

**CHILDREN'S LONG-TERM SUPPORT WAIVERS
 HSRS SLOT CHANGE REQUEST**

Completion of this form is voluntary. In lieu of this form, agencies may use locally designed forms with prior approval from the Children's Services Section. This form, or an approved substitute, is required for requesting the slot changes described below. Personally identifiable information on this form is collected to verify that the requested slot change is allowable, and will be used only for this purpose.

Instructions: Complete all fields and choose the type of change being requested.

CHILD'S INFORMATION

Name – Child (Last, First, MI)	Effective Date of Change
Current HSRS Slot Number	<input type="checkbox"/> County has closed HSRS slot as of the Effective Date shown.

TYPE OF CHANGE OR CHANGES BEING REQUESTED (choose only the change(s) that apply)

Change Funding Match Source (This change will not result in new funds being added to your contract. See Instructions on the back of this form if you are requesting an addition of new funds.)	New Match Source (choose one) <input type="checkbox"/> Local-Match <input type="checkbox"/> State-Match
Change Target Group (DHS may move funds between your contracts, if appropriate, as a result of this change.)	New Target Group (choose one) <input type="checkbox"/> DD <input type="checkbox"/> SED / MH <input type="checkbox"/> PD

INDIVIDUAL COMPLETING THIS FORM

Name (Type or Print)	Title	County Waiver Agency
Telephone Number	Email Address (Confirmation will be sent to this email address)	

Submit this form using ONE of the following methods:

FAX
 FAX: 608-261-8884
 ATTN: Funding Change

E-MAIL
DHSCLTS@wisconsin.gov
 SUBJECT: Funding Change

GROUND MAIL
 Children's Waivers Unit
 DHS/DLTC/Children's Services Section
 PO Box 7851
 Madison WI 53707-7851

NOTE: All documentation and materials related to this CLTS Waiver participant must be maintained in the child's record at the County Waiver Agency, must be available for review upon request, and are necessary for claiming of federal Medicaid funding. Protected Health Information must be secured as detailed in the HIPAA Business Associate Agreement contained in the State-County Contract.

INSTRUCTIONS FOR COMPLETING THE CHILDREN'S LONG-TERM SUPPORT (CLTS) WAIVERS HSRS SLOT CHANGE REQUEST

Who Should Use This Form:

This form is for use by County Waiver Agencies who use the Human Services Reporting System (HSRS) to report service costs that are incurred for the individual named. Use this form if you need to acquire a new HSRS slot number for this child because of change in funding source and/or a change in target group. If you do not use HSRS to report costs for this specific individual, please do not use this form.

How to Complete This Form:

1. **Electronically:** This document has been provided to your agency as a fillable Microsoft Word document. TAB or CLICK between fields. To select a checkbox, either left-click the box itself, or TAB to the box and press the SPACE bar on your keyboard.
2. **Non-Electronically:** Print the document and complete it using pen or typewriter (no pencil, please!). Be sure handwriting is clear and legible. Submit to DHS by FAX or by ground mail.

** ALL FIELDS ON THIS FORM ARE REQUIRED UNLESS OTHERWISE NOTED BELOW. AN INCOMPLETE CHECKLIST MAY HAVE DELAYS IN PROCESSING. **

Child's Information:

Child's Name:	Enter the child's full legal name—Last Name, First Name, and Middle Initial (if any).
Effective Date of Change:	This is the earliest date on which you plan to report service costs to the new slot in HSRS. This date is the SAME date on which you have already closed the child's former slot. (Using the same date allows entry of costs on the old slot up through the day before the Effective Date of Change.)
Current HSRS Slot Number:	This is the "old" slot number – the slot that you have closed.
County has closed HSRS slot as of the Effective Date shown:	Check this box to confirm that the "old" slot is closed on the same date that the new slot will start.

Type of Change or Changes Being Requested:

Choose the change or changes that apply to this particular child. For **Change Funding Match Source**, be sure to check the box to show the NEW match source (local- or state-match). For **Change Target Group**, be sure to check the box to show the NEW target group (DD, SED / MH, or PD)

Requests for New Funds: Please note that if you request a switch from local-matched to state-matched funding, you are responsible to ensure first that you have sufficient funds available in your current state-county contract to cover the cost of the child's service plan. If you are not sure, please get assistance from DHS by contacting the Children's Services Specialist (CSS) assigned to your county. In no case will *new* funds be added to any contract you have with the state based upon this form alone; contact your CSS if you believe that new funds are needed.

When changing from one target group to another, DHS may de-obligate and re-obligate funds between the two contracts if it appears necessary for funding of the service plan.

Individual Completing This Form:

The person who completes this form must provide DHS with their full name, title, agency, phone number, and E-Mail address.

How to Submit This Checklist:

1. For electronic submission, first save the completed document to your computer system for your own records. Submit to DHS as an attachment to an e-mail sent to the address shown at the bottom of the checklist.
2. A paper copy may be faxed or mailed as shown on the form.

What You Will Receive in Return:

The individual submitting this form will receive a reply from DHS within three (3) business days of receipt of this form. If additional information is needed before the request can be processed, the reply will include a request for that information. If the request is able to be processed, the reply will include a letter and an updated Info Sheet showing the completed changes.