WISCONSIN DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-02319 (04/2018)

CIP

HOME AND COMMUNITY-BASED WAIVER MEDICAID ENROLLMENT FOR THE CHILDREN'S LONG-TERM SUPPORT WAIVER PROGRAM

County waiver agencies should use this form to provide information for income maintenance agencies to process Home and Community-Based Waiver (HCBW) Medicaid applications and renewals for the Children's Long-Term Support (CLTS) Waiver Program. The information on this form will only be used to determine and redetermine eligibility and establish a case in CARES. Social Security numbers will only be used for the direct administration of the Medicaid program.

INSTRUCTIONS

County waiver agencies: Complete this form. Submit the completed form and the following to income maintenance using the submission instructions below:

- Completed Wisconsin Medicaid, BadgerCare Plus, and Family Planning Only Services Registration Application, F-10129 (for initial applications only)
- Completed Medicaid Waiver Eligibility and Cost Sharing Worksheet, F-20919
- Verification of the applicant's or participant's income, if any, including child support received on behalf of the child

Submission Instructions

If the applicant or participant lives in **Milwaukee County**, do one of the following:

- Fax the form to 1-888-409-1979.
- Mail the form to:
  MDPU
  P.O. Box 05676
  Milwaukee, WI 53205

If the applicant or participant lives in **another county**, do one of the following:

- Fax the form to 1-855-293-1822.
- Mail the form to:
  CDPU
  P.O. Box 5234
  Janesville, WI 53547

Income maintenance agencies: Be sure to enter the date functional eligibility was established as the program start date on the applicant's or participant's Community Waivers page in CARES Worker Web.

SECTION 1 – PARENT/GUARDIAN INFORMATION

Name – Parent/Guardian (Last, First, MI)		Date of Birth
Social Security Number (optional)	Relationship to Applicant/Participant	Phone Number
Home Address		
City	State	Zip Code
Mailing Address (if different from home address)		
City	State	Zip Code

SECTION 2 –APPLICANT/PARTICIPANT INFORMATION

Part A: Personal Information

Name – CLTS Waiver Program Applicant/Participant (Last, First, MI)	Date of Birth

CARES Case Number or Medicaid ID (if known)	Social Security Number	County of Residence

Sex	Race or Ethnicity (optional)
☐ Male ☐ Female	

Is the applicant/participant a member of an American Indian tribe or the child or grandchild of a member of an American Indian tribe?

☐ Yes ☐ No

Is the applicant/participant an Alaska Native or the child or grandchild of an Alaska Native?

☐ Yes ☐ No

Is the applicant/participant eligible to receive services from Indian Health Services, a tribal clinic, or an urban Indian health program?

☐ Yes ☐ No

Has the applicant/participant received services from Indian Health Services, a tribal clinic, or an urban Indian health program?

☐ Yes ☐ No

Part B: Enrollment/Eligibility Information

Check one for HCBW Medicaid:	Date Functional Eligibility Established
☐ Initial Application ☐ Renewal	

Does the applicant/participant have a cost share as indicated on Section IV of the Medicaid Waiver Eligibility and Cost Sharing Worksheet, F-20919?

☐ Yes ☐ No

Part C: Private Insurance Information (if applicable)

Name – Policy Holder (Last, First, MI)

Name – Insurance Company		Phone Number – Insurance Company

Policy Number	Group Name	Group Number

SECTION 3 – COUNTY WAIVER AGENCY INFORMATION

Name – County Waiver Agency

Name – Support and Service Coordinator (Last, First, MI)

Email Address – Support and Service Coordinator	Phone Number – Support and Service Coordinator

Date Form Submitted to Income Maintenance Agency

RESET FORM