DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 1004 (Rev. 12/04)

STATE OF WISCONSIN

WISCONSIN MEDICAID
SCHOOL-BASED SERVICES MATCHING EXPENDITURES

SECTION I — SCHOOL DISTRICT OR COOPERATIVE EDUCATIONAL SERVICES AGENCY INFORMATION

Name — School District or Cooperative Educational Service Agency			Medicaid Provider Number
Report Period Start Date	Report Period End Date	Name — Preparer	Date Prepared

SECTION II — DIRECT AND INDIRECT EXPENDITURES FOR SERVICES PROVIDED TO ALL RECIPIENTS

	COLUMN A SPEECH THERAPY	COLUMN B OCCUPATIONAL THERAPY	COLUMN C PHYSICAL THERAPY	COLUMN D PSYCH. COUNSEL. SOCIAL WORK	COLUMN E NURSING	COLUMN F TRANSPORTATION	COLUMN G DURABLE MEDICAL EQUIP.
1. Direct Expenditures	$	$	$	$	$	$	$
2. Reimbursement Received	$	$	$	$	$	$	$
3. Direct Expend. Not Reimbursed	$	$	$	$	$	$	$
4. Indirect Allocation Percent	%	%	%	%	%	%	%
5. Indirect Expenditures	$	$	$	$	$	$	$
6. Total Direct and Indirect Expend.	$	$	$	$	$	$	$

SECTION III — ALLOCATION OF DIRECT AND INDIRECT EXPENDITURES FOR SERVICES PROVIDED TO WISCONSIN MEDICAID RECIPIENTS

	COLUMN A	COLUMN B	COLUMN C	COLUMN D	COLUMN E	COLUMN F	COLUMN G
7. Units Provided to All Students							
8. Units Prov. to Medicaid Recipients							
9. Medicaid Allocation Percent	%	%	%	%	%	%	%
10. Allocated Expenditures	$	$	$	$	$	$	$

11. TOTAL Columns A – G (Enter this amount on the Certification of Public Expenditures form [HCF 1003]) . . . . . $

SECTION IV — CALCULATION OF REQUIRED DISTRICT MATCH

	COLUMN A	COLUMN B	COLUMN C	COLUMN D	COLUMN E	COLUMN F	COLUMN G
12. Match Percent	%	%	%	%	%	%	%
13. TOTAL	$	$	$	$	$	$	$

14. TOTAL Columns A – G (Expenditures available for matching federal Medicaid funding) . . . . . $

For Office Use Only	**Name — Provider**	**Report Period**

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