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