



Please complete one application form for each participating community.

ORGANIZATIONAL PROFILE				
Date of Application	Corporate 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 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)	Occupancy Capacity			
Comments:				

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

FACILITY 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 WALA member?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have access to a computer and have internet access?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have a copy of your most recent State Survey Results?	Yes <input type="checkbox"/> No <input type="checkbox"/> (Results attached with application)
Do you have a Quality Assurance Program currently in place?	Yes <input type="checkbox"/> No <input type="checkbox"/>
What are your main objectives for participating in the Diamond Accreditation Program?	

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

PAYMENT INFORMATION

Member Fee: 3 – 8 beds \$100.00 9 – 30 beds \$125.00 31 – 60 beds \$150.00 60 + beds \$200.00

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

Check Enclosed:

Visa MasterCard American Express Discover

Card Number: _____

Exp. Date: _____ Cardholders Name: _____

Checklist of documents to submit with this application:

- Program Fee
- State Survey Results (if applicable)

By participating in the Diamond Accreditation 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 Diamond Accreditation Program. I agree not to make, use, sell, offer for sale, any product or service provided to me from the Diamond Accreditation Program without receiving permission of use defined by WALA 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 WALA Diamond Accreditation Program.

Signature

Date

Fax or Mail Application and Payment to:

WALA –Wisconsin Assisted Living Association, P.O. Box 7730, Madison, WI 53707-7730
Phone: (608) 288-0246 • Fax: (608) 288-0734 • E-mail: info@ewala.org • Website: www.ewala.org

Revised: 10/10/2016