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