA ☐ Mental Illness

Application Checklist

Check the boxes for items included in application. See Pages 5&6.

Items # 1-12

Required of all

1. ☐ Application Signature Sheet (RFA Attachment A)
2. ☐ Assurances (RFA Attachment B)
3. ☐ Residential Services Checklist (RFA Attachment C)
4. ☐ Reference Information (RFA Attachment D)
5. ☐ Resident Satisfaction Summary Report
6. ☐ Incident Report Form and Written Protocol
7. ☐ Facility-Specific Activity Calendar
8. ☐ Facility-Specific Menu
9. ☐ County Employee Disclosure ☐ No County Employees
10. ☐ Licenses, Accreditations, & Certifications
11. ☐ BQA Report &Corrective Action ☐ No BQA Reports
12. ☐ Evidence of Current Insurance Coverage

Items # 13-24

Required of all EXCEPT owner occupied AFH

13. ☐ Excerpts of Personnel Policies
14. ☐ Organizational Chart
15. ☐ Annual Report
16. ☐ Audit/Fiscal Report
17. ☐ Admission Policy/Procedures & Forms
18. ☐ Assessment Forms
19. ☐ Program Statement by Facility
20. ☐ Agency Statement
21. ☐ Master Schedule by Facility
22. ☐ Staff Hiring/Qualifications/Training Procedures
23. ☐ Board of Directors Listing
24. ☐ Evidence of Board Approval

In submitting this application, the organization certifies: 1) that all regulations and policies of KCDHS & the State of Wisconsin Division of Health and Human Services will be adhered to; 2) that all information submitted is complete and correct; 3) that the signer of this application is authorized by the proposing organization to submit and certify this application, and 4) that the proposing organization is a legal entity under laws of the State of WI or authorized to operate in the State of WI.

Authorized Signature: _____ Date: _____

Print Name/Title: _____

ATTACHMENT B – ASSURANCES

COMPLETE, SIGN, AND RETURN WITH APPLICATION

_____("Applicant") **Enter Agency name here & BELOW** agrees to comply with the following Assurances. The undersigned has the legal authority and capacity to enter into this contractual agreement and a motion has been duly passed as an official act of the governing body of the application, authorizing the execution of this agreement and authorizing the person identified as the official representative for Applicant to act in connection with Applicant and to provide such additional information as may be required. (Signature required, bottom of the page.)

Funds

Applicant agrees that (a) funds granted as a result of this request are to be expended for the purposes set forth in this application and in accordance with all applicable laws, regulations, policies and procedures of the State of Wisconsin or the Federal Funding Agency, as applicable; (b) no expenditures occurring prior to the effective date of the grant will be eligible for inclusion; funds awarded by the Wisconsin Department of Health and Family Services may be terminated at any time for violation of any terms and requirements of this agreement.

Title VI of Civil Rights Act of 1964 Applicant ensures compliance with the Title VI of the Civil Rights Act of 1964 (P.L. 88-342), and all requirements imposed by or pursuant to the regulations of the Department of Health and Human Services (45 CRF Part 80) issued pursuant to that title. To that end, and in accordance with Title VI of that act and the regulations, no person shall, on the grounds of race, color or national origin, be excluded from participating in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity in which the designated agency received federal assistance, or financial assistance from the Department; and **HEREBY GIVES ASSURANCE THAT** it will immediately take any measures necessary to effectuate this agreement.

Title IX of the Education Amendment of 1972

Applicant ensures compliance with Title IX of the Education Amendment of 1972 which state that no person in the United States shall, on the basis of sex, be excluded from participating in, be denied the benefit of, or be otherwise subjected to discrimination under any education program or activity for which Applicant receives or benefits from Federal financial assistance.

Rehabilitation Act of 1973 and Age Discrimination Act of 1975

Applicant shall comply with Section 504, Rehabilitation Act of 1973, which prohibits discrimination on the basis of a physical condition or handicap, and the Age Discrimination Act of 1975, which prohibits discrimination because of age.

Wisconsin Statues: 946.10 and 946.13

Applicant shall ensure the establishment of safeguards to prevent employees, consultants, or members of governing bodies from using their position for purpose that are, or give the appearance of being, motivated by a desire for private gain for themselves or others, such as those with whom they have family, business, or other ties as specified in Wisconsin Statutes 946.10 and 946.13.

Alcohol and Substance Abuse and Drug Testing

Applicant shall ensure that it maintains and enforces alcohol and substance abuse policies, to the fullest extent allowed by law, including mandatory drug and alcohol testing for all driving personnel, to ensure drivers are free from intoxicants or drugs that impair driving.

Privacy Rules and Regulations and Confidentiality

Applicant shall ensure that it maintains compliance with the Health Insurance Portability and Accountability Act of 1996, (HIPAA) Privacy Rules and Regulations.

SIGNATURE OF APPLICANT/AGENCY AUTHORIZED REPRESENTATIVE:

Authorized Official (Signature) Date

Print Name & Title of Authorized Official

Print Name of Agency/Organization

ATTACHMENT C – RESIDENTIAL SERVICES (AFH/CBRF) CHECKLIST
SPECIFICATION OF SERVICES

Specification of Services is required by statute and administrative rule (to be provided at a level and frequency needed by each resident). Provider shall indicate which of the following is applicable to the respective facility**. COMPLETE & RETURN**
If you have multiple facilities and services vary, you must complete one for each facility.

Program services listed in HFS Chapter 88 and/or s. HFS 83.33 & s. HFS 83.35	***PRINT NAME OF FACILITY:*** _____ **The service will include these activities:**	**Yes No**
Supervision [as defined in s. HFS 83.04(64)]	· Supervision during day-time hours · Supervision will include overnight staff who may sleep when not needed to monitor or tend to resident needs · Supervision will include overnight awake staff	☐ ☐ ☐ ☐ ☐ ☐
Information and referral	· Information about community activities · Information and referral for appropriate health and social services	☐ ☐ ☐ ☐
Leisure time activities	The AFH/CBRF will promote resident participation in a program of daily activities designed to provide needed stimulation and variety consistent with the interests of the resident. Specific activities include: · Choice of an array of individual activities (e.g. books & magazines, cards, sewing, crafts) · Choice of an array of social activities (e.g. conversation, group projects, games, cards, crafts) · Choice of outdoor activities (e.g. sitting, walking, social events) · Participation in planning and taking outings · Opportunities for indoor and outdoor exercise · Activities to accommodate needs and disabilities of residents (e.g. large print books, books on tape, phone adapters, adaptive utensils, and other equipment, etc.)	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Community activities	· Inform residents about community activities consistent with their personal interests; allow choice (e.g. clubs, sports, religious events, entertainment) · Arrange/provide for participation · Involve community in AFH/CBRF; host social events · Allow use of phone for planning/ arranging events	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Family Contacts	· Assist family contacts through resident phone calls, letter writing, visits, and special occasion events · Arrange contacts (in or out of facility) · Provide family with information about the resident (as authorized by resident)	☐ ☐ ☐ ☐ ☐ ☐
Health Monitoring & Medical Services	Monitor health and make arrangements for health care appointments as needed or support resident to make own arrangements (includes physical health, mental health, and dental care)	☐ ☐

Program services listed in HFS Chapter 88 and/or s. HFS 83.33 & s. HFS 83.35	**The service will include these activities:**	**Yes No**
Medications	· The AFH/CBRF medication program for all medications controlled by the AFH/CBRF is supervised by an RN or an RPh as described in HFS 83.33(3)(e)3 · The AFH/CBRF has **all** medications controlled by the AFH/CBRF prepackaged by an RPh as described in s. HFS 83.33(3)(e)4	☐ ☐ ☐ ☐
	· Resident controls and self-administers medications · Resident controls and AFH/CBRF provides supervision of medications; resident self-administers medications · AFH/CBRF manages and resident self-administers medication · AFH/CBRF provides supervision and assistance · AFH/CBRF manages and administers medications · AFH/CBRF provides medication administration instruction to residents · AFH/CBRF supervises/administers controlled substances/psychotropic medications · AFH/CBRF coordinates medication orders with prescribing physician and pharmacy · AFH/CBRF orders refills of medications from pharmacy when refills are authorized · AFH/CBRF picks up medications from pharmacy for resident	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Meals	AFH/CBRF provides: · 3 meals a day · 2 meals a day · Accommodation for special diets · Nutritious snacks - morning - afternoon - evening · Opportunities for resident food selection/menu planning	**Yes No** ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Transportation to/for	**To / for:** — **Provider**: **PLEASE CHECK**:· . Medical appointments ___Arranges ___Provides · Work/day program ___Arranges ___Provides · Education or training ___Arranges ___Provides · Religious services ___Arranges ___Provides · Community activities - Shopping ___Arranges ___Provides - Banking ___Arranges ___Provides - Hair care ___Arranges ___Provides - Religious activities ___Arranges ___Provides - Government meetings ___Arranges ___Provides - Voting ___Arranges ___Provides - Social/recreational events ___Arranges ___Provides - Visits to family/friends ___Arranges ___Provides	

Cont'd. Other Services Required by Purchaser	Optional detail about included activities:	Yes No
Personal care	Provide training, prompts, or transitional services for, or assistance with: · Eating · Toileting · Personal hygiene · Dressing · Grooming · Bathing · Transferring · Mobility	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Independent living skills	· Arrange for assistive devices to foster independence · Teach/support maintaining skills related to: - Education - Money management - Food preparation - Shopping - Use of public transportation - Vocational activities - Seeking and retaining employment - Laundry care - Cleaning the resident's living area · Provide assistance with self-direction	☐ ☐ ☐
Communication skills	· Speech therapy · Interpreter services · TDD	☐ ☐ ☐ ☐ ☐ ☐
Socialization	· Dealing with anger · Conflict resolution · Strengthening personal relationships	☐ ☐ ☐ ☐ ☐ ☐
Activity programming for persons with irreversible dementia (in addition to activities listed in Attachment 1)	· Participation in household tasks · Activities for sensory stimulation · Activities to stimulate memory and retrieve information from the past · Activities based on earlier life experiences	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Nursing care	· Provided by the facility · Arranged by the facility · Hospice care provided under s. HFS 83.34	☐ ☐ ☐ ☐ ☐ ☐
Monitoring symptom status	· Keep the following persons informed of changes in symptom status in areas specified by the following persons: - Case manager - Physical therapist - Occupational therapist - Mental health therapist	 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Telephone access	· Local · Long-distance	☐ ☐ ☐ ☐

ATTACHMENT D – REFERENCE INFORMATION

COMPLETE, SIGN, & RETURN WITH APPLICATION

List (business) references below who can attest to your ability to provide quality service(s) as those proposed and <u>return this form</u>. Include references of similar services with whom you currently hold contracts.

Agency Name _____
Address _____
Telephone _____Contact Person _____
Type of Business_____

Agency Name _____
Address _____
Telephone _____Contact Person _____
Type of Business_____

Agency Name _____
Address _____
Telephone _____Contact Person _____
Type of Business_____

Submitted by:

_____ _____

Vendor Official Authorized Signature Date

ATTACHMENT E – BUDGET WORKSHEET INFORMATION

REQUIREMENTS – Interested Residential Service Providers must:

1. Submit a completed Residential Budget Worksheet (5 sheets total in workbook)
   - The EXCEL worksheet is also available by navigating to the following KCDHS website: https://www.kenoshacounty.org/151/Doing-Business-w-DHS
2. Submit budget worksheet specific questions to the Division's Fiscal Manager:

   Marcy Gilbertson
   (262)605-6682
   marcy.gilbertson@kenoshacounty.org

ATTACHMENT F – SAMPLE FORMS

SEE SAMPLE FORMS ON THE PAGES THAT FOLLOW.

RESIDENTIAL SERVICES SATISFACTION SURVEY – CONSUMER

Facility_____ **Interview Date**_____

Consumer_____

1.	Are you satisfied that this is the most appropriate place for you to live at this time?	Yes☐	No☐
2.	Have you had any problems in this setting?	Yes☐	No☐
3.	If so, were they been resolved to your satisfaction?	Yes☐	No☐
4.	Did we listen to your suggestions or complaints?	Yes☐	No☐
5.	Is there anything you'd like changed about this setting?	Yes☐	No☐
6.	Do you feel your are safe here?	Yes☐	No☐
7.	Have you been physically or verbally abused in this setting?	Yes☐	No☐
8.	Have you been neglected in this setting?	Yes☐	No☐
9.	Have you been injured in this setting?	Yes☐	No☐
10.	Have you become seriously ill while in this setting?	Yes☐	No☐
11.	If so, was treatment sought in a timely manner?	Yes☐	No☐
12.	Do you know that psychotropic medications require your informed consent?	Yes☐	No☐
13.	Is the staffing of the home adequate?	Yes☐	No☐
14.	Are your physical needs adequately addressed?	Yes☐	No☐
15.	Do we actively encourage/allow you to do as much as you are able?	Yes☐	No☐
16.	Are you given adequate say in the delivery of services?	Yes☐	No☐
17.	Are there things you feel should be done that aren't being done?	Yes☐	No☐
18.	Do you feel your personal belongings are safe?	Yes☐	No☐
19.	Has anything ever been lost, stolen, or broken in this setting?	Yes☐	No☐
20.	If so, has the situation been resolved to your satisfaction?	Yes☐	No☐
21.	Is there adequate storage space available for your property?	Yes☐	No☐
22.	Do we adequately communicate pertinent information in a timely manner?	Yes☐	No☐
23.	Are you kept informed about changes in your condition, care, treatment, and costs?	Yes☐	No☐
24.	Do you fully participate in the planning of your care and treatment?	Yes☐	No☐
25.	Have you been provided with a written copy of a service/treatment plan?	Yes☐	No☐
26.	If so, are you included in its development/revision?	Yes☐	No☐
27.	Do you feel the provider follows this plan?	Yes☐	No☐
28.	Have you ever been denied access to your records?	Yes☐	No☐
29.	Do you know of anyone ever having access to your records without your permission?	Yes☐	No☐

30. Are you able to have visitors without restrictions? Yes☐ No☐

31. Are you able to have phone contacts without restrictions? Yes☐ No☐

32. Are there adequate (frequent) appropriate activities for you? Yes☐ No☐

33. Do you feel your rights are adequately safeguarded? Yes☐ No☐

34. Have you been informed of your options for redress of grievance (appeal process)? Yes☐ No☐

Please use the lines below to add any comments you would like to make about our services or explain any answers to the preceding questions:

RESIDENTIAL SERVICES SATISFACTION SURVEY - GUARDIAN

Facility_____ **Interview Date**_____

Guardian_____ **Consumer**_____

1.	Are you satisfied that this is the most appropriate setting for your ward at this time?	Yes☐	No☐
2.	Have you had any problems with this setting?	Yes☐	No☐
3.	If so, were they been resolved to your satisfaction?	Yes☐	No☐
4.	Were we receptive to your suggestions or complaints?	Yes☐	No☐
5.	Is there anything you'd like changed about this setting?	Yes☐	No☐
6.	Do you feel your ward is safe here?	Yes☐	No☐
7.	Do you suspect your ward has ever been physically or verbally abused?	Yes☐	No☐
8.	Do you suspect your ward has ever been neglected?	Yes☐	No☐
9.	Has your ward ever been injured while in this setting?	Yes☐	No☐
10.	Has your ward ever become seriously ill while in this setting?	Yes☐	No☐
11.	If so, was treatment sought in a timely manner?	Yes☐	No☐
12.	Do you know that psychotropic medications require your **informed** consent?	Yes☐	No☐
13.	Is the staffing of the home adequate?	Yes☐	No☐
14.	Are your ward's physical needs adequately addressed?	Yes☐	No☐
15.	Do we actively encourage/allow your ward to do as much as he/she is able?	Yes☐	No☐
16.	Are you given adequate say in the delivery of services to your ward?	Yes☐	No☐
17.	Are there things you feel should be done that aren't being done?	Yes☐	No☐
18.	Are your ward's personal belongings safe?	Yes☐	No☐
19.	Has anything ever been lost, stolen, or broken in this setting?	Yes☐	No☐
20.	If so, has the situation been resolved to your satisfaction?	Yes☐	No☐
21.	Is there adequate storage space available for your ward's property?	Yes☐	No☐
22.	Do we adequately communicate pertinent information in a timely manner?	Yes☐	No☐
23.	Are you kept informed about changes in your ward's condition, care, treatment, and costs?	Yes☐	No☐
24.	Do you fully participate in the planning of your ward's care and treatment?	Yes☐	No☐
25.	Have you been provided with a written copy of a Service/treatment plan?	Yes☐	No☐
26.	If so, are you included in its development/revision?	Yes☐	No☐
27.	Do you feel the provider follows this plan?	Yes☐	No☐
28.	Have you ever been denied access to your ward's records?	Yes☐	No☐
29.	Do you know of anyone ever having access to your ward's records without your permission?	Yes☐	No☐

30. Are you able to visit your ward without restrictions? Yes☐ No☐

31. Are you able to phone your ward without restrictions? Yes☐ No☐

32. Are there adequate (frequent) appropriate activities for your ward? Yes☐ No☐

33. Do you feel your ward's rights are adequately safeguarded? Yes☐ No☐

34. Have you been informed of your options for redress of grievance (appeal process)? Yes☐ No☐

Please use the lines below to add any comments you would like to make about our services or explain any answers to the preceding questions:

INCIDENT REPORT

NAME OF FACILITY_____

The following guidelines apply for our residential service facility as named above.

All staff are required to abide by this Incident Report Procedure.

GUIDELINES FOR COMPLETING INCIDENT REPORTS

Staff must complete and submit Incident Reports within 24 hours of any reportable occurrence on the Incident Report Forms, using the Consumer Incident Report and/or the Non-Consumer Incident Report form. Submit the completed form to: Kari Foss, DADBHS Director at kari.foss@kenoshacounty.org

Staff are encouraged to submit incident reports even if doubt exists as to its necessity ("when in doubt, fill it out"), because a seemingly insignificant or minor occurrence, event, or incident may have a significant impact.

Examples of reportable incidents include, but are not limited to the following:

1. Illness-any consumer illness or if consumer expressed feeling ill
2. Medical Emergency-any sudden or serious medical incident or seizure
3. Missing/Elopement-whereabouts of a consumer is not known
4. Significant Changes in Client Status-includes but is not limited to hospitalization, accident, or illness requiring hospitalization or emergency treatment at an urgent care clinic
5. Death
6. Unusual Behavior-consumer exhibits any behavior out of the ordinary for that individual or requires excessive attention from staff
7. Injuries/Accident-any incident causing injury, i.e., falling, car accident, self-inflicted injury, etc.
8. Alleged Abuse-consumer alleges abuse by a staff member or another consumer, or staff is made aware of any such incident or witnessed same
9. Intrusive Behavior
10. Behavior Resulting in Property Damage-any incident involving the consumer destroying or damaging any property
11. Fire and/or Emergency Medical Services-including emergency room visits and hospitalizations
12. Behavior Requiring Law Enforcement Intervention-anytime police are called due to consumer behavior
13. Recreation-anytime recreation is missed or ended prematurely
14. Facility or Home Environment Hazard
15. Errors in Medical or Medication Management (also use Medication Error Form)
16. Medical Concerns of Any Kind
17. Consumer Complaints of Any type
18. Significant Inquiries-any contact from guardians, case managers, parents, friends, relatives, etc.
19. Other-any other reportable incidents not listed above

NON-CONSUMER INCIDENT REPORT

Person Making Report (print): _____ **Phone Number:** _____

Location/Facility _____

_____

Date of Incident (Month, Day, Year): _____ **Time of Incident:** _____

Type of Incident: (please check one)

☐ Injuries/Accident ☐ Staff Not Completing Duties or Consumer Concerns

☐ Property Damage ☐ Vehicle Concerns

☐ Fire ☐ Other

☐ Facility or Home Environment Hazard, Home Repairs

Describe the incident, what you saw or witnessed and/or what was stated to you. Describe Who, What, When, Where, How. Be accurate and complete, clear and factual. (EXCLUDE personal comments, opinions, or judgements.) Please print. [Use the reverse of these forms for additional writing space if needed.]

_____

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What was done to solve the emergency/incident (Describe what you or others did to solve the situation or make it less painful.)
State the facts only: _____

_____

_____

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_____

_____

What is the Plan to Prevent future incidents (Describe actions steps that will be taken to prevent similar situations)**:**_____

Witness(es) (print name(s):_____

Supervisor Notified:_____ Time Supervisor Notified_____

Any Other Person(s) Notified (print names): _____

Supervisor or Designated Person Notified Physician or Others: No ☐ Yes ☐ (print names) Describe Action Taken:_____

Person Making Report (print): _____ Phone Number:_____

Signature of Person Making Report:_____ Date:_____

Report Reviewed By (Management Signature):_____ Date:_____

Review Comments:_____

Original of Report to Supervisor or Designated Person ☐ Date:_____

Copies of Report - Supervisor or Designated Person to Provide Copies to the following:

Copy to County Case Manager ☐ Date: _____
Other:_____ ☐ Date: _____

CONSUMER INCIDENT REPORT

Client Name:_____ **Person Making Report (print):**_____

Location/Facility_____

Date of Incident (Month, Day, Year):_____ **Time of Incident:**_____

Type of Incident: (please check one)

- ☐ Illness of Any Kind
- ☐ Significant Change in Client Status
- ☐ Death
- ☐ Injuries/Accident
- ☐ Behavior Resulting in Property Damage
- ☐ Fire and/or Emergency Medical Services
- ☐ Behavior Requiring Law Enforcement Intervention
- ☐ Errors in Medical or Medication Management
- ☐ Medical Emergency
- ☐ Missing/Elopement
- ☐ Unusual Behavior
- ☐ Alleged Abuse
- ☐ Intrusive Behavior
- ☐ Recreation
- ☐ Facility or Home Environment Hazard
- ☐ Consumer Complaint
- ☐ Medical Concerns
- ☐ Significant Inquiries
- ☐ Other

Describe the incident, what you saw or witnessed and/or what was stated to you. Describe Who, What, When, Where, How. Be accurate and complete, clear and factual. (EXCLUDE personal comments, opinions, or judgements.) Please print. [Use the reverse of these forms for additional writing space if needed.]

What was done to solve the emergency/incident (Describe what you or others did to solve the situation or make it less painful.
State the facts only:

What is the Plan to Prevent future incidents (Describe actions steps that will be taken to prevent similar situations)**:**

Witness(es) (print name(s):

Supervisor Notified: Time Supervisor Notified

Supervisor or Designated Person Notified Guardian No ☐ Yes ☐ Date/Time Notified
Describe How Guardian Was Notified

Supervisor or Designated Person Notified Physician: No ☐ Yes ☐ Describe Action Taken:

Person Making Report (print): Phone Number:

Signature of Person Making Report: Date:

Report Reviewed By (Management Signature): Date:

Review Comments:

Original of Report to Supervisor or Designated Person ☐ Date:

Copies of Report - Supervisor or Designated Person to Provide Copies to the following:

Copy to Consumer File ☐ Date: Copy to County Case Manager ☐ Date:
Copy to Guardian ☐ Date: Other: ☐ Date:

MEDICATION ERROR REPORTING FORM

If more than one client's medication was involved, complete a report for each client involved.
Please Print [Use the reverse side of this form for additional writing space if needed.]

Staff Person Reporting Error/Completing Form:_____ Date of Report:_____

Staff On Duty When Error Occurred:_____

Client Name:_____ Facility/Location:_____

Name of Medication(s):_____

Prescribed Dosage:_____ Date/Time of Error:_____

Explain the nature of the error, and what if any, corrective action steps were taken:_____

Physician was contacted: Yes ☐ Name of Physician:_____

Physician's recommendations: _____

Was any other person(s) contacted when the error was discovered? Yes ☐ Name(s) _____

Recommendations made by any other person(s) contacted:_____

Signature of Staff Person Completing Form :_____ Date:_____

Report Reviewed By: (Management Signature):_____ Date:_____

Review Comments:_____

IMPORTANT: ATTACH THIS FORM TO THE CONSUMER INCIDENT REPORT