

**DEPARTMENT OF HEALTH SERVICES**

Division of Enterprise Services  
F-22018 (Rev. 12/2008)

**STATE OF WISCONSIN**

SOS Desk (608) 266-9198  
Completion of this form meets the requirements of  
the State / County contract specified under the  
Wisconsin Statutes. S. 46.031(2g).  
P.L. 97-35; Federal Regulations: 42 CFR 441

**HSRS LONG-TERM SUPPORT MODULE  
MODULE TYPE A**

REGISTRATION - Screen L1 N/U/I/E (Module Key: )												
1 Worker ID		2a Last Name			2b First Name		2c Middle Name		2d Suffix	3 MA Number (10 digits) OR SSN (9 digits)		
4 Client ID		5 Birthdate (mm/dd/yyyy)		6 Sex <input type="checkbox"/> F <input type="checkbox"/> M	7a Hispanic/Latino <input type="checkbox"/> Yes <input type="checkbox"/> No		7b Race (Circle up to 5) <input type="checkbox"/> A=Asian <input type="checkbox"/> B=Black or African American <input type="checkbox"/> W=White <input type="checkbox"/> I=American Indian or Alaska Native <input type="checkbox"/> P=Native Hawaiian or Pacific Islander			8 Client Characteristics		
9 Level of Care	10 Marital Status	11 Living Arrangement Prior      Current      People		12 Natural Support Source	13 Type of Movement / Prior Location (Check 1) (Optional for COP assessment, plan, applicant register) <input type="checkbox"/> N=Relocated from general nursing home <input type="checkbox"/> D=Diverted from entering any type of institution <input type="checkbox"/> F=Relocated from ICF / MR facility <input type="checkbox"/> B=Relocated from brain injury rehab unit							
14 Special Project Status		15 County of Fiscal Responsibility	16 Court Ordered Placement <input type="checkbox"/> Y=Yes <input type="checkbox"/> N=No	17 MA Waiver Financial Eligibility Type <input type="checkbox"/> A=Categorically eligible <input type="checkbox"/> B=Categorically financially eligible - special income limit <input type="checkbox"/> C=Medically needy <input type="checkbox"/> D=COP eligible			18 Indicator for Waiver Mandate (Optional for COP assessment, plan, applicant register) <input type="checkbox"/> A=MA Waiver eligible <input type="checkbox"/> B=Not MA Waiver eligible <input type="checkbox"/> C=MA Waiver eligible but exempt					
SERVICES - Screen L2 U/I (Module Key: )												
19 Episode End Date		20 Closing Reason		CIP1A and CLTS-W Only			*Provider Number Required for SPCs: 102 Adult day care 202/01/02 Adult family home 506 CBRF 604 Supportive and service coordination (CIP1A, 1B, BIW, CLTS-W, COR) 711 Residential care apt. complex 896 ICF-MR/NH residents					
				21 Slot Number	22 Start Date	23 End Date						
				STATE USE ONLY	STATE USE ONLY							
PGM No	24 SPC/Subprogram	25 Target Group	26 LTS Code	27 Funding Source	28 SPC Start Date	29 SPC End Date	30 Provider Number * Required for some SPCs			31 SPC Review Date mm      yyyy		
OPTIONAL DATA - Screen 18												
Street Address				City		State	Zip Code	County		Telephone (      )		
Case Review Date		Diagnosis		Family ID		Local Data		<b>Shaded areas are optional.</b>				

