

**AGENCY POSITION ON THE PAYMENT ERROR RATE MEASUREMENT (PERM)
ERROR FINDING**

Complete, sign and return this form with documentation to the address below.

Wisconsin Department of Health Services
Division of Health Care Access and Accountability
Bureau of Enrollment Management / Attn: Payment Error Rate Measurement
P.O. Box 309
Madison, WI 53701-0309

CARES Case Number	Case Name
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- We agree with the error finding.**
If necessary, correct the case and submit documentation of your corrective action within 30 days. If an overpayment occurred due to client error, establish a claim to initiate benefit recovery. For error reduction initiatives, what information from the client, agency or state would have helped prevent this error? **Please respond within 30 days.**

- We disagree with the error finding.**
Provide additional information and/or documentation to explain why you feel the eligibility determination was correct. **Please respond within 14 days.**

SIGNATURE – Agency Representative	Title/Position	Date Signed
AGENCY NAME		