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| **DEPARTMENT OF HEALTH SERVICES**  Division of Quality Assurance  F-00309 (09/2018) | | | | **STATE OF WISCONSIN**  Wis. Admin. Code ch. DHS 105.17(1f) | | | | | | | | |
| **MEDICAID PROVIDER REPORT**  **County Departments, Independent Living Centers, and American Indian Tribes or Bands**  **Providing Personal Care Services** This form is used to collect contact and personal care services information from Wisconsin Medicaid (MA) personal care providers that are Counties, Independent Living Centers, or American Indian Tribes or Bands and that contract, provide, or arrange for personal care services.Questions about completion of this form may be directed to the Division of Quality Assurance, Bureau of Health Services at 608-266-2702. | | | | | | | | | | | | |
| **RETURN THIS COMPLETED FORM TO:** | DHS / Division of Quality Assurance  ATTN: BHS / Personal Care Agency  PO Box 2969 Madison, WI 53701-2969 | | | | | | | | | | | |
| **MEDICAID CERTIFIED AGENCY / ORGANIZATION** | | | | | | | | | | | | |
| Type of Organization / Agency *(Medicaid Provider)*  County Social / Human Service Department  Independent Living Center (ILC)  American Indian Tribe or Band | | | | | | | | | | | | |
| Name – Organization / Agency *(Medicaid provider)* | | | | | | | | Medicaid Provider No. | | | | |
| Street Address *(physical address where personal care records are kept)* | | | | | City | | | | | State | | Zip Code |
| Mailing Address | | | | | City | | | | | State | | Zip Code |
| Name – Contact Person | | | | | | | Telephone No. | | | | | |
| Email Address | | | | | | | Fax No. | | | | | |
| **OWNER OF AGENCY / ORGANIZATION** | | | | | | | | | | | | |
| *Indicate the County Department of Human Services Director, Tribal Chairperson, or person(s) with decision-making authority.* | | | | | | | | | | | | |
| Name – Owner | | | | | | | | | | | | |
| Mailing Address | | | City | | | | | | State | | Zip Code | |
| **GEOGRAPHICAL AREA OF PERSONAL CARE SERVICES (Counties Served***)* | | | | | | | | | | | | |
| *Indicate, by county, the geographical service area of personal care services.* | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| *If your county is no longer providing personal care services or billing under your Medicaid number, sign and date below.* | | | | | | | | | | | | |
| SIGNATURE – Director | | Date Signed | | | | Name – Director *(Print or type.)* | | | | | | |