

## 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 DQA's 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

#### MA 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 Number

E-mail Address

Fax Number

#### 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.*)