

BACKGROUND INFORMATION DISCLOSURE (BID)

- **PENALTY:** Knowingly providing false information or omitting information may result in a forfeiture of up to \$1,000 and other sanctions as provided in Wis. Admin. Code § DHS 12.05(4).
- Completion of this form is required under the provisions of Wis. Stat. § 50.065. Failure to comply may result in a denial or revocation of your license, certification, or registration, or denial or termination of your employment or contract.
- Refer to DQA form F-82064A, *BID Instructions*, for additional information.
- Providing your social security number is voluntary; however, your social security number is one of the unique identifiers used to prevent incorrect matches.
- **PRINT OR TYPE YOUR ANSWERS.**

Check the box that applies to you.

- | | |
|--|--|
| <input checked="" type="checkbox"/> Employee / Contractor (including new applicant) | <input type="checkbox"/> Household member (lives on premises, but is not a client) |
| <input type="checkbox"/> Applicant for a license, certification, or registration (including continuation or renewal) | <input type="checkbox"/> Other – Specify: _____ |

NOTE: If you are an owner, operator, board member, or non-client resident of a facility regulated by the Division of Quality Assurance (DQA), complete the BID, F-82064 and the [Appendix, F-82069](#), and submit both forms to the address noted in the Appendix Instructions.

Full Legal Name – First Michelle	Middle Marie	Last Phelps
Position Title (Complete only if a prospective or current employee or contractor.) Owner / Clinical Director	Birth Date (MM/dd/yyyy) 11/21/1980	Sex <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female

Any Other Names By Which You Have Been Known (Including Maiden Name)

Race / Ethnicity (Check ONLY one.) <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Black <input checked="" type="checkbox"/> White <input type="checkbox"/> Unknown	Social Security Number 399-88-7983		
Home Address 23926 4th Avenue	City Siren	State WI	Zip Code 54872

Business Name and Address – Employer or Care Provider (Entity)

Lakeside Trinity Care & Wellness - 23926 4th Avenue, Siren WI. 54872

A “NO” answer to all questions does not guarantee employment, residency, a contract, or regulatory approval.

SECTION A – ACTS, CRIMES, AND OFFENSES THAT MAY ACT AS A BAR OR RESTRICTION

1. Do you have any criminal charges pending against you, including in federal, state, local, military, and tribal courts?

If **Yes**, list each charge, when it occurred or the date of the charge, and the city and state where the court is located.

You may be asked to supply additional information, including a copy of the criminal complaint or any other relevant court or police documents.

Yes No

2. Were you ever convicted of any crime anywhere, including in federal, state, local, military, and tribal courts?

If **Yes**, list each crime, when it occurred or the date of the conviction, and the city and state where the court is located.

You may be asked to supply additional information including a certified copy of the judgment of conviction, a copy of the criminal complaint, or any other relevant court or police documents.

Yes No

3. **IMPORTANT: Read before completing item 3.**

Wis. Stat. § 48.981 **Abused and neglected children and abused unborn children.** (7)(a) **CONFIDENTIALITY.** "All reports made under this section, notices provided under sub. (3) (bm), and records maintained by an agency and other persons, officials, and institutions shall be confidential." Reports and records may be disclosed only to the persons identified in this section.

If you are the employer or prospective employer of the person completing this form and are entitled to obtain this information per the above, check this box.

Has any government or regulatory agency (other than the police) ever found that you committed child abuse or neglect?

Yes No

If the above box has been checked, provide an explanation below, including when and where the incident(s) occurred.

4. Has any government or regulatory agency (other than the police) ever found that you abused or neglected any person or client?

Yes No

If Yes, explain, including when and where it happened.

5. Has any government or regulatory agency (other than the police) ever found that you misappropriated (improperly took or used) the property of a person or client?

Yes No

If Yes, explain, including when and where it happened.

6. Has any government or regulatory agency (other than the police) ever found that you **abused an elderly person?**

Yes No

If Yes, explain, including when and where it happened.

7. Do you have a government issued credential that is not current or is limited so as to restrict you from providing care to clients?

Yes No

If Yes, explain, including credential name, limitations or restrictions, and time period.

SECTION B – OTHER REQUIRED INFORMATION

1. Has any government or regulatory agency ever limited, denied, or revoked your license, certification, or registration to provide care, treatment, or educational services? Yes No

If Yes, explain, including when and where it happened.

2. Has any government or regulatory agency ever denied you permission or restricted your ability to live on the premises of a care providing facility? Yes No

If Yes, explain, including when and where it happened and the reason.

3. Have you been discharged from a branch of the US Armed Forces, including any reserve component? Yes No

If Yes, indicate the year of discharge: _____

Attach a copy of your DD214, if you were discharged within the last three (3) years.

4. Have you resided outside of Wisconsin in the last three (3) years? Yes No

If Yes, list each state and the dates you resided there.

5. If you are employed by or applying for the State of Wisconsin, have you resided outside of Wisconsin in the last seven (7) years? Yes No

If Yes, list each state and the dates you resided there.

6. Have you had a caregiver background check done within the last four (4) years? Yes No

If Yes, list the date of each check, and the name, address, and phone number of the person, facility, or government agency that conducted each check.

DHS background check completed 12/28/2025 as part of
Medicaid supportive home care agency enrollment
1 West Wilson Street, Room 150, Madison, WI 53703
Phone: 608-266-0955

7. Have you ever requested a rehabilitation review with the Wisconsin Department of Health Services, a county department, a private child placing agency, school board, or DHS-designated tribe?

Yes No

If Yes, list the review date and the review result. You may be asked to provide a copy of the review decision.

Read and initial the following statement.

MP I have completed and reviewed this form (F-82064, BID) and affirm that the information is true and correct as of today's date.

Name – Person Completing This Form

Michelle Phelps

Date Submitted

02/19/2026