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| **DEPARTMENT OF HEALTH SERVICES**Division of Public HealthF-00046 (02/2024) | **STATE OF WISCONSIN** |

**FAMILY CARE PROGRAM ENROLLMENT**

**INSTRUCTIONS AND IMPORTANT INFORMATION**

Completion of this form is voluntary; however, this form must be completed if you are interested in enrolling in the Family Care program. If you want to apply for this program, you must contact your local aging and disability resource center (ADRC) or if you are a tribal member, you may also contact your Tribal Aging and Disability Resource Specialist (ADRS). Contact information for local ADRCs or Tribal ADRS can be found at [www.dhs.wisconsin.gov/adrc/consumer/index.htm](http://www.dhs.wisconsin.gov/adrc/consumer/index.htm).

**HOW TO USE THIS FORM**

1. Read the Important Information section and all the instructions before signing the form. If you need information in another language or format, please contact your local ADRC or Tribal ADRS.
2. Only the individual, their legal guardian, conservator, or activated power of attorney, can sign this form.

**IMPORTANT INFORMATION**

* Signing this form does not guarantee you will be eligible for the Family Care program.
* After you sign this form, you can choose not to enroll.
* Enrollment in Family Care is voluntary, and you may disenroll at any time.
* Changes in your health or financial situation may affect your eligibility for this program. If such changes occur, talk with your managed care organization (MCO) care manager or Tribal case manager, if applicable.

**SIGNING THIS FORM**

I understand that my signature (or the signature of my legal guardian, conservator, or activated power of attorney) on this form means I have read and understand the contents of this form, including information about date of enrollment and assurance of choice below. I certify that all my answers are complete to the best of my knowledge. I understand that if I intentionally hide information or provide false information on this form, I may be disenrolled from the program. I understand that my signature authorizes the ADRC or Tribal ADRS to release my information to:

* The Managed Care Organization
* Another ADRC or Tribal ADRS
* The tribe of affiliation, if provided
* Income maintenance agencies
* Medicaid
* Medicare
* Service providers and their authorized representatives for the purpose of providing my care.

**REQUESTED DATE OF ENROLLMENT**

You may choose the date you would like to enroll in the program. However, enrollment cannot occur before the date:

* The ADRC or Tribal ADRS receives this signed form.
* You meet all functional and financial eligibility requirements.

**ASSURANCE OF CHOICE**

The primary purpose of the Family Care program is to help you get the services you need to live in your own home or community whenever possible.

**PERSONAL INFORMATION**

Under Wis. Stat. § 49.45(4), your personally identifiable information is kept confidential and is only used for the direct administration of the Family Care program.

**ADDITIONAL INSTRUCTIONS**

**Section I**

* “County of Residence” means the county in which you physically live.
* “County of Responsibility” means the county that has responsibility to provide mental health or other services.
* “Permanent Street Address” means the address of the residence in which you physically live.

**Section II**

This section will be completed if you have a legal guardian, conservator, activated power of attorney, or Medicaid authorized representative.

**Section III**

Please provide emergency contact information of a friend or relative whom we can contact in case of an emergency.

**Section IV**

This section will be completed if applicable.

**Section V**

Your signature or the signature of your legal guardian, conservator, or activated power of attorney is required. If you sign with a mark, two witness signatures are required. If you are physically unable to sign, you may direct an adult to sign the form in front of two witnesses. The person who signs on your behalf should indicate that they are signing at the direction of the applicant.

The ADRC or Tribal ADRS must retain the originally signed enrollment form, or an electronically scanned copy of the signed form, for ten years in the event of a records request.

**FAMILY CARE PROGRAM: ENROLLMENT**

**CIP**

**INSTRUCTIONS**: Before signing this form, read all instructions.

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| **SECTION I –PERSONAL INFORMATION** |
| Individual Name (First, MI, Last)      | Date of Birth      |
| Current Marital Status(Check one box only)[ ]  Single [ ]  Married [ ]  Widowed | If Currently Married, Name of Spouse(First, MI, Last)      |
| Mailing Address      | City      | State     | Zip Code      |
| Phone Number      | County of Residence      | County of Responsibility      |
| American Indian or Alaskan Native [ ]  Yes [ ]  No | American Indian/Alaskan Native Affiliation      |
| Email Address      |
| Permanent Street Address (If different than above)      | City      | State     | Zip Code      |
| Facility Name—Check Type:      | [ ]  NH [ ]  ICF-IID [ ]  CBRF[ ]  AFH [ ]  RCAC | Date of NH/ICF-IID Admission      |
| Facility Street Address (If different than above)      | City      | State     | Zip Code      |
| **SECTION II – ALTERNATIVE ENROLLMENT AUTHORITY** |
| Do you have a Legal Guardian? [ ]  Yes [ ]  NoType: [ ]  Guardian of Person [ ]  Guardian of Estate [ ]  Guardian of Person and Estate |
| Name of Guardian (First, MI, Last)      | Phone Number      |
| Mailing Address Street Address      | City      | State     | Zip Code      |
| Do you have a Legal Guardian? [ ]  Yes [ ]  NoType: [ ]  Guardian of Person [ ]  Guardian of Estate [ ]  Guardian of Person and Estate |
| Name of Guardian (First, MI, Last)      | Phone Number      |
| Mailing Address Street Address      | City      | State     | Zip Code      |
| Do you have an Activated Power of Attorney for Finance and Property (POAF)? [ ]  Yes [ ]  No |
| Name of POAF (First, MI, Last)      | Phone Number      |
| Mailing Address Street Address      | City      | State     | Zip Code      |
| Do you have an Activated Power of Attorney for Health Care (POAHC)?[ ]  Yes—Date Activated:       [ ]  No |
| Name of POAHC (First, MI, Last)      | Phone Number      |
| Mailing Address Street Address      | City      | State     | Zip Code      |
| Do you have a Conservator? [ ]  Yes—Date conservator ordered       [ ]  No |
| Name of Conservator (First, MI, Last)      | Phone Number      |
| Mailing Address Street Address      | City      | State     | Zip Code      |
| Do you have a Medicaid Authorized Representative as Designated on DHS form[F-10126A](https://www.dhs.wisconsin.gov/forms/f10126a.pdf) or [F-10126B](https://www.dhs.wisconsin.gov/forms/f10126b.pdf)  [ ]  Yes—Date Signed:       [ ]  No |
| Name of Medicaid Authorized Representative (First, MI, Last)      | Phone Number      | County of Residence      |
| Mailing Address Street Address      | City      | State     | Zip Code      |
| **SECTION III –ADDITIONAL CONTACT INFORMATION** |
| List the name of a friend or relative we can contact in case of an emergency.      |
| Name of Contact (First, MI, Last)      | Daytime Phone Number)      | Evening Phone Number       |
| Relationship to You      |
| **SECTION IV – INSURANCE INFORMATION** |
| Do you currently have medical/health insurance coverage such as employer-provided health insurance, private insurance, VA benefits, TRICARE or federal employee health benefits coverage? [ ]  Yes [ ]  No |
| Name and Address of Insurance Company      | Policy or Identification Number      |
| Group Number      |
| Do you currently have prescription drug coverage? [ ]  Yes [ ]  No |
| Name of Coverage      | Policy or Identification Number      | Group Number      |
| Do you receive Social Security Benefits? [ ]  Yes [ ]  No |
| Do you receive Railroad Retirement Board (RRB)? [ ]  Yes [ ]  No |
| **For individuals who are eligible for Medicare**: | Effective Date: (mm/dd/yyyy) |
| Beneficiary Name (first, MI, last):        | **HOSPITAL (PART A)**       |
| Medicare Beneficiary Identifier (MBI):        | **MEDICAL (PART B)**       |
| **SECTION V – ENROLLMENT CHOICE AND SIGNATURE** |
| Enrollment for: [ ]  Family Care  | Name of MCO:       |
| Family Care Tribal Care Management if selected:[ ]  Menominee [ ]  Oneida | Name of MCO:      |
| **I, the undersigned, do hereby state my intent and do hereby agree to enroll into the Family Care program identified above.** |
| **SIGNATURE –** Individual | Date Signed |
|  |  |
| **SIGNATURE –** Legal Guardian, Conservator, or Activated Power of Attorney | Date Signed |
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| **SIGNATURE** – Witness (if applicable) | Date Signed |
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| **SIGNATURE** – Witness (if applicable) | Date Signed |
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| **For ADRC or Tribal ADRS Office Use Only** |
| ADRC or Tribe:       | County:       |
| ADRC or Tribal ADRS Worker:       | Phone Number:       |
| Email Address:       |
| Enrollment Date Information:Actual Date of Enrollment:     [ ]  Enrollment date pending: Urgent Services[ ]  Enrollment date pending: Pre-Release Agreement[ ]  Enrollment date pending: Transfer to new agency with move. | Program:[ ]  Family Care | Verify HMO End Date if applicable:      |
| Enrollment Status in FHiC:[ ]  Enrollment date in FHiC[ ]  Enrollment date not in FHiC pending MA or IRIS entry in system. MCO does not update LTCFS until enrollment is verified in FHiC. |  |  |
| Medicaid Recipient [ ]  Yes [ ]  NoMedicaid ID No:      Language for CARES Notice:[ ]  English [ ]  Spanish | Level Of CareCheck the assigned NH/NNH LOC in the left column and then check the appropriate DD LOC in the right column. A maximum of two boxes should be checked.

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| Choose 1 | Choose 1 |
| [ ] NH-ISN[ ] NH-SNF[ ] NH-ICF[ ] NNH | [ ] DD1A[ ] DD1B[ ] DD2[ ] DD3[ ] NDD |

 | Target Group:[ ]  FE[ ]  ID/DD[ ]  PD  |
| [ ]  Individual is currently enrolled in Children’s Waiver (CLTS) |
| Name – CLTS Worker      | County      |
| Phone Number      | Email Address      |
| Distribution of completed form: | [ ]  Individual, Guardian, Conservator, or Activated Power of Attorney[ ]  Selected MCO[ ]  Income Maintenance, if applicable[ ]  Tribe, if applicable[ ]  CLTS Worker, if applicable |