Case Management Target Population "Change Request" Form

Please send this form to:

Wisconsin Medicaid
Provider Maintenance
6406 Bridge Rd
Madison WI 53784-0006

Please note that you may add target populations at any time. If you *add* a target population, specify whether you want the population added retroactive to the first day of the calendar quarter or when Wisconsin Medicaid receives this form. You may also subtract target populations at any time. If you *subtract* a population, the subtraction is effective when Wisconsin Medicaid receives this form or at a date after Wisconsin Medicaid receives this form, as specified on this form.

NAME: _____ TITLE: _____

ADDRESS: _____

COUNTY: _____ PROVIDER NUMBER: _____

SIGNATURE: _____ DATE SIGNED: _____

By signing this form, I am indicating to the Division of Health Care Financing (DHCF) the approval of this change by my County Board of Supervisors or Indian Tribal Government as required under s. 49.45 (25), Wis. Stats.

Indicate populations you will be adding or subtracting:

	ADDING	**OR *SUBTRACTING***
Persons who are age 65 or older	( )	( )
Persons who have a diagnosis of Alzheimer's disease or related dementia	( )	( )
Persons with a physical or sensory disability	( )	( )
Persons with a developmental disability	( )	( )
Persons with a chronic mental illness	( )	( )
Persons with alcohol and/or drug dependency	( )	( )
Persons who are severely emotionally disturbed and are under the age of 21	( )	( )
Persons diagnosed as having Human Immunodeficiency Virus infection	( )	( )
Families with child at risk of serious physical, mental, or emotional dysfunction	( )	( )
Children enrolled in a Birth to 3 program	( )	( )
Children with asthma	( )	( )
Persons infected with tuberculosis	( )	( )
Women age 45-64	( )	( )

Complete one of the following:

1. EFFECTIVE UPON RECEIPT? Y N

   or

2. EFFECTIVE ON: _____
   (Specify date)