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| **DEPARTMENT OF HEALTH SERVICES**  Division of Medicaid Services  F-20582 (03/2023) | | | **STATE OF WISCONSIN**  Federal Regulation 42 CFR § 435.225 & 435.916 | | | | | | |
| **KATIE BECKETT MEDICAID APPLICATION** | | | | | | | | | |
| Child’s Last Name | Child’s First Name | | | | Child’s MI | Date of Birth (mm/dd/yyyy) | | | Sex |
|  |  | | | |  |  | | | M  F |
| Race/Ethnicity | | | | | | | | | |
| Asian  Black or African American  Hispanic  American Indian  Native Hawaiian/Other Pacific Islander  White  Other: | | | | | | | | | |
| Social Security Number (Required) | | | | Date of Wisconsin Residency | | | | | |
|  | | | |  | | | | | |
| Street Address | | | | City | | | | State | Zip Code |
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| County | | | | Phone Number (include area code) | | | | | |
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| Is the child a U.S. Citizen?  Yes  No | | | | Immigration Registration Number | | | | | |
| (If no, include the Immigration Registration Number) | | | |  | | | | | |
| Does this household speak English?  Yes  No  If no, what language does this household speak? | | | | | | | | | |
| Federal law requires that all U.S. citizens applying for or receiving Medicaid benefits must show proof of their U.S. citizenship and identity. If you are applying for Medicaid through Katie Beckett, you will have 95 days from the date of your application to provide proof of your child’s U.S. citizenship and identity. Immigration status (or proof of being a lawfully admitted permanent resident or lawfully residing child under 19) is also verified with the U.S. Department of Homeland Security for all immigrants who apply for Medicaid benefits. Immigration status will not be verified for people in your household who are not applying for Medicaid. An eligibility specialist will work with you to complete this step.  I understand the questions and statements on this application form. I understand the penalties for giving false information or breaking rules. I certify, under penalty of false swearing, that all my answers are complete to the best of my knowledge. I understand that persons or organizations listed in this form may be contacted to obtain the necessary proof of this child’s eligibility and level of benefits. Application for Katie Beckett Medicaid is voluntary. Failure to sign this form (by telephone, electronically, or with a handwritten signature) will prevent the processing of the eligibility determination.  **Sign and date.**  If applicant/child is under 18:  Forms must be signed by the parent or guardian with legal authority over the child. This is true even if it is someone else who is most familiar with the child's needs.  If the applicant is over age 18:  The applicant must sign the form.  If you need help or would like to submit these forms electronically, you can call an **eligibility specialist at 888-786-3246** or email [DHSKatieBeckett@dhs.wisconsin.gov](mailto:DHSKatieBeckett@dhs.wisconsin.gov). | | | | | | | | | |
| Person Completing Form – Name | | **SIGNATURE** (if child/applicant is under 18) | | | | | Date Completed | | |
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| Relationship – A copy of guardianship/adoption papers is required if you are not the child’s birth parent. | | | | | | | | | |
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| Name of Applicant (if age 18 or older) | | **SIGNATURE** (if age 18 or older) | | | | | Date Completed | | |
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| **Complete the following.** | | | | | | |
| **Parent/Guardian 1** | | | | | | |
| Name/Relationship | | | Email | | | |
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| Street Address (if different than the child’s information) | | | City | | State | Zip Code |
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| Home Phone Number (include area code) | | Cell Phone Number (include area code) | | Work Phone Number (include area code) | | |
|  | |  | |  | | |
| **Parent/Guardian 2** | | | | | | |
| Name/Relationship | | | Email | | | |
|  | | |  | | | |
| Street Address | | | City | | State | Zip Code |
|  | | |  | |  |  |
| Home Phone Number (include area code) | | Cell Phone Number (include area code) | | Work Phone Number (include area code) | | |
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| Who may be contacted for questions? Do you prefer phone or email? | | | | | | |
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| **INCOME OF CHILD** | | | | | | |
| Does this child have any personal monthly income?  Yes  No  If yes, list the source and amount. | | | | | | |
| **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 | | | 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 checked 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. **Current Medications:** List all prescription medications (including chemotherapy) the child takes on a routine basis. | | | | | | | | | | |
| Name of Medication | | How Often | | | How Taken | | Describe any Significant Side Effects The child is Having | | | |
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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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**ATENCIÓN:** si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-786-3246 (TTY: 711).

**LUS CEEV:** Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-888-786-3246 (TTY: 711).

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| **FOR INTERNAL USE ONLY** |
| Eligibility specialist notes |