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| **DEPARTMENT OF HEALTH SERVICES**Division of Medicaid ServicesF-22018 (03/2017) | **HSRS LONG-TERM SUPPORT MODULE****MODULE TYPE A** | **STATE OF WISCONSIN**SOS Desk (608) 266-9198Completion of this form meets the requirements ofthe State / County contract specified under theWisconsin Statutes: §§ 46.031(2)g; 46.27, 46.272P.L. 97-35; Federal Regulations: 42 CFR 441 |
| **REGISTRATION - Screen L1 N / U / I / E (Module Key:** **)** |  |
| 1 Worker ID | 2a Last Name | 2b First Name | 2c Middle Name | 2d Suffix | 3 MA Number **OR MCI** (10 digits) **OR** SSN (9 digits) |
|       |       |       |       |       |       |
| 4 Client ID | 5 Birth Date (mm/dd/yyyy) | 6 Sex | 7a Hispanic/Latino | 7b Race (Circle up to 5) | 8 Client Characteristics |
|       |    |    |      | [ ]  F[ ]  M |  [ ]  Yes [ ]  No |  [ ]  A=Asian [ ]  B=Black or African American [ ]  W=White [ ]  I=American Indian or Alaska Native [ ]  P=Native Hawaiian or Pacific Islander |    |    |    |
| 9 Level of Care | 10 Marital Status | 11 Living Arrangement | 12 Natural Support Source | 13 Type of Movement / Prior Location (Check 1) (Optional for COP assessment, plan, applicant register) |
|  |  | Prior | Current | People |  |  |
|   |   |    |    |    |   |  [ ]  N=Relocated from general nursing home [ ]  D=Diverted from entering any type of institution [ ]  F=Relocated from ICF / IID facility [ ]  B=Relocated from brain injury rehab unit [ ]  3=Relocated from RCC [ ]  4=Relocated from IMD |
| 14 Special  Project Status      | 15 County of Fiscal Responsibility   | 16 Court Ordered Placement [ ]  Y=Yes [ ]  N=No | 17 MA Waiver Financial Eligibility Type [ ]  A=Categorically eligible [ ]  B=Categorically financially eligible - special income limit [ ]  C=Medically needy [ ]  D=COP eligible [ ]  N=Non nursing home level of care | 18 Indicator for Waiver Mandate (Optional for COP assessment,plan, applicant register) [ ]  A=MA Waiver eligible [ ]  B=Not MA Waiver eligible [ ]  C=MA Waiver eligible but exempt |
| **SERVICES - Screen L2 U/I (Module Key:** **)** |  \*Provider Number Required for SPCs: 102 Adult Day Care 202/01/02 Adult Family Home 506 CBRF 604 Support and Service Coordination (CIP1A, 1B) 711 Residential Care Apartment Complex 896 ICF-IID / NH residents |
| 19 Episode End Date | 20 Closing Reason | CIP1A and CLTS-W Only |  |
|  |  | 21 NA | 22 Start Date | 23 End Date |  |
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|    |    |      |    | STATE USE ONLY | STATE USE ONLY |    |    |      |  |
| PGM No | 24 SPC/Subprogram | 25 Target Group | 26 LTS Code | 27 Funding Source | 28 SPC Start Date | 29 SPC End Date | 30 Provider Number \* Required for some SPCs | 31 SPC Review Date mm yyyy  |
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| **OPTIONAL DATA - Screen 18** | **NOTE:** Street address, city, state, zip code and county are required for CIP 1A, 1B, CCOP |
| Street Address      | City      | State   | Zip Code      | County    | Telephone(     )       |
| Case Review Date | Diagnosis | Family ID | Local Data |  | **Shaded areas are optional.** |
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| **DEPARTMENT OF HEALTH SERVICES**Division of Medicaid ServicesF-22018 (03/2017) | **STATE OF WISCONSIN****2** |Page |
| **UNITS / COSTS - Screen L3 U / I (Module Key:** **)** |
| PGM No | 32 Units | 33 Costs | 34 Delivery Date mm yyyy |  |
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