DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-22018 (03/2017)

HSRS LONG-TERM SUPPORT MODULE
MODULE TYPE A

STATE OF WISCONSIN
SOS Desk (608) 266-9198
Completion of this form meets the requirements of the State / County contract specified under the Wisconsin Statutes: §§ 46.031(2)g; 46.27, 46.272
P.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 Prior / Current / People	12 Natural Support Source	13 Type of Movement / Prior Location (Check 1) (Optional for COP assessment, plan, applicant register)
				☐ 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	17 MA Waiver Financial Eligibility Type	18 Indicator for Waiver Mandate (Optional for COP assessment, plan, applicant register)
		☐ Y=Yes ☐ N=No	☐ A=Categorically eligible ☐ B=Categorically financially eligible - special income limit ☐ C=Medically needy ☐ D=COP eligible ☐ N=Non nursing home level of care	☐ A=MA Waiver eligible ☐ B=Not MA Waiver eligible ☐ C=MA Waiver eligible but exempt

SERVICES - Screen L2 U/I (Module Key:)

19 Episode End Date	20 Closing Reason	CIP1A and CLTS-W Only		
		21 NA STATE USE ONLY	22 Start Date STATE USE ONLY	23 End Date

*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

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

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.

UNITS / COSTS - Screen L3 U / I **(Module Key:)**

PGM No	32 Units	33 Costs	34 Delivery Date mm yyyy
		$	
		$	
		$	
		$	
		$	
		$	
		$	
		$	
		$	
		$	
		$	
		$	
		$	
		$	
		$	
		$	
		$	
		$	
		$	
		$	