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.)*