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| **DEPARTMENT OF HEALTH SERVICES**Division of Medicaid ServicesF-20448 (03/2017) |  | **STATE OF WISCONSIN** |
| **REQUEST FOR MEDICAID ADMINISTRATIVE FUNDS****Staff Position** |
| 1. |       | county |       | agency hereby requests authorization to |
|  | use Medicaid administrative funds for the position identified below and certifies that the use of such funds will result in a net increase in the number of staff employed to manage community care programs funded by Medicaid. |
|  |  |
| 2. | Title of Position | Percent FTE | Calendar Year (yyyy) |
|  |       |       |       |
|  |  |
| 3. | Position |
|  | [ ]  New [ ]  Existing |
| **NOTE:** Any changes in salary during the year must be reported to Bureau of Fiscal Management (BFM).  Asterisk\* Indicates to Explain in Section Provided |
| 4. | Budget | Position Cost |  Medicaid Administrative Pass-Through (MAPT) Cost |
|  | (a) Salary |       |  |       |  |
|  | (b) Fringe |       |  |       |  |
|  | (c) Travel/Supplies |       |  |       |  |
|  | (d) Purchase of Services Contract\* |       |  |       |  |
|  | (e) Other\* |       |  |       |  |
|  | (f) Total |       |  |       |  |
|  | \* Explain |
|  |       |
|  |  |
| 5. | Required Match (50% of total MAPT cost Line 4f above) |
|  |       |
|  |  |
|  | The Non-Federal Source of Match is: |
|  | COP (With Approval) |       | % |
|  | Community Aids |       | % |
|  | County Funds\* |       | % |
|  | Other\* |       | % |
|  | Total |       | 100% |
|  | \* Explain |
|  |       |
|  |  |
| 6. | Attach the position description. Include the percent of time spent on each activity or groups of activities. Indicate which activities are MAPT reimbursable and which are not. |
|  |  |
| Signature | Date Signed | Print Name |
|  |  |       |
| Phone Number |
|       |