

WISCONSIN MEDICAID REQUEST FOR INSTITUTION OF MENTAL DISEASE DETERMINATION FOR CHILDREN'S RESIDENTIAL SETTINGS

INSTRUCTIONS: Federal Medicaid funding for services rendered in institutions of mental disease for non-elderly adults and children has been restricted since the founding of the Medicaid program. In response to the Family First Prevention Service Act, Wisconsin implemented a process to determine whether or not children's residential settings are considered institutions of mental disease based on criteria outlined by the Centers for Medicare & Medicaid Services.

Residential agencies must upload this form along with copies of all facility licenses and certifications, such as Qualified Residential Treatment Program certification, to the Department of Children and Families Provider Information Exchange. The submitted information will be reviewed and a final written determination will be provided to the facility. In some cases, additional information, including a site visit to the facility or facilities, may be necessary to determine the facility's status. Failure to complete this form fully and accurately may result in a delay in processing. All sites associated with an agency that does not complete this form will be considered institutes of mental disease.

If a facility changes ownership or capacity, an updated determination request must be submitted.

Additional comments or supporting information that should be considered in determining whether or not the facility is an institute of mental disease may be included with supporting documentation.

Parent Agency Name

Agency Address

Agency Contact Person

Agency Contact Email

List all sites owned by the parent agency. Provide details about each site regarding the type of facility (for example, residential care center or group home), bed count, whether or not the site provides treatment services, and shared staff, if applicable.

TABLE 1

Site Name	Address	Facility Type (Residential Care Center, Group Home, Shelter Care)	Licensed Bed Count	Does this site provide treatment services?*	Sites That Share Staff With This Site
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	

Site Name	Address	Facility Type (Residential Care Center, Group Home, Shelter Care)	Licensed Bed Count	Does this site provide treatment services?*	Sites That Share Staff With This Site
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	

* Treatment services are mental health or substance use disorder services, such as counseling or psychotherapy, rendered by a Wisconsin Department of Safety and Professional Services-licensed/certified professional who is employed or contracted by the agency.

If the agency has multiple sites, complete Table 2.

TABLE 2

	Yes	No
1. Do all facility licenses list the same parent agency as the facility owner?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do all sites share one chief medical officer or clinical director responsible for the clinical staff activities in all facilities?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do all sites share one chief executive office responsible for the administrative activities in all facilities?	<input type="checkbox"/>	<input type="checkbox"/>
4. Are all sites licensed separately?	<input type="checkbox"/>	<input type="checkbox"/>
5. Are the sites separated from one another by at least a mile?	<input type="checkbox"/>	<input type="checkbox"/>
6. Do the sites share direct care staff or treatment staff?	<input type="checkbox"/>	<input type="checkbox"/>
7. Are residents ever moved between sites during their episode of care?	<input type="checkbox"/>	<input type="checkbox"/>

I attest that I am duly authorized by the applicant/licensee to sign on its behalf. The applicant/licensee accepts responsibility for the accuracy of the information provided.

I attest under penalty of the law that the information provided above is truthful and accurate to the best of my knowledge. I understand that knowingly providing false information or omitting information may result in legal action by Wisconsin Medicaid.

SIGNATURE

Date Signed (mm/dd/ccyy)