

**WISCONSIN MEDICAID  
ADULT LONG-TERM CARE (LTC) WAIVER PROVIDER APPLICATION  
INFORMATION AND INSTRUCTIONS**

In order to care for members and participants in the Family Care, Family Care Partnership, Program of All Inclusive Care for the Elderly (PACE), and IRIS (Include, Respect, I Self-Direct) programs, providers are required to enroll in Wisconsin Medicaid.

When a provider requests assistance enrolling in Wisconsin Medicaid, a managed care organization (MCO) or IRIS fiscal employer agent (FEA) will use the information on this form to complete the electronic enrollment application on behalf of the provider.

Personally identifiable information about providers is used for purposes directly related to program administration and application processing.

The use of this form is mandatory.

**INSTRUCTIONS:** The provider must type or print applicable information on this form. Complete all sections. If a question does not apply to the provider, they should write "N/A" in the field. Failure to complete all sections of this form will cause a delay in enrollment.

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**SECTION I – TYPE OF APPLICATION**

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Individual       Organization

This application is for one of the following:

Initial Enrollment

Re-enrollment of Previous Provider ID

Previous Provider ID \_\_\_\_\_

Change in Ownership

Previous Provider ID \_\_\_\_\_

Effective Date of Change in Ownership \_\_\_\_\_

Revalidation – Occurs every three years after initial enrollment

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**SECTION II – IDENTIFYING INFORMATION**

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**Individual Applicant Only**

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Name – Provider Applicant (Last Name, First Name, Middle Initial)

Date of Birth

Gender

Male       Female

Social Security Number (SSN)

Are you currently employed by a clinic?

Yes

No

**Note: This question is not part of enrollment for LTC waiver only providers; therefore, an answer of no will be included for all such enrollments.**

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**Organization Applicant Only**

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Special Instructions:

**Name – Provider Applicant:** Enter only one name. Organizations using a “doing business as” (DBA) identity must enter the DBA name. The name entered on this line must exactly match the applicant’s name used on all other information supplied to Wisconsin Medicaid.

**Language:** Indicate the language(s) spoken by the organization applicant's staff who are available to interpret for members.

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Name – Provider Applicant

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Language:

English

Spanish

Russian

Hmong

Other:

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**SECTION III – ADDRESS INFORMATION**

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Special Instructions:

**Practice Location Information:** Practice location is the street address where the provider’s office is physically located (even if services are delivered in a home or community setting), or where the provider’s facility is physically located and/or where you render services.

Note: Some providers with multiple practice locations will need a separate enrollment application for each location. Additional information is in the Family Care, Family Care Partnership, PACE, or IRIS program area of the Online Handbook.

**Medicaid Contact Person and Phone Number:** Enter the name, phone number, and extension of the Medicaid contact person. This information will be used for Medicaid administrative purposes only.

**Phone Number for Member Use:** Enter the phone number members should use when contacting the provider. If applicable, this number will be made available to the public in a provider directory search. See Section IX – Provider Directory.

**Mailing Information:** Indicate the address where Wisconsin Medicaid should send general information and correspondence. Audit correspondence may be sent certified mail. Failure to sign for certified mail could result in disenrollment.

**Email Address:** An email address is required.

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**Practice Location Information**

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Address – Practice Location (Street, City, State, Zip+4 Code)

County

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Name – Medicaid Contact Person

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Phone Number – Medicaid Contact Person

Phone Number for Member Use

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**Mailing Information**

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Name

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Attention

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Address (Street, City, State, Zip+4 Code)

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Email Address (Required)

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#### SECTION IV – PROVIDER TYPE AND SPECIALTY

Check the provider type and specialty for this application from the list below. Choose only one provider type and specialty per application. Additional information about the following provider types and specialties is in the Family Care, Family Care Partnership, PACE, or IRIS program area of the Online Handbook to help you make your selection.

- |  |   |
|--|---|
| <input type="checkbox"/> Waiver Aging and Disability Support Agency        | <input type="checkbox"/> Waiver Living Environment Adaptation             |
| <input type="checkbox"/> Aging and Disability Support Agency               | <input type="checkbox"/> Contractors—Licensed                             |
| <input type="checkbox"/> Aging and Disability Support Facility             | <input type="checkbox"/> Mover/Moving Company                             |
| <input type="checkbox"/> Waiver Community Services & Support               | <input type="checkbox"/> Public Utilities                                 |
| <input type="checkbox"/> Camp  | <input type="checkbox"/> Real Estate Agency/Landlords                     |
| <input type="checkbox"/> Community Services & Support                      | <input type="checkbox"/> Waiver Microboard                                |
| <input type="checkbox"/> Education & Training Agency                       | <input type="checkbox"/> Waiver Non-Residential Day & Vocational Services |
| <input type="checkbox"/> Fitness Center                                    | <input type="checkbox"/> Non-Residential & Vocational Facility            |
| <input type="checkbox"/> Housing Counseling Agency                         | <input type="checkbox"/> Non-Residential & Vocational Services            |
| <input type="checkbox"/> Personal Assistant, Teacher                       | <input type="checkbox"/> Waiver Nurse Service                             |
| <input type="checkbox"/> Waiver Counseling & Therapeutic Services          | <input type="checkbox"/> Waiver Personal Emergency Response Systems       |
| <input type="checkbox"/> Waiver Equipment & Accessibility-Related Services | <input type="checkbox"/> Waiver Residential Services                      |
| <input type="checkbox"/> Accessibility Assessment                          | <input type="checkbox"/> 1–2 Bed Adult Family Home                        |
| <input type="checkbox"/> Assistive, Communication, or Adaptive Aids        | <input type="checkbox"/> 3–4 Bed Adult Family Home                        |
| <input type="checkbox"/> Medical Equipment & Supplies                      | <input type="checkbox"/> Community-Based Residential Facility             |
| <input type="checkbox"/> Support Broker                                    | <input type="checkbox"/> Residential Care Apartment Complex               |
| <input type="checkbox"/> Waiver Financial Management                       | <input type="checkbox"/> Waiver Retail Store                              |
| <input type="checkbox"/> Waiver Fiscal Employer Agent                      | <input type="checkbox"/> Waiver Supportive Home Care Agency               |
| <input type="checkbox"/> Waiver Interpreter                                | <input type="checkbox"/> Waiver Transportation                            |
|  | <input type="checkbox"/> Common Carrier/Mass Transit                      |
|  | <input type="checkbox"/> Specialized Transport                            |
|  | <input type="checkbox"/> Waiver Tribal Provider                           |

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#### SECTION V – LTC WAIVER PROVIDER SERVICE ENROLLMENT

Enter all applicable waiver services provided. Additional information about which services the provider may provide is in the Family Care, Family Care Partnership, PACE, or IRIS program area of the Online Handbook.

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#### SECTION VI – LTC WAIVER PROVIDER PROGRAM ENROLLMENT

Select all applicable waiver programs:

- |  |                               |
|--|-------------------------------|
| <input type="checkbox"/> Family Care             | <input type="checkbox"/> PACE |
| <input type="checkbox"/> Family Care Partnership | <input type="checkbox"/> IRIS |
-

**SECTION VII – TYPE OF BUSINESS**

Note: This section is for Organization applicants only. State of Registration is only required for Partnership or Corporation for Profit.

Applicant's type of business (Check appropriate box.)

Corporation for Nonprofit

Corporation for Profit

State of Registration \_\_\_\_\_

Limited Liability

Partnership

State of Registration \_\_\_\_\_

Names of all partners and SSNs (Use additional sheets if needed.)

Name \_\_\_\_\_ SSN \_\_\_\_\_

Name \_\_\_\_\_ SSN \_\_\_\_\_

Name \_\_\_\_\_ SSN \_\_\_\_\_

Government (Check one)

County Agency

State Agency

Municipality (City, Town, Village)

Tribal Agency

City / County Agency

**SECTION VIII – PROVIDER FINANCIAL INFORMATION**

Special Instructions:

**Name – Taxpayer:** Enter the taxpayer's name for the Taxpayer Identification Number (TIN) exactly as it is recorded with the Internal Revenue Service (IRS). Individuals reporting income to the IRS under an SSN must enter the individual name recorded with the IRS for the SSN.

**TIN:** Enter the TIN that should be used to report income to the IRS. The number entered must be the TIN of the taxpayer's name entered. The taxpayer's name and TIN must match exactly what is on record with the IRS.

**TIN Type:** Check whether the TIN is an Employer Identification Number (EIN) or an SSN.

**Taxpayer Information**

Name – Taxpayer

TIN	TIN Type <input type="checkbox"/> EIN <input type="checkbox"/> SSN
TIN Effective Date	TIN End Date

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**Checks and Remittance Advice Information**

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Address (Street, City, State, Zip+4 Code)

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Name – Financial Contact Person

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Phone Number – Contact Person

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**1099 Mailing Address**

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Address (Street, City, State, Zip+4 Code)

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**SECTION IX – PROVIDER DIRECTORY**

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The following information will appear in the Provider Directory:

- Name
- Address
- Phone Number
- Waiver Service
- Waiver Program
- Counties Served
- Tribes Served

The following provider types are required to appear in the Provider Directory:

- Waiver Aging and Disability Support Agency
- Waiver Community Services and Support
- Waiver Counseling and Therapeutic Services
- Waiver Equipment and Accessibility-Related Services
- Waiver Financial Management
- Waiver Interpreter
- Waiver Living Environment Adaptation
- Waiver Non-Residential Day and Vocational Services
- Waiver Nurse Service
- Waiver Personal Emergency Response Systems
- Waiver Residential Services
- Waiver Supportive Home Care Agency
- Waiver Transportation

If your provider type is not listed above, you have the option to opt out of being listed in the provider directory.

Do you wish to appear in the Provider Directory?     Yes     No

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**SECTION X – COUNTIES AND/OR TRIBES SERVED**

Check each county and tribe for which services will be provided. If you are a provider outside of Wisconsin but travel to Wisconsin counties or tribes to serve members or know the counties and tribes in which the members you serve reside, check each county and tribe below.

Select if you are a provider outside of Wisconsin and do not travel into the state to serve members or do not know the counties or tribes in which the members you serve reside.

- |                                     |                                      |                                    |                                      |
|-------------------------------------|--------------------------------------|------------------------------------|--------------------------------------|
| <input type="checkbox"/> Adams      | <input type="checkbox"/> Florence    | <input type="checkbox"/> Marathon  | <input type="checkbox"/> Rusk        |
| <input type="checkbox"/> Ashland    | <input type="checkbox"/> Fond du Lac | <input type="checkbox"/> Marinette | <input type="checkbox"/> Sauk        |
| <input type="checkbox"/> Barron     | <input type="checkbox"/> Forest      | <input type="checkbox"/> Marquette | <input type="checkbox"/> Sawyer      |
| <input type="checkbox"/> Bayfield   | <input type="checkbox"/> Grant       | <input type="checkbox"/> Menominee | <input type="checkbox"/> Shawano     |
| <input type="checkbox"/> Brown      | <input type="checkbox"/> Green       | <input type="checkbox"/> Milwaukee | <input type="checkbox"/> Sheboygan   |
| <input type="checkbox"/> Buffalo    | <input type="checkbox"/> Green Lake  | <input type="checkbox"/> Monroe    | <input type="checkbox"/> St. Croix   |
| <input type="checkbox"/> Burnett    | <input type="checkbox"/> Iowa        | <input type="checkbox"/> Oconto    | <input type="checkbox"/> Taylor      |
| <input type="checkbox"/> Calumet    | <input type="checkbox"/> Iron        | <input type="checkbox"/> Oneida    | <input type="checkbox"/> Trempealeau |
| <input type="checkbox"/> Chippewa   | <input type="checkbox"/> Jackson     | <input type="checkbox"/> Outagamie | <input type="checkbox"/> Vernon      |
| <input type="checkbox"/> Clark      | <input type="checkbox"/> Jefferson   | <input type="checkbox"/> Ozaukee   | <input type="checkbox"/> Vilas       |
| <input type="checkbox"/> Columbia   | <input type="checkbox"/> Juneau      | <input type="checkbox"/> Pepin     | <input type="checkbox"/> Walworth    |
| <input type="checkbox"/> Crawford   | <input type="checkbox"/> Kenosha     | <input type="checkbox"/> Pierce    | <input type="checkbox"/> Washburn    |
| <input type="checkbox"/> Dane       | <input type="checkbox"/> Kewaunee    | <input type="checkbox"/> Polk      | <input type="checkbox"/> Washington  |
| <input type="checkbox"/> Dodge      | <input type="checkbox"/> La Crosse   | <input type="checkbox"/> Portage   | <input type="checkbox"/> Waukesha    |
| <input type="checkbox"/> Door       | <input type="checkbox"/> Lafayette   | <input type="checkbox"/> Price     | <input type="checkbox"/> Waupaca     |
| <input type="checkbox"/> Douglas    | <input type="checkbox"/> Langlade    | <input type="checkbox"/> Racine    | <input type="checkbox"/> Waushara    |
| <input type="checkbox"/> Dunn       | <input type="checkbox"/> Lincoln     | <input type="checkbox"/> Richland  | <input type="checkbox"/> Winnebago   |
| <input type="checkbox"/> Eau Claire | <input type="checkbox"/> Manitowoc   | <input type="checkbox"/> Rock      | <input type="checkbox"/> Wood        |

**Tribes Served**

- |   |   |
|---|---|
| <input type="checkbox"/> Bad River Band           | <input type="checkbox"/> Oneida Nation                      |
| <input type="checkbox"/> Forest County Potawatomi | <input type="checkbox"/> Red Cliff Band                     |
| <input type="checkbox"/> Ho-Chunk Nation          | <input type="checkbox"/> St. Croix Chippewa Community       |
| <input type="checkbox"/> Lac du Flambeau Band     | <input type="checkbox"/> Sokaogon Chippewa Community        |
| <input type="checkbox"/> Lac Courte Oreilles Band | <input type="checkbox"/> Stockbridge-Munsee Band of Mohican |
| <input type="checkbox"/> Menominee Indian Tribe   |   |

**SECTION XI – MEDICAID SERVICE PROVIDER COUNT AND MEDICAID MEMBER COUNT**

The Wisconsin Department of Health Services is collecting the number of Medicaid service providers and number of Medicaid members the provider can serve. This information will be used in analysis of the Medicaid provider network, to ensure an adequate number of providers are available in the state to serve Medicaid members and participants.

**Medicaid Service Provider Count:** Enter the approximate number of providers who serve Medicaid members, including members enrolled in an LTC program. Do not include administrative or other staff who do not directly provide services to Medicaid members, including members enrolled in an LTC program.

**Medicaid Member Count:** Enter the approximate number of Medicaid members, including members enrolled in an LTC program, the provider’s organization can typically serve at any given point in time.

Number of Providers	Number of Medicaid Members

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**SECTION XII – STATE LICENSE INFORMATION**

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Check the license type and enter the license number and issuing state.

<input type="checkbox"/> DAT – Dept of Agriculture, Trade and Consumer Protection License # _____ Issuing State: _____	<input type="checkbox"/> FDA – Federal Drug Administration License # _____ Issuing State: _____
<input type="checkbox"/> DCF – Department of Children and Families License # _____ Issuing State: _____	<input type="checkbox"/> NCC – National Commission for Certifying Agencies License # _____ Issuing State: _____
<input type="checkbox"/> DOT – Department of Transportation License # _____ Issuing State: _____	<input type="checkbox"/> OSP – Out of State License # _____ Issuing State: _____
<input type="checkbox"/> DPH – Department of Public Health License # _____ Issuing State: _____	<input type="checkbox"/> OTH – Other License # _____ Issuing State: _____
<input type="checkbox"/> DSP – Department of Safety and Professional Services License # _____ Issuing State: _____	

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**SECTION XIII – OTHER CREDENTIALS OR CERTIFICATIONS**

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Check the license credential certification type and write in the license credential certification number, if applicable.

License credential certification types:

<input type="checkbox"/> American Camp Association Accreditation	<input type="checkbox"/> Adult Day Care – Division of Quality Assurance (DQA) # _____
<input type="checkbox"/> Department of Labor Fair Labor Standards Act 14(c) # _____	<input type="checkbox"/> 3–4 Bed Adult Family Home – DQA # _____
<input type="checkbox"/> Home and Community-Based Services Compliance	<input type="checkbox"/> Community-Based Residential Facilities (CBRF) – DQA # _____
<input type="checkbox"/> Wisconsin Microboard Association Approval Letter	<input type="checkbox"/> Residential Care Apartment Complexes (RCAC) – DQA # _____
<input type="checkbox"/> 1–2 Bed Adult Family Home Certified by: _____	

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**SECTION XIV – MEDICARE ENROLLMENT INFORMATION**

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Check one to indicate the provider's Medicare Part A enrollment.

- Enrolled
- In the Process of Enrolling
- Not Enrolled or in the Process of Enrolling

If enrolled, provide the following:

Centers for Medicare & Medicaid Services Certification Number \_\_\_\_\_

Effective date of enrollment \_\_\_\_\_

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Check one to indicate the provider's Medicare Part B enrollment.

- Enrolled
- In the Process of Enrolling
- Not Enrolled or in the Process of Enrolling

If enrolled, provide the effective date of enrollment: \_\_\_\_\_

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Is the provider enrolled in Medicaid or the Children's Health Insurance Program (CHIP) in a state other than Wisconsin?

- Enrolled
- In the Process of Enrolling
- Not Enrolled or in the Process of Enrolling

If enrolled, list states and effective dates:

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**SECTION XV – NATIONAL PROVIDER IDENTIFIER (NPI) AND TAXONOMY INFORMATION**

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Note: This section is required for waiver nurse service providers only.

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NPI

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Taxonomy (List as many as apply.)

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**SECTION XVI – CRIMINAL CONVICTION AND TERMINATION DISCLOSURES**

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An answer is required for each question. If the answer to any question is Yes, details regarding the criminal conviction or termination must be reported in the area provided.

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1. Has the applicant ever been convicted of a criminal offense related to the involvement in any federal health care program?

- Yes       No

If yes, list the name, date of conviction, and explanation for each criminal conviction.

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2. Has any person or entity having an ownership or control interest in the applicant ever been convicted of a criminal offense related to the person's or entity's involvement in any federal health care program?

Yes                       No

If yes, list the name, date of conviction, and explanation for each criminal conviction.

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3. Has any agent of the applicant ever been convicted of a criminal offense related to that person's involvement in any federal health care program?

Yes                       No

If yes, list the name, date of conviction, and explanation for each criminal conviction.

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4. Has any managing employee of the applicant ever been convicted of a criminal offense related to that person's involvement in any federal health care program?

Yes                       No

If yes, list the name, date of conviction, and explanation for each criminal conviction.

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5. Has the applicant or any person or entity with a 5 percent or greater direct or indirect ownership interest in the applicant been convicted of a criminal offense related to the person's involvement with the Medicare, Medicaid, or Title XXI program in the last 10 years?

Yes                       No

If yes, list the name, date of conviction, and explanation for each criminal conviction.

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6. Has the applicant been terminated from Medicare, Medicaid, or CHIP in any state on or after January 1, 2011, under title XVII of the Social Security Act (Medicare) or under the Medicaid program or CHIP of any other state?

Yes                       No

If yes, list the name, date of termination, and termination reason.

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**SECTION XVII – CONTROLLING INTEREST IN OTHER HEALTH CARE PROVIDERS**

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**Owner/Controlling Interest in Applicant – Detail**

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Individual providers can select the No Owner Information to Disclose box below.

Organizations that do not have an owner or person with control interest of at least five percent can select the No Owner Information to Disclose box below.

No Owner Information to Disclose (Go to Section XVIII.)

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Indicate all individuals or entities with an ownership or controlling interest:

- For non-profit organizations or governmental organizations, list the names and principal business addresses of all owners, board members, and chief officers.
- Provide information in the fields below if the owner or person with control interest in the disclosing entity (that is, the applicant) has an ownership or control interest in any other disclosing entity. Other disclosing entities may include fiscal agents, managed care entities, or any subcontractors in which the disclosing entity has 5 percent or more interest.
- List all names, principal business addresses, and the percentage or ownership interest of all owners, board members, or chief executive officers (CEOs) owning 5 percent or more interest in the disclosing entity. Owner relationship to another person with ownership or control interest in the disclosing entity may include a spouse, parent, child, or sibling.

Attach additional pages if needed.

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**Individuals**

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Name (Last, First, Middle Initial)

Date of Birth

SSN

Address (Street, City, State, Zip+4 Code)

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Title

- Board Member
- CEO
- Owner
- Other:

Owner Relationship

- Spouse                       Child
- Parent                          Sibling
- Other:

Percentage of Controlling Interest or Ownership

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**Organizations**

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Name – Legal Business

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Name – DBA

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TIN

Percentage of Ownership

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Primary Business Address (Street, City, State, Zip+4 Code)

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Title (Individual)

- Board Member       Owner  
 CEO                       Other:

Percentage of Controlling Interest or Ownership

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**Owner/Controlling Interest in Applicant – Disclosing Organizations Detail**

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Only fill in this section if an organization is disclosed in the Owner/Controlling Interest in Application – Detail section. Provide the name, title, date of birth, SSN, and address for all individuals that have a controlling interest in a disclosing organization.

If no organizations disclosed in the Owner/Controlling Interest in Applicant – Detail section, go to Section XVIII.

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Name (Last, First, Middle Initial)

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Title

- Board Member       CEO       Owner       Other:
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Date of Birth

SSN

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Address (Street, City, State, Zip+4 Code)

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**SECTION XVIII – MANAGING EMPLOYEE INFORMATION**

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A managing employee is a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation, of an institution, organization, or agency. If you are a sole proprietor and do not have a managing employee, enter your own information.

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Name (Last, First, Middle Initial)

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Address (Street, City, State, Zip+4 Code)

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Date of Birth

SSN

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Name (Last, First, Middle Initial)

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Address (Street, City, State, Zip+4 Code)

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Date of Birth

SSN

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**SECTION XIX – SUBCONTRACTORS AND OWNER RELATIONSHIPS TO SUBCONTRACTORS**

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Does the applicant have an ownership or control interest in any subcontractors to which the applicant has contracted or delegated some of its management functions or responsibilities of providing care to its patients?

Yes       No

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If yes, list the names of subcontractor(s):

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Are any persons with an ownership or control interest in the applicant related as a spouse, parent, child, or sibling to any person with ownership or controlling interest in the subcontracts?

Yes       No

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If yes, provide names and type of relationship (spouse, parent, child, or sibling) for all relationships.

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**SECTION XX – SIGNATURE**

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Read and sign the following statement.

All information entered on this application is accurate and complete, and if any information changes after this application is submitted, the provider applicant will notify the applicable IRIS FEA or MCO of any changes.

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**SIGNATURE** – Provider or Authorized Representative

Date Signed

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