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| **DEPARTMENT OF HEALTH SERVICES**  Division of Medicaid Services  F-22018 (03/2017) | | | | | | | | | | | | | | | | | | | | | **HSRS LONG-TERM SUPPORT MODULE**  **MODULE TYPE A** | | | | | | | | | | | | | | | | | | | | | | | | **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: §§ 46.031(2)g; 46.27, 46.272  P.L. 97-35; Federal Regulations: 42 CFR 441 | | | | | | | | |
| **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 **OR MCI** (10 digits) **OR** SSN (9 digits) | | | | | | | |
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| 4 Client ID | | | | | | | | | | | | | 5 Birth Date (mm/dd/yyyy) | | | | | | | | | 6 Sex | | | 7a Hispanic/Latino | | | | | | | | 7b Race (Circle up to 5) | | | | | | | | | | | | | | | | 8 Client Characteristics | | | | |
|  | | | | | | | | | | | | |  | |  |  | | | | | | F  M | | | Yes  No | | | | | | | | A=Asian  B=Black or African American  W=White  I=American Indian or Alaska Native  P=Native Hawaiian or Pacific Islander | | | | | | | | | | | | | | | |  | |  | |  |
| 9 Level of  Care | | | | | 10 Marital  Status | | | | | | 11 Living Arrangement | | | | | | | | | | | | | 12 Natural Support  Source | | | | | 13 Type of Movement / Prior Location (Check 1)  (Optional for COP assessment, plan, applicant register) | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | |  | | | | | | Prior | | | Current | | | People | | | | | | |  | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | |  | | | | | |  | | |  | | |  | | | | | | |  | | | | | N=Relocated from general nursing home  D=Diverted from entering any type of institution  F=Relocated from ICF / IID facility  B=Relocated from brain injury rehab unit  3=Relocated from RCC  4=Relocated from IMD | | | | | | | | | | | | | | | | | | | | | | | | |
| 14 Special  Project Status | | | | | | | 15 County of Fiscal  Responsibility | | | | | | | 16 Court Ordered  Placement  Y=Yes  N=No | | | | | | 17 MA Waiver Financial Eligibility Type  A=Categorically eligible  B=Categorically financially eligible - special income limit  C=Medically needy  D=COP eligible  N=Non nursing home level of care | | | | | | | | | | | | | | | | | | | | | | | 18 Indicator for Waiver Mandate (Optional for COP assessment,  plan, applicant register)  A=MA Waiver eligible  B=Not MA Waiver eligible  C=MA Waiver eligible but exempt | | | | | | | | | | |
| **SERVICES - Screen L2 U/I (Module Key:** **)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | \*Provider Number Required for SPCs:  102 Adult Day Care  202/01/02 Adult Family Home  506 CBRF  604 Support and Service Coordination (CIP1A, 1B)  711 Residential Care Apartment Complex  896 ICF-IID / NH residents | | | | | | | | | | | | | | |
| 19 Episode End Date | | | | | | | | 20 Closing Reason | | | | | | | CIP1A and CLTS-W Only | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | |
|  | | | | | | | |  | | | | | | | 21 NA | | | | | | | | 22 Start Date | | | | | 23 End Date | | | | | | | | | | |  | | | | | | | | | | | | | | |
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|  |  | | |  | | | |  | | | | | | | 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 | | | |
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| **OPTIONAL DATA - Screen 18** | | | | | | | | | | | | | | | **NOTE:** Street address, city, state, zip code and county are required for CIP 1A, 1B, CCOP | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Street Address | | | | | | | | | | | | | | | | | | | City | | | | | | | | | | | State | | | | | | | Zip Code | | | | County | | | | | | Telephone  (     ) | | | | | | |
| Case Review Date | | | | | | | | | | | | Diagnosis | | | | | | | Family ID | | | | | | | | | | | Local Data | | | | | | | | | | | | | |  | | | **Shaded areas are optional.** | | | | | | |
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| **DEPARTMENT OF HEALTH SERVICES**  Division of Medicaid Services  F-22018 (03/2017) | | | | | | | **STATE OF WISCONSIN**  **2** |Page | |
| **UNITS / COSTS - Screen L3 U / I (Module Key:** **)** | | | | | | | |
| PGM No | 32 Units | 33 Costs | | 34 Delivery Date  mm yyyy | |  | | |
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