

Southwest Family Care Alliance  
**Insurance Attestation**  
**(1-2 Bedroom Adult Family Homes)**



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Submit form to: **Southwest Family Care Alliance, Attn: Provider Network**

*Mail:* 28526 US HWY 14, Lone Rock, WI 53556 or *Fax:* (608) 647-4754

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(please print all information except signature)

Facility Name: \_\_\_\_\_

Facility Address: \_\_\_\_\_  
(street)

\_\_\_\_\_  
(city) (state) (zip)

Owner/Operator Name: \_\_\_\_\_

I attest that the aforementioned facility is currently carrying and will continue to carry the appropriate insurance commensurate with operating a certified Adult Family Home in the State of Wisconsin, and indemnification as noted in my contract with Southwest Family Care Alliance (Section VIII. A-D).

\_\_\_\_\_  
Owner/Operator Name (signature)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Owner/Operator Name (print)

An electronic version of this form is available on our website at <http://familycarealliance.org/providers.html>.