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| **DEPARTMENT OF HEALTH SERVICES**Division of Medicaid ServicesF-03144 (09/2024) | **STATE OF WISCONSIN**Federal Regulation 42 CFR § 435.225 & 435.916  |
| **KATIE BECKETT MEDICAID** **Disability Redetermination: Provider Information**Please provide information for any providers who have completed evaluations, treatment or services/supports over the past two years. This information will be used to complete the disability redetermination required for Katie Beckett Medicaid. |
| Child’s Last Name | Child’s First Name | Child’s MI | Date of Birth (mm/dd/yyyy)  |
|       |       |       |       |
| **Complete the following.** |
| **DIAGNOSES INFORMATION** |
| 1. **Diagnoses**: What are the child’s current diagnoses?
 |
| Diagnosis | Provider Name, Clinic Name, and Address | Date of diagnosis?  |
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|       |       |       |
|       |       |       |
| 1. **Mental Health Needs**
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| Does the child require any of the following supports for their behaviors or mental health needs?[ ]  Clinical Case Management and Service Coordination[ ]  Criminal Justice System[ ]  Mental Health Services (check all that apply)[ ]  Psychiatric Medication checks with Psychiatrist or another Physician [ ]  Counseling Sessions with Psychologist or Licensed Clinical Social Worker[ ]  Inpatient Psychiatric Treatment[ ]  Day Treatment – either partial or full day[ ]  Behavioral Treatment for Children with Autism Spectrum Disorders under the supervision of a mental health professional[ ]  In Home Psychotherapy under the supervision of a mental health professional[ ]  Substance Abuse Services[ ]  In-school Supports for Emotional and/or Behavioral Problems  |
| Enter the Type of Support, Provider Name, Address, and Phone Number for any support checked above. For in-school supports include the school’s name and contact person at the school. |
| Type of Support | Provider Name, Clinic Name, and Address | Phone Number (include area code) |
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|       |       |       |
|       |       |       |
| 1. **Other Providers (Physicians, Home Health, and Social Service)**: List all current providers along with their address and phone number.
 |
| Provider Name and Clinic Name | Address | Phone Number (include area code) |
|       |       |       |
|       |       |       |
|       |       |       |
| Approximately how many hours each week are required for all the services listed above?       |
| 1. **Therapy**: List any therapies in which the child participates (e.g., occupational therapy, physical therapy, speech therapy).
 |
| Type of Therapy | Provider Name, Address, and Phone Number  | Place of Therapy(home, school, clinic) | Number of Sessions/ Week |
|       |       |       |       |
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| 1. **Hospitalizations**: Has the child been in the hospital in the past two years? [ ]  Yes [ ]  No
 |
| Reason for Hospitalization | Admission Date | Discharge Date | Name and Address of Hospital |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
| 1. **School:** Does the child have an Individualized Education Program (IEP) or Individual Family Service Plan (IFSP)? [ ]  Yes [ ]  No Is the child enrolled in Special Education? [ ]  Yes [ ]  No
 |
| School Name | Grade Level | Teacher/Provider Name(s), Address, Phone |
|       |       |       |
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