LTSS Provider Contract Request Form

Thank you for your interest in becoming a Molina Healthcare Provider. To ensure the proper contract and credentialing packet is generated, please complete this Contract Request Form and return along with a current W-9 to **MHWIProviderNetworkManagement@MolinaHealthcare.com** or call **(855) 326-5059** for assistance.

PLEASE SELECT PROVIDER TYPE					
☐ Adaptive Aids	☐ Licensed Adult Day Care	☐ Adult Family Home 1-2 Bed	☐ Adult Family Home 3-4 Bed	☐ Community Based Residential Facility 5-8 Bed	☐ Community Based Residential Facility 9+ bed
☐ Supported Employment	☐ Supportive Home Care	☐ Transportation Services	☐ Vocational Futures Planning & Support	☐ Environmental Accessibility Adaptations (home modifications)	☐ Other Therapy (non-fee schedule services)
☐ Financial Management Services (fiscal intermediary for SDS)	☐ Financial Management Services (organizational rep payee)	☐ Home Delivered Meals	☐ Housing Counseling	☐ Personal Emergency Response Services (PERS)	☐ Prevocational Services
☐ Residential Community Apartment Complex	☐ Assistive Technology/Communication Aids	☐ Consumer Education & Training (including mental health peer specialist)	☐ Daily Living Skills Training	☐Day Habilitation	☐Other:

1-2 Bed AFH Certification Fees (If Certification is Required) – Instructions and Certification Fee Form will be provided with Applications		
Does the facility require Certification?	☐ Yes ☐ No	If yes, the Certification Form will be provided with the applications

LINE OF BUSINESS					
☐ Family Care	☐ Family Care Partnership				

CONTACT INFORMATION	
Requestor Name: _____	Requestor Phone: _____
Requestor Email: _____	Requestor Fax: _____

PROVIDER INFORMATION	
Legal Entity Name: _____	
Business/Service Address: _____ (If additional locations, please attach roster.)	Mailing address: _____ (Contract will be emailed.)
City, State, Zip: _____	City, State, ZIP: _____
Office Phone: _____	Contact Phone: _____
Office Fax: _____	Contact Fax: _____

Office Email: _____	Contact Email: _____
Rendering Facility Name:	Rendering Facility County:

Please check the **counties** you serve.							
☐	**Adams**	☐	**Ashland**	☐	**Barron**	☐	**Bayfield**
☐	**Brown**	☐	**Buffalo**	☐	**Burnett**	☐	**Chippewa**
☐	**Clark**	☐	**Columbia**	☐	**Crawford**	☐	**Dane**
☐	**Dodge**	☐	**Douglas**	☐	**Dunn**	☐	**Eau Claire**
☐	**Grant**	☐	**Green**	☐	**Green Lake**	☐	**Iowa**
☐	**Iron**	☐	**Jackson**	☐	**Jefferson**	☐	Juneau
☐	**Kenosha**	☐	**La Crosse**	☐	**Lafayette**	☐	**Manitowoc**
☐	**Marquette**	☐	**Milwaukee**	☐	**Monroe**	☐	**Ozaukee**
☐	**Pepin**	☐	**Pierce**	☐	**Polk**	☐	**Price**
☐	**Racine**	☐	**Richland**	☐	**Rock**	☐	**Rusk**
☐	**Sauk**	☐	**Sawyer**	☐	**Sheboygan**	☐	**St Croix**
☐	**Taylor**	☐	**Trempealeau**	☐	**Vernon**	☐	**Walworth**
☐	**Washburn**	☐ Washington ☐ Waukesha ☐ Waushara ☐ Winnebago					

PROVIDER IDENTIFICATION	
Group Specialty: _____	Tax ID (TIN):_____
Wisconsin Medicaid ID Number is mandatory: _____ HCBS Compliance is mandatory – Provider attests HCBS compliance: Please initial here:	
HCBS Settings for Compliance: Residential settings • Community-based residential facilities • Licensed 3-4 bed adult family homes • Certified adult family homes, including 1-2 bed homes and homes certified under Wis. Admin. Code ch. DHS 82 • Residential care apartment complexes • Adult day care centers • Day habilitation service settings (adult day services) • Prevocational service settings (center-based sites where individuals receive pre-vocational services intended to enable progression to integrated employment) • Group-supported employment settings (enclaves/work crews)	

Please note that completion of the above information is not confirmation of your participation status with Molina Healthcare of Wisconsin. Final contractual status is based upon your ability to meet credentialing standards and any additional contractual obligations. If you have any questions regarding completion of this form, email the Provider Network Management team at MHWIProviderNetworkManagement@MolinaHealthcare.com