DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-02746 (12/2020)

STATE OF WISCONSIN

REQUEST FOR INSTITUTION OF MENTAL DISEASE DETERMINATION FOR RESIDENTIAL SUBSTANCE USE DISORDER FACILITIES

Federal Medicaid funding for services rendered in institutions of mental disease (IMDs) for non-elderly adults has been forbidden since the founding of the Medicaid program. Through a 1115 demonstration waiver, the Centers for Medicare & Medicaid Services (CMS) has authorized Wisconsin Medicaid to reimburse for residential substance use disorder (SUD) treatment in IMDs. To comply with federal reporting requirements, Wisconsin Medicaid must determine the IMD status of each residential SUD treatment facility. This determination must be made prior to enrolling as a Wisconsin Medicaid residential SUD treatment provider. **If a facility changes ownership or capacity, an updated determination request must be submitted.**

INSTRUCTIONS

Submit this completed form along with copies of all licenses and certifications required for operation of a Wisconsin residential SUD treatment facility to DHSMedicaidSUD@dhs.wisconsin.gov. The Division of Medicaid Services will review the submitted information and will determine whether additional steps to gather information, including a site visit to the facility or facilities, are necessary to determine the facility's IMD status. A final written determination will be provided to the facility administrator for use during enrollment as a Wisconsin Medicaid residential SUD treatment provider. Failure to complete this form fully and accurately may result in a delay in processing or a denial of enrollment.

Call Provider Services at 800-947-9627 or email DHSMedicaidSUD@dhs.wisconsin.gov with questions regarding the completion of this form.

Section I – Facility Information

Name – Facility A				
Street Address – Facility	City	State	Zip Code	County
Facility License Number	Treatment Service Certification Number			
Name – Legal Representative	Email – Legal Representative			

Section II – Licensee Information

Name – Corporation or Legal Entity	Federal Employer ID Number			
Name – Licensee/Legal Representative	Email – Licensee/Legal Representative			
Street Address – Licensee/Legal Representative	City	State	Zip Code	County
Phone Number – Licensee/Legal Representative	Agency Website Address			

Section III – Affiliated Facilities

Does the licensee in Section II own or have affiliations with any other Wisconsin residential SUD facilities?

☐ Yes ☐ No

If the licensee is a corporation, limited liability company, board, or other governing body, do the individuals with a financial or controlling interest in the licensed facility in Section I also own or have affiliations with any other Wisconsin residential SUD facilities?

☐ Yes ☐ No

For each facility owned by or associated with the licensee or the individuals who control the licensee, provide the information requested below, including the people who are responsible for key business functions. Attach additional sheets if necessary. If there are no additional facilities, skip to Section IV.

Name – Facility B

Street Address – Facility	City	State	Zip Code	County

Phone Number – Facility	Email – Administrator

Name – Facility C

Street Address – Facility	City	State	Zip Code	County

Phone Number – Facility	Email – Administrator

Name – Facility D

Street Address – Facility	City	State	Zip Code	County

Phone Number – Facility	Email – Administrator

People Responsible for Key Business Functions

Facility	Name of Person Responsible for Company Administration and Title (For Example, CEO)	Name and National Provider Identifier of Medical Director or Person in Charge of Clinical Services	Names of Related Facilities That Share Staff With This Facility
Facility A			
Facility B			
Facility C			
Facility D			

❑ Check this box to request determination of IMD status for the additional facilities listed in Section III. Complete Sections I, II, and IV of this form for each facility for which a determination of IMD status is requested. Submit the additional forms with this form along with copies of supporting licenses and certificates.

Section IV – Capacity and Population

For each facility listed in Sections I and III, provide information about the psychological or SUD services provided, the licensed capacity, and the number of licensed beds used to provide psychological or SUD treatment.

Facility	Psychological or SUD Services Provided at This Location (For Example, Outpatient, Intensive Outpatient, Day Treatment, Detoxification)	Total Number of Licensed Beds	Number of Beds for Psychological or SUD Treatment
Facility A			
Facility B			
Facility C			
Facility D			

Are any facilities listed above long-term residential care settings for individuals receiving services through a home and community-based waiver program?

☐ Yes ☐ No

If individuals are residing at any facility listed above for reasons other than psychological or SUD treatment, identify the number of beds used and services provided to these individuals.

Section V – Attestation

The signatory of this document is duly authorized by the applicant/licensee to sign on its behalf. The applicant/licensee accepts responsibility for the accuracy of the information provided.

I attest under penalty of law that the information provided above is truthful and accurate to the best of my knowledge. I understand that knowingly providing false information or omitting information may result in denial or termination of Medicaid enrollment, a fine of up to $10,000, or imprisonment per Wis. Stat. § 946.32.

SIGNATURE – Licensee/Legal Representative	Date Signed
Printed Name – Licensee/Legal Representative	Title/Position

Reset Form