

**WISCONSIN MEDICAID  
HEALTHCHECK SCREENER AFFIRMATION**

Wisconsin Medicaid requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Personally identifiable information about providers or other entities is used for purposes directly related to program administration such as determining the certification of providers or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of payment for services.

The use of this form is mandatory.

**INSTRUCTIONS:** Type or print clearly.

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**SECTION I – ELIGIBLE PROVIDERS**

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I hereby affirm that \_\_\_\_\_ is eligible for certification under Wis. Admin. Code § DHS 105.37, as a provider of HealthCheck health assessment and evaluation services and is the following type of provider of health services.

Check one.

- 1. Physician
- 2. Nurse practitioner
- 3. Outpatient hospital facility
- 4. HMO
- 5. Local public health agency
- 6. Visiting nurse association
- 7. Home health agency
- 8. Rural health clinic
- 9. Indian health agency
- 10. Neighborhood health center
- 11. Clinic operated under a physician's supervision

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If the provider does not fit any of the categories above, which are stated in Wis. Admin. Code § DHS 105.37 but can respond affirmatively to the balance of this affirmation, the provider may request a waiver of the requirements of this section by following the instructions located in Wis. Admin. Code § DHS 106.13.

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**SECTION II – PROCEDURES AND PERSONNEL REQUIREMENTS**

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As a provider of HealthCheck services, I/we shall provide periodic comprehensive child health assessments and evaluations of the general health, growth, development, and nutritional status of infants, children, and youth. Immunizations shall be administered at the time of screening if determined medically necessary and appropriate. The results of a health assessment and evaluation shall be explained to the member’s parent or guardian and to the member if appropriate.

Assessments and evaluations shall be performed only by personnel who meet the requirements stated below. Documentation of meeting the requirements stated below will be maintained as part of the individual provider’s personnel file and will be available for review by Wisconsin Medicaid. A list of the skilled medical personnel and registered nurses (RNs) currently performing HealthCheck services is attached with the following information: 1) Name or description of course, 2) who gave the course, and 3) month/year the course was completed. (A transcript with the information highlighted will be accepted for any individual.)

**Skilled Medical Personnel**

HealthCheck assessment and evaluation services shall be delivered under the supervision of skilled medical personnel within their scope of practice as allowed by state and federal law. Skilled medical personnel are physicians, physician assistants, nurse practitioners, public health nurses, or RNs. Skilled medical personnel who perform physical assessment screening procedures shall have successfully completed either a formal pediatric assessment or an in-service training course on physical assessments.

**Paraprofessional Staff**

Paraprofessional staff may complete individual procedures, as allowed by law, under the appropriate supervision of qualified medical personnel.

All conditions uncovered that warrant further care shall be diagnosed or treated, or both, by the provider, if appropriate, or referred to other appropriate providers. A referral may either be a direct referral to the appropriate health care provider, or a referral recommendation submitted through the agency responsible for the patient’s case management and advocacy.

HMOs and prepaid health plans providing HealthCheck services shall meet all requirements of 42 C.F.R. § 441.60, in addition to the requirements under subds. 1 to 3.

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**SECTION III – RECORDS AND DOCUMENTATION**

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As a provider of HealthCheck services, I/we shall complete an individual health and developmental history for each client and maintain a file on each client receiving HealthCheck services. This file will include a copy of the health and developmental history and follow-up for necessary diagnosis and treatment services.

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**SECTION IV – SKILLED MEDICAL PERSONNEL AND RNS**

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Name – Skilled Medical Personnel or RN	Type of Provider (MD, PA, NP, PHN, RN*)
Course	
Given By	Date Completed (mm/ccyy)
Name	Type of Provider (MD, PA, NP, PHN, RN)
Course	
Given By	Date Completed (mm/ccyy)

Name	Type of Provider (MD, PA, NP, PHN, RN)
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Course
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Given By	Date Completed (mm/ccyy)
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Name	Type of Provider (MD, PA, NP, PHN, RN)
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Course
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Given By	Date Completed (mm/ccyy)
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Name	Type of Provider (MD, PA, NP, PHN, RN)
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Course
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Given By	Date Completed (mm/ccyy)
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Name	Type of Provider (MD, PA, NP, PHN, RN)
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Course
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Given By	Date Completed (mm/ccyy)
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Name	Type of Provider (MD, PA, NP, PHN, RN)
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Course
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Given By	Date Completed (mm/ccyy)
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I/we shall release information on the results of the health assessment to appropriate health care providers and health authorities when authorized by the patient or the patient's parent or guardian to do so.

**Affirmation**

I hereby affirm that, to the best of my knowledge, all of the above are true representations and that the qualification of newly hired personnel will comply with the above requirements.

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**SIGNATURE** – Provider

Date Signed

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Printed Name / Title

Provider ID

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

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- \* MD: Medical doctor
  - PA: Physician assistant
  - NP: Nurse practitioner
  - PHN: Public health nurse
  - RN: Registered nurse