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| **STATE OF WISCONSIN** **DEPARTMENT OF HEALTH SERVICES**Division of Public HealthF-02053 (03/09/2021) |  | **CIP** |
| **ADRC referral to income maintenance For Managed Long-TeRM Care Services** |
|  | Date of Referral to (IM) | RFA/Case Number |
|  |       |       |
| Name – ADRC Staff Completing Form | Phone | Email |
|       |       |       |
| Referral for:  |
| [ ]  Family Care | [ ]  IRIS | [ ]  PACE | [ ]  Partnership |
|  | [ ]  Medicare Savings Program | [ ]  MA Only | [ ]  MAPP |
| [ ]  Divestment | [ ]  Asset Assessment |  |  |
| Long-Term Care Functional Screen Eligibility Determined on Date:The LTCFS Eligibility Results page must also be submitted with this referral. |       |
| If the individual was previously determined functionally eligible, please include the first date on which the individual was determined functionally eligible:  |       |
| Type of Application Process Requested: [ ]  Face-to-Face [ ]  Mail [ ]  Phone |
| Applicant is Currently Enrolled in: (If Applicable) |
| [ ]  MAPP [ ]  MA Waiver Program [ ]  Institutional MA [ ]  SSI [ ]  BadgerCare Plus [ ]  Medicaid Savings Program [ ]  Katie Becket |
| Name – Applicant (Last, First, MI) | DOB | Medicaid ID |
|       |       |       |
| Street Address | City | State | Zip Code | Phone |
|       |       | WI |       |       |
| Marital Status | Living Arrangement |
| [ ]  Single [ ]  Divorced[ ]  Married [ ]  Widowed[ ]  Separated [ ]  Legally Separated | [ ]  Own Home/Apartment [ ]  Nursing Home [ ]  ICF-MR [ ]  CBRF [ ]  AFH [ ]  RCAC[ ]  Other – Specify:        |
| County of Residence | County of Responsibility |
|       |       |
| Protective Placement | Protective Placement County of Venue (if applicable) |
| [ ]  Yes [ ]  No |       |
| Name – Contact Person | Phone |
|       |       |
| Relationship to Applicant (e.g., guardian of person, guardian of finances, POA, Rep. payee, authorized representative, son, daughter) |
|       |
| Street Address | City | State | Zip | Phone |
|       |       |    |       |       |
| Anticipated Program Start Date: | $      |
| Special Housing Amount in Substitute Care – **Rent only** from Room and Board costs: | $      |
| Medical/Remedial Expenses: Attach Form [F-00295](https://www.dhs.wisconsin.gov/forms/f0/f00295.doc) if applicable: | $      |
| The following documents are attached: |
| [ ]  Family Care Program Enrollment Form [F-00046](https://www.dhs.wisconsin.gov/library/f-00046.htm)[ ]  IRIS Authorization Form [F-00075](https://www.dhs.wisconsin.gov/library/f-00075.htm)[ ]  PACE and Partnership Program Enrollment Form [F-00533](https://www.dhs.wisconsin.gov/library/f-00075.htm)[ ]  LTCFS Eligibility Results Page[ ]  Medical and Remedial Expenses Checklist Form [F-00295](https://www.dhs.wisconsin.gov/forms/f0/f00295.doc)[ ]  Guardianship, POA, Representative Payee Documentation | [ ]  Declaration Regarding Transfer of Resources Form [F-20919D](https://www.dhs.wisconsin.gov/library/f-20919d.htm)[ ]  Medicaid Asset Assessment Form [F-10095](https://www.dhs.wisconsin.gov/library/F-10095.htm)[ ]  Wisconsin Medicaid for the Elderly, Blind or Disabled Application Form [F-10101](https://www.dhs.wisconsin.gov/library/F-10101.htm)[ ]  BadgerCare Plus Application Form [F-10182](https://www.dhs.wisconsin.gov/library/F-10182.htm)[ ]  Medicaid/BadgerCare Plus Verification Documents[ ]  MADA Form [F-10112](https://www.dhs.wisconsin.gov/library/F-10112.htm) and ADDD Form [F-14014](https://www.dhs.wisconsin.gov/library/F-14014.htm) |
| [ ]  Other Documentation – Describe: |       |