REHABILITATION REVIEW APPLICATION

INSTRUCTIONS

Any person who is ineligible to be a caregiver as defined in Wis. Stat. § 50.065 (1) (ag) 1. a, b, or c (see Section C) for a reason specified in Wis. Stat. § 50.065 (4m) (a) or (b) (see Section B of this application) may request a rehabilitation review from the Department of Health Services (DHS) if the person has not requested one for a similar type of regulatory approval, job function or non-client resident status within the preceding year. Section D lists the entities for which DHS is authorized to conduct rehabilitation reviews.

A rehabilitation review application is considered complete when all requested information and documentation is received by the DHS Office of Legal Counsel. Your application may either be denied or returned to you for completion due to lack of a comprehensive response so be sure to carefully respond to all sections of this application. Attach supplementary pages if needed. You may be asked to provide additional information and documents. Provide updates as necessary.

Once the required information is complete, you will be invited to attend a DHS rehabilitation review panel meeting where your application materials will be discussed. Your attendance is not mandatory but is advisable so that the panel may ask additional questions. It also provides you the opportunity to expand upon your previously submitted information. A written approval, denial, deferral or a combination of any of these three will be issued.

An approval grants authorization to seek employment as a caregiver, to seek regulatory approval to own or operate a covered entity, to seek approval to contract with an entity, or to seek approval to reside as a non-client at a covered entity. An approval does not remove the governmental finding and/or criminal conviction that required rehabilitation review nor does it ensure that you will receive employment, regulatory approval, contracts, or permission to reside at an entity. Some approval decisions may be granted conditionally with limitations.

If the review panel does not find sufficient evidence of rehabilitation, the decision will provide the reasons for denial and inform you of any appeal rights available to you. If your application is denied, you may not apply for rehabilitation review again for the same or similar reason until after one year from the rehabilitation review panel's decision. A decision may be deferred for up to 6 months to gather additional information or for other reasons.

PERSONALLY IDENTIFIABLE INFORMATION

Information you provide is used to obtain relevant data as required by the provisions set forth by Wis. Stat. § 50.065 and Wis. Admin. Code § DHS 12.12. That information is subject to Wisconsin's public records laws and may be used for secondary purposes pursuant to Wis. Stat. § 15.04(1)(m). It will not be used for any improper purposes under Wisconsin's employment laws. Providing your social security number is voluntary; however, it is requested so that it may be used as one of the unique identifiers to prevent incorrect matches with other individuals. Failure to provide your correct social security number may result in a delay in processing your application.

ADDITIONAL INFORMATION

Federal laws 42 CFR § 483.13 and 42 USC § 1396r(e)(2)(A) permanently ban employment at a Federally Certified Nursing Facility (this includes most nursing homes) of an individual who has been found guilty by a court of law of abusing, neglecting, or mistreating residents or who has a finding entered into the State nurse aide registry concerning abuse, neglect or mistreatment of residents or misappropriation of their property if the victim was a resident of a federally certified nursing facility or skilled nursing facility and if the perpetrator was a nurse aide. Rehabilitation approval does not change this. Federal law 42 CFR § 483.420 permanently bans employment at a federally certified facility serving people with developmental disabilities of an individual who has a conviction or prior employment history of abuse, neglect or misappropriation. Rehabilitation approval does not change this.

The DHS Division of Quality Assurance Caregiver Program website at www.dhs.wisconsin.gov/caregiver/index.htm contains additional information including the list of offenses affecting caregiver eligibility. Also refer to Wis. Admin. Code § DHS 12.12 for more specific information about the rehabilitation review process.

CONTACT INFORMATION

Contact the Rehabilitation Review Coordinator at 608-266-1900 if you have questions or need assistance with completing this application.

SECTION A – PERSONAL INFORMATION

Last Name	**First Name**	**Middle Name**	
Street Address		**City**	
State	**Zip Code**	**County**	
Maiden Name	**Nickname(s) or Alias(es)**		
Date of Birth	**Gender**	**Social Security Number**	
Place of Birth – City	**State**	**County**	**Country**
Phone Number (include area code)		**Email Address**	

If under age 18 provide name, address, and telephone number of parent, guardian, or legal representative

SECTION B – REASON FOR INELIGIBILITY TO BE A CAREGIVER [Wis. Stat. § 50.065 (4m) (a) or (b)]

Check the box that matches the reason for which you require rehabilitation approval. Check all that apply.

- ☐ You have been **convicted of a serious crime** as defined in Wis. Stat. § 50.065 (1) (e)or comparable crime from other states or jurisdictions. Please identify in Section G.
- ☐ A final determination has been made that you have **abused or neglected a child**. Please identify in Section H, question number 2.
- ☐ A unit of government or a state agency has made a finding that you have **abused or neglected a client or misappropriated the property of a client**. Please identify in Section H, question number 3.
- ☐ Your Department of Safety and Professional Services **credential is not current or is limited** so as to restrict you from providing adequate care to a client. Please identify in Section H, question number 4.

SECTION C – APPLICANT TYPE [Wis. Stat. § 50.065 (1) (ag) 1. Wis. Admin. Code § DHS 12.12 (1)]

Check the box that matches the type of approval for which you are seeking rehabilitation review approval. Check all that apply.

- ☐ A person who is, or is expected to be, an **employee** of an entity, who has, or is expected to have, regular, direct contact with clients of the entity.
- ☐ A person who is, or is expected to be, a **contractor** of an entity, who has, or is expected to have, regular, direct contact with clients of the entity (e.g. employed by a different company to provide personal care workers).
- ☐ A person who expects to be **under the control of** an entity other than those identified above who has, or is expected to have, regular, direct contact with clients of the entity (e.g. for student clinical).
- ☐ A person who has or is seeking a license, certification, registration or certificate of approval issued or granted by the department **to own and/or operate an entity**.
- ☐ A person who is a **non-client resident** of an entity who has or is expected to have regular, direct contact with clients of the entity (e.g. adult family member of a person licensed to operate an Adult Family Home also living at the Adult Family Home).
- ☐ A person who is, or is expected to be, an **employee of the board on aging and long-term care** and who has, or is expected to have, regular, direct contact with clients.

SECTION D – ENTITIES COVERED AND JOB RESPONSIBILITIES [Wis. Admin. Code § DHS 12.02]

Entity means a facility, organization or service that is registered with or licensed or certified by DHS to provide direct care or treatment services to clients, or an agency that employs or contracts with an individual to provide personal care services. Wis. Stat. § 50.065(1)(c).

1. Check the box that matches the type of entity for which you expect to be employed, licensed, contracted with, or a non-client resident and where you will have or are expected to have regular, direct contact with clients of the entity. Check all that apply.

	DHS Entity Type	Regulatory Organization	Admin. Code Reference	Statutory Reference
☐	Adult Family Homes (3 and 4 bed state licensed)	DQA	DHS 82, DHS 88	50.02(2), 50.02(2)(am)
☐	Ambulance Service Providers (does not include EMTs or First Responders)	DPH	DHS 110	256.08(4)
☐	Board on Aging and Long Term Care (includes ombudsman)	GOV		50.065(1)(c), 16.009
☐	Community Based Residential Facilities	DQA	DHS 83	50.02(2)
☐	Community Mental Health and Developmental Disabilities (includes mental illness, developmental disabilities and alcohol and other drug abuse programs or services)	DQA	DHS 61	51.42
☐	Community Substance Abuse Service Standards	DQA	DHS 75	51.42
☐	Community Support Programs for Chronically Mentally Ill Persons	DCTS	DHS 63	51.421
☐	Comprehensive Community Services for Persons with Mental Disorders and Substance Use Disorders	DQA	DHS 36	51.42(7)(b)
☐	Emergency Mental Health Services Programs	DQA	DHS 34	51.42(1)(b)
☐	Facilities Serving People with Developmental Disabilities	DQA	DHS 134	50.02(2)&(3)
☐	Home Health Agencies (state licensed)	DQA	DHS 133	50.49(2)
☐	Hospices	DQA	DHS 131	50.95
☐	Hospitals	DQA	DHS 124	50.36(1)
☐	Mental Health Day Treatment Services for Children	DQA	DHS 40	51.42
☐	Non-Profit Corporations and Unincorporated Associations as Guardians	DQA	DHS 85	54.15(7)
☐	Nursing Homes	DQA	DHS 132	50.03
☐	Outpatient Mental Health Clinics	DQA	DHS 35	51.42(7)(b)11
☐	Pain Clinics	DQA		50.60
☐	Personal Care Providers (includes county departments, independent living centers, American Indian tribes or bands, and freestanding personal care agencies)	DQA	DHS 101-109, 105.17	49.45(42)
☐	Residential Care Apartment Complexes	DQA	DHS 89	50.034
☐	Rural Medical Centers	DQA	DHS 127	50.51
☐	Any other direct client care or treatment program that may be licensed or certified or registered by the department. Please specify:		DHS 12.02(1)(b)	50.065

2. Responsibilities you will have or expect to have at the entity type(s) you selected. Attach additional sheets if necessary.

a. Job title

b. Name, address and telephone number of the entity (if known)

c. Summary of responsibilities

d. Type and amount of supervision you expect to have

SECTION E – EMPLOYMENT HISTORY

List all of your employers from at least the last 5 years. Explain any employment lapses. Attach letters, dated and signed, from current and previous employers about your character and job performance. Attach additional sheet(s) if necessary.

	Employer – Name, Address, and Phone Number	Position Held/Job Title	From	To	Reason(s) for Leaving
a.					
b.					
c.					
d.					

SECTION F – ADDRESSES

List all addresses below that you have used for at least the past 5 years. Include out-of-state addresses and addresses where you resided while serving in the U.S. Armed Forces. Attach and additional sheets if necessary.

	Date of Residence From	To	Street Address City, State, and Zip Code
a.			
b.			
c.			
d.			

SECTION G – CRIMINAL CONVICTIONS, PENDING CHARGES OR ARRESTS

1. Yes ☐ No ☐ Have you ever been convicted of a crime? If Yes, list each crime below for which you were convicted. Attach a copy of each criminal complaint and Judgment of Conviction. Copies may be obtained from the Clerk of Courts in the county where the conviction occurred. If unable to obtain, please explain why. Attach additional sheet(s) if necessary. In the Sentence box, include any ordered counseling or therapy, assessments, or participation in treatment or other programs. Attach proof or documentation of compliance.

Date of Conviction	Name of Crime and Statute Number	Sentence	Location of Court where Convicted (City, County, State)

Date of Conviction	Name of Crime and Statute Number	Sentence	Location of Court where Convicted (City, County, State)

Date of Conviction	Name of Crime and Statute Number	Sentence	Location of Court where Convicted (City, County, State)

2.	**Yes** ☐	**No** ☐	For any of the convictions listed in Section G, question number 1, have you ever requested clemency (pardon, commutation of sentence or a reprieve)? If Yes, indicate the date of the request, the name of the crime or offense and the result. Attach additional sheets if necessary.

Date of Request	**Name of Crime/Offense**	**Result**

3.	**Yes** ☐	**No** ☐	Are there any pending or existing criminal or civil arrests, warrants, judgments or other legal enforcement actions or injunctions against you? If Yes, state the date you were arrested or charged, the name of the offense or charge, the city, county and state in which you were charged and your explanation for the offense or charge. Attach additional sheets if necessary.

Date Charged	**Name of Offense**	**Name of Arresting Agency**

Place of Offense – City	**County**	**State**

Please explain:

SECTION H – OTHER GOVERNMENT OR REGULATORY FINDINGS OR INVESTIGATIONS

1.	**Yes** ☐	**No** ☐	Are you the subject of any pending investigation by a government or regulatory agency? If Yes, state the date of the alleged offense, the name of the offense, the name of the government or regulatory agency conducting the investigation, the city, county and state within which the investigation is being conducted, and your explanation of the reasons for the investigation. Attach additional sheets if necessary.

Date of Offense	**Name of Offense**	**Name of Agency**

Place of Offense – City	**County**	**State**

Please explain:

2.	**Yes** ☐	**No** ☐	Has a government or regulatory agency ever found that you abused or neglected a child? If Yes, state the date of the substantiated finding, the name of the offense, the name of the government or regulatory agency that made the finding, and the city, county and state where the incident occurred. Provide your explanation of what you did and the reason(s) why. Attach additional sheets if necessary.

Date of Finding	**Name of Offense**	**Name of Agency**

Place of Offense – City	**County**	**State**

Please explain:

3.	**Yes** ☐	**No** ☐	Has a government or regulatory agency determined that you abused or neglected an adult person or inappropriately took or used the property of a client or patient? If Yes, state the date of the substantiated finding, the name of the offense, the name of the government or regulatory agency that made the finding, and the city, county and state where the incident occurred. Provide your explanation of what you did and the reason(s) why. Attach additional sheets if necessary.

Date of Finding	**Name of Offense**	**Name of Agency**

Place of Offense – City	**County**	**State**

Please explain:

4.	**Yes** ☐	**No** ☐	Have you ever had a license, certification, or approval to provide care, treatment, or educational services revoked, limited, suspended or denied? If Yes, state the date of the action, the name of the license or certification, the name of the regulatory agency involved, indicate whether the license, certification, or approval was revoked, limited, suspended or denied, and the city, county and state where this occurred. Attach additional sheets if necessary.

Date of Action	**Name of License or Certification**	**Name of Agency**	☐ **Revoked** ☐ **Suspended** ☐ **Limited** ☐ **Denied**

Place of Offense – City	**County**	**State**

Please explain:

SECTION I – ADDITIONAL INFORMATION

1. Have you been required to participate in or voluntarily participated in any of the following? Check the box for each item as applicable. Your application may be returned to you if left blank. If Yes, provide proof of participation in or completion of programs.

	Yes	**No**	
a.	☐	☐	Counseling, therapy or other assessments
b.	☐	☐	Probation or parole
c.	☐	☐	Public or community service
d.	☐	☐	Volunteer work
e.	☐	☐	Restitution to victim or community
f.	☐	☐	Treatment program for anger management
g.	☐	☐	Treatment program for violence
h.	☐	☐	Treatment program for aggression
i.	☐	☐	Treatment program for parenting management
j.	☐	☐	Treatment program for sex offender issues
k.	☐	☐	Treatment program for alcohol or other drug related issues
l.	☐	☐	Other court ordered systems or procedures
m.	☐	☐	Recognition by other public or private authorities for accomplishments or efforts
n.	☐	☐	Registration as a sex offender Specify jurisdiction:
o.	☐	☐	Prison or jail

2. After reviewing the information obtained, the review panel shall decide whether the person has demonstrated, by clear and convincing evidence, that the person is rehabilitated for purposes of receiving regulatory approval, employment as a caregiver, or contracting with or residing at an entity. The panel shall consider at least the factors listed below. [Wis. Admin. Code DHS 12.12(4)(d)] Be sure to include information and documentation as applicable or supplemental to your responses to other sections of this application.

a. Personal reference checks and comments from employers, persons, and agencies familiar with the applicant and statements from therapists, counselors and other professionals.

b. Evidence of successful adjustment to, compliance with or proof of successful completion of parole, probation, incarceration or work release privileges.

c. Proof that the person has not had subsequent contacts with law enforcement agencies leading to probable cause to arrest or evidence of noncompliance leading to investigations by other regulatory enforcement agencies.

d. Any pending or existing criminal or civil arrest warrants, civil judgments or other legal enforcement actions or injunctions against the person.

e. Any aggravating or mitigating circumstances surrounding the crime, act or offense.

f. Evidence of rehabilitation, such as public or community service, volunteer work, recognition by other public or private authorities for accomplishments or efforts or attempts at restitution, and demonstrated ability to develop positive social interaction and increased independence or autonomy of daily living.

g. The amount of time between the crime, act or offense and the request for rehabilitation review, and the age of the person at the time of the offense.

h. Whether the person is on the sexual offender registry under Wis. Stat.§ 301.45, or on a similar registry in another jurisdiction.

i. A victim's impact statement, if appropriate.

j. Employment history, including evidence of acceptable performance or competency in a position and dedication to the person's profession.

k. The nature and scope of the person's contact with clients in the position requested.

l. The degree to which the person would be directly supervised or working independently in the position requested.

m. The opportunity presented for someone in the position to commit similar offenses.

n. The number, type and pattern of offenses committed by the person.

o. Successful participation in or completion of recommended rehabilitation, treatment or programs.

p. Unmet treatment needs.

q. The applicant's veracity.

SECTION J – DOCUMENTS AND INFORMATION TO BE SUBMITTED

The following is provided to help you ensure that your application for rehabilitation review approval is complete.

	Yes	No	Check the box for each item if applicable to you and provide the requested documents. The "Yes" box is already checked for items required of all applicants. Your application may be returned to you if left blank.
a.	☒	☐	Send the completed Wisconsin Criminal History Single Name Request (form DJ-LE-250) with a check or money order for $15 **to the WI Department of Justice**, Crime Information Bureau, Attn: Record Check Unit, P.O. Box 2688, Madison, WI 53701-2688. DOJ will send the results directly to the DHS Office of Legal Counsel. A partially completed copy of this form is included with this application – if not, contact the Rehabilitation Review Coordinator at 608-266-1900.
b.	☒	☐	Attach a completed and signed Background Information Disclosure (BID) form F-82064. A blank copy of this form is included with this application – if not, contact the Rehabilitation Review Coordinator at 608-266-1900.
c.	☒	☐	Character references, dated and signed, from at least 3 acquaintances.
d.	☒	☐	Dated and signed letters from current and/or past employers about your character and job performance.
e.	☒	☐	A completed and signed Confidential Information Release Authorization form F-82009 (copy included with this application – if not, contact the Rehabilitation Review Coordinator at 608-266-1900).
f.	☐	☐	Did you list anything in response to Section G, question number 1? If so, check the Yes box and provide the Criminal Complaint and Judgment of Conviction for each one listed.
g.	☐	☐	Were you sentenced for anything listed in response to Section G, question number 1? If Yes, provide proof or documentation of compliance with court orders.
h.	☐	☐	Have you resided outside of the state of Wisconsin over the past 5 years (see Section F)? If Yes, provide results of a recent criminal history check from each state.
i.	☐	☐	Have you served in a branch of the U.S. Armed Services? If Yes, provide the dates that you served, the branch you served with, and a copy of your discharge papers (DD-214).
j.	☐	☐	Did you answer Yes to any of the items in Section I, question number 1? If so, provide written proof of successful participation in or completion of programs, a signed and dated letter from your probation or parole officer, etc.
k.	☐	☐	Do you wish to provide documentation not already provided in response to any other question regarding any information associated with the factors listed in Section I, question number 2? If yes, please do so.
l.	☐	☐	Is there anything else you would like to provide that helps prove rehabilitation? If Yes, please do so.

ATTACHMENTS

Wisconsin Criminal History Single Name Request (Send to DOJ – see Section J.1.a.)

Background Information Disclosure (Return completed form with your completed application – see Section J.1.b)

Confidential Information Release Authorization (Return completed form with your completed application – see Section J.1.e)

APPLICANT'S SIGNATURE AND DATE

I certify that the information in this application is true and complete to the best of my knowledge. I understand that knowingly providing false information or omitting information may result in rehabilitation denial.

SIGNATURE – Applicant	Date Signed

MAILING INSTRUCTIONS: Send your completed application and associated documents to:

Department of Health Services, Office of Legal Counsel
1 West Wilson Street, Room 651
PO Box 7850
Madison, WI 53707-7850