DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-03250 (02/2025)

STATE OF WISCONSIN
Wis. Stat. § 49.45

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.

SECTION I – TYPE OF APPLICATION

❑ 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

SECTION II – IDENTIFYING INFORMATION

Individual Applicant Only

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

Date of Birth	Gender	Social Security Number (SSN)
	❑ Male ❑ Female	

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.

Organization Applicant Only

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.

Name – Provider Applicant

Language:

❑ English ❑ Spanish ❑ Russian ❑ Hmong

❑ Other:

SECTION III – ADDRESS INFORMATION

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.

Practice Location Information

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

Name – Medicaid Contact Person

Phone Number – Medicaid Contact Person	Phone Number for Member Use

Mailing Information

Name

Attention

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

Email Address (Required)

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.

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

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.

SECTION VI – LTC WAIVER PROVIDER PROGRAM ENROLLMENT

Select all applicable waiver programs:

- ❑ Family Care
- ❑ Family Care Partnership
- ❑ PACE
- ❑ 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
	❑ EIN ❑ SSN

TIN Effective Date	TIN End Date

Checks and Remittance Advice Information

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

Name – Financial Contact Person

Phone Number – Contact Person

1099 Mailing Address

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

SECTION IX – PROVIDER DIRECTORY

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 Health and Wellness
- Waiver Interpreter
- Waiver Living Environment Adaptation
- Waiver Non-Residential Day and Vocational Services
- Waiver Nurse Service
- Waiver Personal Emergency Response Systems
- Waiver Remote Monitoring and Support
- Wavier 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

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.

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

Tribes Served

❑ Bad River Band	❑ Oneida Nation
❑ Forest County Potawatomi	❑ Red Cliff Band
❑ Ho-Chunk Nation	❑ St. Croix Chippewa Community
❑ Lac du Flambeau Band	❑ Sokaogon Chippewa Community
❑ Lac Courte Oreilles Band	❑ Stockbridge-Munsee Band of Mohican
❑ 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

SECTION XII – STATE LICENSE INFORMATION

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

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

SECTION XIII – OTHER CREDENTIALS OR CERTIFICATIONS

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

License credential certification types:

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

SECTION XIV – MEDICARE ENROLLMENT INFORMATION

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 _____

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: _____

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:

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

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

NPI

Taxonomy (List as many as apply.)

SECTION XVI – CRIMINAL CONVICTION AND TERMINATION DISCLOSURES

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.

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.

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.

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.

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.

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.

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.

SECTION XVII – CONTROLLING INTEREST IN OTHER HEALTH CARE PROVIDERS

Owner / Controlling Interest in Applicant – Detail

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.)

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.

Individuals

Name (Last, First, Middle Initial)

Date of Birth	SSN

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

Title	Owner Relationship
❑ Board Member ❑ CEO ❑ Owner ❑ Other:	❑ Spouse ❑ Child ❑ Parent ❑ Sibling ❑ Other:

Percentage of Controlling Interest or Ownership

Organizations

Name – Legal Business

Name – DBA

TIN	Percentage of Ownership

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

Title (Individual)	Percentage of Controlling Interest or Ownership
❑ Board Member ❑ Owner ❑ CEO ❑ Other:	

Owner / Controlling Interest in Applicant – Disclosing Organizations Detail

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.

Name (Last, First, Middle Initial)

Title

❑ Board Member ❑ CEO ❑ Owner ❑ Other:

Date of Birth	SSN

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

SECTION XVIII – MANAGING EMPLOYEE INFORMATION

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.

Name (Last, First, Middle Initial)

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

Date of Birth	SSN

Name (Last, First, Middle Initial)

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

Date of Birth	SSN

SECTION XIX – SUBCONTRACTORS AND OWNER RELATIONSHIPS TO SUBCONTRACTORS

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

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

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

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

SECTION XX – SIGNATURE

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.

SIGNATURE – Provider or Authorized Representative	Date Signed