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| **Department of Health Services**  Division of Medicaid Services  F-21334 (03/2025) | |  | | **State of Wisconsin** | | | | |
| **Encounter New User Request** | | | | | | | | |
| Completion of this form is voluntary, but is required in order to have access to the LTCare Encounter Reporting System. | | | | | | | | |
| Name – User (First) | | (Last) | | Phone Number | | | | Extension |
|  | |  | | -     - | | | |  |
| Address 1 | | | | | | | | |
|  | | | | | | | | |
| Address 2 | | | City | | | | ZIP Code | |
|  | | |  | | | |  | |
| Email Address | | | | | | Fax Number | | |
|  | | | | | | -     - | | |
| User Preferred Login ID (special characters such as punctuation or spaces are not allowed) | | | | | | | | |
|  | | | | | | | | |
| Organization(s) ID (assigned numeric ID) | | | | | Access Requested for | | | |
|  | | | | |  | | | |
| Role Requested – Higher Levels Include Lower Level Access (i.e., certifier can purge and submit) | | | | | | | | |
|  | | | | | | | | |
| Children’s Incident Tracking and Reporting (CITR) Role Requested | | | | | | | | |
|  | | | | | | | | |
| Name - Supervisor | | | Phone Number | | | | Date of Request | |
|  | | | -     - | | | |  | |
| After this form is completed, the supervisor must email it as follows:  Requests for access to Children’s Incident Tracking and Reporting (CITR) must be emailed to [VDXCLTCIESHelp@wisconsin.gov](mailto:VDXCLTCIESHelp@wisconsin.gov).  For all other requests, including Batch and Restrictive Measures access, email this form to to [DHSLTCareEncounterHelp@dhs.wisconsin.gov](mailto:DHSLTCareEncounterHelp@dhs.wisconsin.gov)  The supervisor should cc the user on the request submission to ensure the appropriate email address for the user is current, and to indicate the supervisor approves the request.  If you have questions regarding any fields on this form such as Organization ID please contact the appropriate help listed in these instructions. | | | | | | | | |
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| For Official Use Only  IAT  Production |  | | | | | | | |