Please complete one application form for each participaping community.

ORGANIZATIONAL INFORMATION				
Date of Application	Corporation Name			Date License Issued
Facility Name as listed on the BAL website*	Name of Licensee as listed on the BAL website*			BAL License Number *
Facility Mailing Address – Street	City	State	ZIP Code	County
Facility Location - Street (only if different than above)	City	State	ZIP Code	County
Licensure Type (AFH, CBRF, RCAC)	Class Description		Registered or Certified?	
Primary Client Group	Secondary Client Group			
RN on staff: Yes ☐ No ☐ Comments:	Occupancy Capacity			

**Link to BAL for this information: http://www.dhs.wisconsin.gov/bqaconsumer/Assistedliving/AsLivDirs.htm*

FACILTY CONTACT INFORMATION	
Administrator's Name	
Phone Number	Email Address
Facility Quality Contact Person *(if different than listed above)*	
Phone Number	Email Address
Secondary email address required:	

DAP PROGRAM REQUIREMENTS			
Are you a current DSPN member?	Yes ☐	No ☐	
Do you have access to a computer and have internet access?	Yes ☐	No ☐	
Do you have a copy of your most recent State Survey Results?	Yes ☐	No ☐	*(Results attached with application)*
Do you have a Quality Assurance Program currently in place?	Yes ☐	No ☐	
What are your main objectives for participating in the STAR Quality Assurance Program?			

Disability Service Provider Network (DSPN)
16 N. Carroll St., Ste 300, Madison, WI 53703
Phone: 608-244-5310 Fax: 888-435-7455 Email: support@dspn.org , www.dspn.org

STATEMENT OF COMPLIANCE

Please select one of the following statements:

☐ My assisted living community is in compliance with state regulations that are required by my license type.

☐ My assisted living community needs assistance with achieving compliance of state regulations that are required by my license type.

Print name and title of person authorized to represent this application

Signature Date

PAYMENT INFORMATION

Member Fee: ☐ AFH $25.00 ☐ CBRF $50.00 ☐ RCAC $50

If applicant is not approved, fee will be completely refunded or applied to another DSPN event.

☐ Check Enclosed:

☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

Card Number: ______________________ Exp: __________ CVV: __________

Zip Code: __________ Cardholders Name: ______________________

Checklist of documents to submit with this application:

- ☐ Program Fee
- ☐ State Survey Results *(if applicable)*

By participating in the STAR Quality Assurance & Quality Improvement program, I understand that I may be receiving sensitive and/or confidential information. I agree to uphold the integrity of this program and will not share information received through conversations with peer members outside of the STAR Quality Assurance & Quality Improvement Program. I agree not to make, use, sell, offer for sale, any product or service provided to me from the STAR Quality Assurance & Quality Improvement Program without receiving permission of use defined by DSPN first.

With the submission of this application, I am acknowledging that I have read, understand and agree to the requirements of this program and the expectations of my participation. I certify that the information I have provided on this application is true and complete to the best of my knowledge. If it is not, I understand that I may risk obtaining approval to participate in the DSPN STAR Quality Assurance & Quality Improvement Program.

Signature Date

Email, Mail or Fax Application and Payment to:

Revised: 02/20/2019

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