**MAXIMUS /FAST Unit’s email address:** DCFBMCWC4KMedicaid@wisconsin.gov or DCFBMCWC4K@wi.gov (DCF BMCW C4K Medicaid)

**Department of Health Services (DHS):** Care4kids@automated-health.com

**Maximus/FAST Unit must be emailed Templates 1-4 when applicable.**

**DHS does not need to be emailed when Template 1 (initial or secondary referral) is applicable.**

**\*\*The worker must email the DHS AND Maximus/FAST Unit when there is a change (Templates 1-4).**

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| 1. **Initial or Secondary Contact Template**

**To the MA Certification Worker to begin enrollment into Care4Kids** Date child was placed into OHC or parent’s requested enrollment:      Child’s full name (first, middle, last):       Child’s DOB:     I have reviewed the Eligibility Checklist and confirmed that the child meets all eligibility criteria for enrollment in Care4Kids.  |

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| 1. **Child Becomes Eligible Template after being discharged from ineligible setting**

**To the Enrollment Specialist (CC. MA Certification @** **DCFBMCWC4KMedicaid@wisconsin.gov** **or** **DCFBMCWC4K@wi.gov****)) requesting enrollment into Care4Kids after the child is discharged from Milwaukee WrapAround or an ineligible OHC setting:**Date child became eligible for Care4Kids:      Child’s full name (first, middle, last):       Child’s DOB:     I have reviewed the Eligibility Checklist and confirmed that the child meets all eligibility criteria for enrollment in Care4Kids.  |

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| 1. **Child Become Ineligible Template**

**To the Enrollment Specialist (CC. MA Certification @** **DCFBMCWC4KMedicaid@wisconsin.gov** **or** **DCFBMCWC4K@wi.gov****) when child becomes ineligible for Care4Kids benefit:**Date child became ineligible for Care4Kids:      Child’s full name (first, middle, last):       Child’s DOB:     Check appropriate box(es) [ ]  No longer resides in one of the six counties [ ]  Has moved to an ineligible setting (Residential Care Center or Secure Setting) [ ]  Has a parent/legal guardian who requested disenrollment  [ ]  Has enrolled in Milwaukee Wraparound [ ]  Has enrolled in Family Care or IRIS |

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| 1. **Adoption or Transfer of Guardianship Template**

**Email from the Child Welfare worker or Special Needs Adoption Program worker to Enrollment Specialist (and CC MA Certification @** **DCFBMCWC4KMedicaid@wisconsin.gov** **or** **DCFBMCWC4K@wi.gov****) when a child reaches permanency through adoption or guardianship and continues to meet eligibility criteria for the 12 month extension (child remains eligible for Medicaid and continues to reside in the six county area):**Date of transfer of guardianship or adoption:      Child’s full name (first, middle, last):       Child’s DOB:     I have reviewed the Eligibility Checklist and confirmed that the child continues to meet all eligibility criteria for enrollment in Care4Kids.  |