**DEPARTMENT OF HEALTH SERVICES**
Division of Long Term Care
F-20582AA (05/2016)

**STATE OF WISCONSIN**
Federal Regulation 42 CFR § 435.225 & § 435.913 (a)
Wisconsin Statutes § 49.82 (2)

# ADDENDUM TO THE KATIE BECKETT PROGRAM RECERTIFICATION FORM FOR ADDITIONAL APPLICATION FOR WISCONSIN'S CHILDREN'S LONG TERM SUPPORT PROGRAMS

| 1. Child's Last Name | Child's First Name | Child's MI | 2. Sex ☐ M ☐ F | 3. Date of Birth (mm/dd/yyyy) |
|---|---|---|---|---|
| | | | | |

12. Which program were you first interested in, the program that was the reason you called for an application?
☐ Children's Community Options Program ☐ Katie Beckett Program – Medicaid ☐ CLTS Waiver

13. How did you learn about where to apply for this program(s)?

14. Check the programs for which you are applying.
☐ Children's Community Options Program ☐ Katie Beckett Program–Medicaid ☐ CLTS Waiver

15. Would you be willing to participate in a short survey regarding your experiences with this application process? ☐ Yes ☐ No

35. **AGREEMENTS AND AUTHORIZATIONS**

I understand that personally identifiable information on this form is used to help determine eligibility for all Wisconsin Children's Long Term Support Programs. Further, this information is used to complete the Children's Long-Term Support Functional Screen (CLTS FS) as part of the functional eligibility review and determination. I accept that the CLTS FS determines functional eligibility or level of care for each of the following programs: Comprehensive Community Services, Community Recovery Services, Children's Community Options Program, Katie Beckett Medicaid Program, Medicaid Home and Community-Based Children's Services Waivers, and Mental Health Wrap Around Services. I further realize the results of the screen affect eligibility for all of these programs.

I certify, under the penalty of perjury, that the information on this application and given in connection with it is a true and complete statement of facts according to my best knowledge and belief. I also understand that I may be asked to provide proof of any information given on this application form and that giving false information may subject me to prosecution for fraud.

Although the information obtained on this application is used for the purposes stated, the information may also be disclosed without a separate written consent by the Bureau of Children's Services as authorized by Federal laws such as the Privacy Act, Social Security Act, and Medicaid State Statutes to enable the coordination of application and service delivery with a third party (e.g., contracted private service provider) or other government agency (e.g., county human services agency).
If I disagree with the agency's decision regarding my child's eligibility for the program(s) being applied for, a request for a Fair Hearing may be made to Division of Hearings and Appeals, 5005 University Avenue, Suite 201, Madison, WI 53705-5400.

Application for all Wisconsin Children's Long Term Support programs is voluntary, but failure to sign the application will prevent the processing of eligibility determination for all programs.

_____ ☐ Check here if child is unable to sign _____
**SIGNATURE** - Child (If age 14 years or older) Date Signed

_____ _____ _____
**SIGNATURE** - Parent or Guardian Relationship to Child Date Signed

_____ _____
**SIGNATURE** – Threshold Consultant Date Signed