ORGANIZATIONAL PROVIDER APPLICATION ATTACHMENT:
LTC & Family Care Partnership Services

Independent Care Health Plan ("*i*Care") is a Family Care Partnership Program Managed Care Contractor (http://dhs.wisconsin.gov/wipartnership) in **Milwaukee, Racine, Kenosha and Dane Counties**. The *i*Care contracting process is guided by the following values:

- Assure adequate numbers and types of providers to meet the full range of health care services to meet the needs of *i*Care members
- Rewarding cost and service efficiencies

INSTRUCTIONS: Type or print your information on this application. If a question does not apply to your application, please write "N/A" in the field. Read instructions for information detail. Include copies of supporting documentation.

Responding providers are requested to return this form by mail (*i*Care, 1555 N. RiverCenter Drive, Suite 206, Milwaukee, WI 53212), fax (414-272-5618) or email (netdev@icare-wi.org). ***i*Care will acknowledge receipt of completed application and return incomplete applications.**

Please note that contracted participation in the *i*Care network will not include a guarantee of utilization or exclusivity.

Sections I-III are required for all locations.

Match the Location Number for each location as listed in Section III of the Organizational Provider Application.

If multiple locations provide the exact same services, list each location number on one LTC attachment.

SECTION I:
Organizational Information

Location Number (matched to Provider Application Location #):	Location Name:
Federal TIN or SSN:	Email:
Counties Served: ☐Dane ☐Kenosha ☐Milwaukee ☐Racine	**Population Served:** ☐Advanced Aged ☐AODA ☐Developmentally Disabled ☐Frail Elderly ☐Emotionally Disturbed/Mental Illness ☐Irreversible ☐Dementia/Alzheimer's ☐Physically Disabled ☐Terminally Ill ☐Traumatic Brain Injury
Any enhanced services offered: (e.g. Transportation, enriching daily activity programing):	

Accessibility: • Facility is accessible to wheelchairs from the street: ☐Yes ☐No	• All facility doorframes are at least 36 inches wide: ☐Yes ☐No	• Bathroom is accessible to wheelchairs: ☐Yes ☐No

Section II: Services, Credentials & Rates

For each service category checked above, provide a detailed list of service elements, their rates, and unit definitions. Use additional pages as necessary, providing the same information.
Please include procedure codes for each service.

Family Care Partnership Service Category:	Certification/Licensure:
Service Description and Procedure Code 1. _____ 2. _____ 3. _____ 4. _____ 5. _____	Rate/Unit of Service: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____
Family Care Partnership Service Category:	Certification/Licensure:
Service Description and Procedure Code 1. _____ 2. _____ 3. _____ 4. _____ 5. _____	Rate/Unit of Service: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____

Section III: Assurances

By signing this Application, the respondent confirms that it (he/she) understands and assures the following:
The Signor below is authorized to represent the provider in this Application.
This Application is not a contract for the utilization or provision of long term care services.
The information provided in this Application is accurate, truthful and current.

Authorized signature & title:	Date:
Print signature & title:	

Section IV: Attestation

Agency attests that it has:

Has verified qualifications of each staff member, including academic preparation and relevant licenses, permits, and certifications.	☐ Yes ☐ No
Has proof of all permits, licenses and certifications, required of staff members, to perform the services.	☐ Yes ☐ No
Maintains a training plan for each staff member and has a mechanism for ensuring that all necessary training has been completed *prior* to performing work.	☐ Yes ☐ No
Completes Caregiver Background Checks (CBC) on all employees *prior* to the employee providing direct services to Member, and every four (4) years thereafter or any time that entity has a reason to believe that a new check should be obtained.	☐ Yes ☐ No
Has a mechanism to track the completion of Caregiver Background Checks to ensure compliance with the requirements of Wisconsin Administrative Code §§ DHS 12 and 13, Wis. Stats. §50.065, and The Wisconsin Caregiver Program Manual.	☐ Yes ☐ No
Maintains the CBC on its premises for at least the duration of network participation with *i*Care .	☐ Yes ☐ No

Please include this completed and signed LTC Attachment, Organizational Provider Application, and a program statement along with your application submission. Documentation of selected employee caregiver and criminal background checks may be requested prior to the completion of a Long Term Care Services Agreement.

The individual identified below acknowledges that they have reviewed the statements above and attests that the information herein is true and accurate.

Name: _____

Signature: _____

Title: _____

Date: _____

Please return completed application to:

Independent Care Health Plan (*i*Care)
c/o Network Development
1555 N. RiverCenter Drive, Suite 206
Milwaukee, WI 53212
Fax: 414-272-5618
Email: netdev@icare-wi.org