Wisconsin Family Care Provider Application

Wisconsin | Anthem Blue Cross and Blue Shield | BadgerCare Plus and Medicaid Supplemental Security Income (Medicaid SSI) programs

To start the contracting and credentialing process, please fill out this application completely and submit it along with all necessary documentation. Applications missing any required information will not be processed.

Note, for multiple locations with separate NPI numbers or different Tax IDs, a separate application is required for each NPI and Tax ID combination.

Acceptance of this enrollment form by MCO does not guarantee network participation. All requirements related to network participation are governed by the MCO Provider Handbook.

If you have not registered with the Wisconsin Department of Health Services (DHS) by January 1, 2026, we cannot accept your application. Care providers must have a valid Wisconsin Medicaid ID number before contracting with an MCO. To register with Wisconsin Medicaid, visit the ForwardHealth Portal and ensure you have a signed agreement with DHS.

Required documents should be provided to MCO upon completion of this application:

- Copy of applicable State Licensure, Certification, or Registration required for provided services
- Copy of the waiver approval issued by the State of Wisconsin for services offered
- Program Statement (required from all licensed and certified providers)
- W-9 Form
- Copy of the current General and Professional Liability Certificate of Insurance form
- Copy of the current Auto Liability Certificate of Insurance Form
- Copy of current Workers' Compensation Insurance (applicable to Non-Residential and Residential Service providers with one or more employees – must comply with state law and is applicable to CBRF, RCAC, & Adult Family Home- Corporate 3-4 Bed)
- Proof of accreditation(s), a copy of the most recent CMS or State on-site survey results, and the plan of corrections acceptance letter
- DHS HCBS Compliance Letter (applicable to Facility Day Services, Prevocational, Group Supported Employment, and Residential Settings)
- Training Attestation (applicable to Supportive Home Care/Daily Living Skills)
- Civil Right Compliance (if applicable)

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Please submit your completed Family Care Application and credentialing documents to: WI-LTSSNetwork@anthem.com

General provider information

Legal name:	DBA name:	Application type: ☐New provider ☐Adding address/counties/services ☐Changing address/counties/services
Tax ID:	NPI:	
Medicaid ID:	Medicare ID:	
Medicaid ID certified: ☐Yes ☐ No	DHS signed agreement: ☐Yes ☐No	Ethnicity served: ☐African American ☐Hispanic American ☐Women ☐Native American ☐Asian American
Minority business: ☐Yes ☐ No	Minority business certified: ☐Yes ☐No	
Agency website URL:		

Provider primary address:

Street:	City:	State:	Zip code:
Phone number:	Primary fax number:	Credentialing contact:	Contact title:
Email address:			
Handicap accessible: ☐ Yes ☐No Bariatric accessible: ☐ Yes ☐No Memory care: ☐ Yes ☐No High behavioral: ☐ Yes ☐No High medical: ☐ Yes ☐No If a residential location: number of beds: Does the care provider have any other cultural or linguistic services (including ASL): ☐ Yes ☐No If Yes, please indicate what type and which language:			

Provider primary mailing address:

Street:	City:	State:	Mailing zip code:
Phone number:	Fax number:	Mailing contact:	Contact title:

Email address:

Provider payment/remit address:

Street:	City:	State:	Billing zip code:
Billing phone number:	Billing fax number:	Billing contact:	Contact title:
Email address:			

Hours of operation:

☐24 hours	Mon: to	Tues: to	Wed: to	Thur: to
	Fri: to	Sat: to	Sun: to	

Emergency contact information:

Emergency phone number:	Emergency contact:	Emergency contact title:	Emergency email address:

Cultural competency (mandatory network requirements):

Did the care provider complete cultural competency training?
☐Yes ☐No
Does the care provider require and document cultural competency training annually?
☐Yes ☐No
Does your office(s) meet American with Disabilities Act accessibility requirements?
☐Yes ☐No
Does the care provider have interpretation services?

☐Yes ☐No
If Yes, please indicate what type:

Provider additional locations tied to a licensure (same Tax ID/NPI as primary address):

Location 1:

Street address:	City:	State:	Zip code:
Phone number:	Fax number:	Administrator name:	

Email address:
Handicap accessible: ☐ Yes ☐ No Bariatric accessible: ☐ Yes ☐ No Memory care: ☐ Yes ☐ No High behavioral: ☐ Yes ☐ No High medical: ☐ Yes ☐ No If a residential location: number of beds: Does the care provider have any other cultural or linguistic services (including ASL): ☐ Yes ☐ No If Yes, please indicate what type and which language:

Location 2:

Street address:	City:	State:	Zip code:
Phone number:	Fax number:	Administrator name:	
Email address:			
Handicap accessible: ☐ Yes ☐ No Bariatric accessible: ☐ Yes ☐ No Memory care: ☐ Yes ☐ No High behavioral: ☐ Yes ☐ No High medical: ☐ Yes ☐ No If a residential location: number of beds: Does the care provider have any other cultural or linguistic services (including ASL): ☐ Yes ☐ No If Yes, please indicate what type and which language:			

Location 3:

Street address:	City:	State:	Zip code:
Phone number:	Fax number:	Administrator name:	
Email address:			
Handicap accessible : ☐ Yes ☐ No Bariatric accessible: ☐ Yes ☐ No Memory care: ☐ Yes ☐ No High behavioral: ☐ Yes ☐ No High medical: ☐ Yes ☐ No If a residential location: number of beds: Does the care provider have any other cultural or linguistic services (including ASL): ☐ Yes ☐ No If Yes, please indicate what type and which language:			

Location 4:

Street address:	City:	State:	Zip code:
Phone number:	Fax number:	Administrator name:	
Email address:			
Handicap accessible: ☐ Yes ☐ No Bariatric accessible: ☐ Yes ☐ No Memory care: ☐ Yes ☐ No High behavioral: ☐ Yes ☐ No High medical: ☐ Yes ☐ No If a residential location: number of beds: Does the care provider have any other cultural or linguistic services (including ASL): ☐ Yes ☐ No If Yes, please indicate what type and which language:			

Location 5:

Street address:	City:	State:	Zip code:
Phone number:	Fax number:	Administrator name:	
Email address:			
Handicap accessible: ☐ Yes ☐ No Bariatric accessible: ☐ Yes ☐ No Memory care: ☐ Yes ☐ No High behavioral: ☐ Yes ☐ No High medical: ☐ Yes ☐ No If a residential location: number of beds: Does the care provider have any other cultural or linguistic services (including ASL): ☐ Yes ☐ No If Yes, please indicate what type and which language:			

*For additional address locations, submit a separate attachment including demographics with the application packet.

Population served (select all that apply):

☐ Physical disability	☐ Frail elderly	☐ Intellectual and developmental disabilities	☐ Mental health

Please select the applicable Family Care Services qualified to provide:

☐Adult day care (licensed) ☐Assistive technology ☐CIE exploration ☐Communication assistance ☐Community Support Program (CSP) (licensed) ☐Consultative Clinical and Therapeutic Services for Caregivers (CCTS) (training for paid and unpaid caregivers) ☐Consumer education and training (including non-Medicaid-certified therapies) ☐Daily living skills training ☐Day habilitation services ☐Facility ☐ Community ☐Disposable medical supplies (including OTC) ☐Environmental accessibility adaptations (home modifications) ☐Financial management services (fiscal intermediary for SDS) ☐Financial management services (organizational rep payee) ☐Health and wellness ☐Home-delivered meals ☐Housing counseling ☐Nursing services (independent/private)	☐Personal care agency (Wisconsin Medicaid certified) ☐Personal Emergency Response Service (PERS) ☐Prevocational services ☐Facility ☐ Community <u>Residential Services:</u> ☐Adult family home 1-2 Bed (AFH) ☐Corporate ☐ Owner occupied ☐Adult family home 3-4 bed (AFH) ☐☐Corporate ☐ ☐Owner occupied ☐Community Based Residential Facility (CBRF) ☐ Residential Care Apartment Complex (RCAC) ☐Remote monitoring and support ☐Respite care – in-home ☐Respite care – substitute living facility Specialized Medical Equipment and Supplies Support Broker ☐Supported employment Individual Employment Support Small Group Employment Support ☐Supportive home care (chore services) ☐Supportive home care (general; including non-medical personal care) ☐ Supportive home care day/community supported living ☐Transportation services ☐Vehicle modification ☐Vocational futures planning and support
Service listing continued: If applying for any of the following services in addition to the Family Care Services list above, you may be required to complete an HDO Application and additional credentialing documents as determined by Anthem.	
☐Alcohol and Other Drug Abuse services (AODA) ☐Day treatment services – AODA ☐Day treatment services – medical/behavioral ☐Durable medical equipment (except hearing aids or prosthetics) ☐Home health agency (licensed and Medicare certified; Medicare may also be required depending on service)	☐Mental health services ☐Nursing facility (licensed) ☐Occupational therapy services (outpatient) ☐Physical therapy services (outpatient) Respiratory Care ☐Speech and language pathology services (outpatient)

Indicate selected services provided by subcontractor:

Please select the applicable counties covered, qualified, and capable of serving within:

☐ Adams	☐ Iowa	☐ Price
☐ Ashland	☐ Jackson	☐ Racine
☐ Barron	☐ Jefferson	☐ Richland
☐ Bayfield	☐ Juneau	☐ Rock
☐ Brown	☐ Kenosha	☐ Rusk
☐ Buffalo	☐ Kewaunee	☐ Sauk
☐ Burnett	☐ La Crosse	☐ Sawyer
☐ Calumet	☐ Lafayette	☐ Shawano
☐ Chippewa	☐ Langlade	☐ Sheboygan
☐ Clark	☐ Lincoln	☐ St. Croix
☐ Columbia	☐ Manitowoc	☐ Taylor
☐ Crawford	☐ Marathon	☐ Trempealeau
☐ Dane	☐ Marinette	☐ Vernon
☐ Dodge	☐ Marquette	☐ Vilas
☐ Door	☐ Menominee	☐ Walworth
☐ Douglas	☐ Milwaukee	☐ Washburn
☐ Dunn	☐ Monroe	☐ Washington
☐ Eau Claire	☐ Oconto	☐ Waukesha
☐ Florence	☐ Outagamie	☐ Waupaca
☐ Fond du lac	☐ Ozaukee	☐ Waushara
☐ Forest	☐ Pepin	☐ Winnebago
☐ Grant	☐ Pierce	☐ Wood
☐ Green	☐ Polk	
☐ Green Lake	☐ Portage	☐ Statewide

If all services do not apply to every county selected above, explain why here:

Credentialing questions:

Has the Provider had any professional liability claim judgments or settlements? ☐ Yes ☐ No Has the license to do business in any applicable jurisdiction ever been denied, restricted, suspended, reduced, or not renewed?

☐Yes ☐ No

Has the business been denied participation, suspended from, or denied renewal from Medicare or Medicaid?
☐Yes ☐ No

Has the business ever had its professional liability coverage canceled or not renewed?
☐Yes ☐ No

Has the business been denied accreditation by its selected accrediting body or had its accreditation status reduced, suspended, revoked, or in any way revised by the accrediting body?
☐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 on all employees prior to the employee providing direct services to Member, and every four (4) years thereafter, or anytime 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 in the Anthem contract?
☐Yes ☐ No

Maintains the Caregiver Background Check results on its premises for at least the duration of the Long-Term Care contract with Anthem?
☐Yes ☐ No

Care provider attests that it is in compliance with DHS requirements for Civil Rights/Affirmative Action and has provided Anthem with a Letter of Assurance https://www.dhs.wisconsin.gov/library/F00165.htm. In addition, providers with more than 50 employees or receiving more than $50,000 in government funding must complete a Civil Right Compliance Plan [https://www.dhs.wisconsin.gov/civilrights/index.htm]
☐Yes ☐ No

Provider agrees to follow all operational and administrative requirements, including certification/licensure, policies, staff qualifications, member rights, statutes, and quality assurance for services provided to members as defined, but not limited to, the State of Wisconsin Legislature Administrative Codes for the Department of Health Services (DHS), and Anthem's Provider Agreement and Provider Manual(s).
☐Yes ☐ No

If the answer is “Ye to any of the above questions, please provide additional details below and/or submit documentation for reasons why you marked Yes:

Attestation and information release authorization:

- All information provided in this application or related to it is complete and accurate to the best of my knowledge. I will promptly notify MCO of any changes. I understand that submitting this application does not guarantee participation with MCO. By applying to be an MCO participating provider, I authorize the plan, its medical director, and relevant representatives to consult with administrators and members of other institutions I have been associated with, including past and current malpractice carriers, who may have information regarding my professional competence, character, and ethical qualifications. I also give consent for MCO, its medical director, and authorized representatives to inspect all records and documents — excluding medical records of non-MCO plan members — that are relevant to assessing my professional qualifications, competence, and moral and ethical suitability for provider status with MCO.

- The applicant certifies, to the best of its knowledge and belief, that it is not an “Ineligible Organization.” The applicant also certifies, to the best of its knowledge and belief, that it and its principals: (1) are not currently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or agency; (2) have not, within the three years prior to this application, been convicted of or had a civil judgment rendered against them for committing fraud or a criminal offense related to obtaining, attempting to obtain, or performing a public transaction (Federal, State, or local), violating Federal or State antitrust laws, or committing embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property; (3) are not currently indicted or otherwise criminally charged by a government entity (Federal, State, or local) with the offenses listed in (2); and (4) have not, within the three years prior to this application, had one or more public transactions (Federal, State, or local) terminated for cause or default.

I understand that as an applicant for participation in MCO, I have the right to review information obtained from primary verification sources during the credentialing process. I also understand that upon notification from MCO, I have the right to explain any

information obtained that may differ significantly from what I provided and to correct any incorrect information submitted by another party. This can be done by submitting a written explanation or by appearing before the Credentialing Committee if requested. I further understand that I may appeal the committee's decision, either in writing or by appearing before the Credentialing Committee if requested.

Authorized signature:		
Printed name: (Owner/Registered Authorized Agent)	**Signature:** (Owner/Registered Authorized Agent)	**Date:**
Title: (Owner/Registered Authorized Agent)		