

**Please complete one application form for each participating community.**

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| **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 B**A**L website\* | | | BAL License Number \* |
| Facility Mailing Address – Street | | City | State  WI | 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 or No)  Comments: | | Occupancy Capacity | | | |

*\*Link to BAL for this information:* [*http://www.dhs.wisconsin.gov/bqaconsumer/Assistedliving/AsLivDirs.htm*](http://www.dhs.wisconsin.gov/bqaconsumer/Assistedliving/AsLivDirs.htm)

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| **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: | | |

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

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| **STATEMENT OF COMPLIANCE** |
| Please check 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 |

Card Number:

Exp. Date: Cardholders Name:

Discover

American Express

MasterCard

Visa

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

Check Enclosed:

CBRF $50.00

Member Fee: AFH $25.00

**PAYMENT INFORMATION**

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:**

DSPN, 16 N. Carroll Street., Suite 300, Madison, WI 53703

Phone: (608) 244-5310  Fax: (608) 244-9097  E-mail: [support@dspn.org](mailto:support@dspn.org%20)  Website: www.dspn.org

*Revised: 10/10/2016*