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| **DEPARTMENT OF HEALTH SERVICES**  Division of Medicaid Services  F-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) | | |
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| **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** | | | | | | | | |
| 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) | | | |
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| 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 |
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| 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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