

## WISCONSIN CHRONIC RENAL DISEASE PROGRAM RESIDENCY AND HEALTH CARE BENEFITS VERIFICATION

Wisconsin Chronic Disease Program (WCDP) requires the information requested in this form to enable WCDP to determine member eligibility for other health care programs or if the member is unable to provide a copy of either of the following documents:

- A copy of their most recent rental agreement OR property tax bill.
- A copy of their Wisconsin drivers license with current address OR state identification with current address OR Student ID (only for applicants under age 19).

This form should be completed by a county / facility social worker or transplant clinic financial counselor. The social worker / financial counselor will fill out this form, sign it and send it to the member. After the member has the completed form, it should be sent to WCDP with the member's completed Financial Need Statement. It is the member's responsibility to ensure that section 1,2,5,6 and 7 on the Financial Need Statement are completed. Do not mail the Financial Need Statement to the social worker / financial counselor. The use of this form is mandatory, if the member is unable to supply the documents listed above. Failure to supply the information requested on the Residency and Health Care Benefits Verification form may result in a denial of WCDP eligibility. Provision of your Social Security Number is voluntary, however, your Social Security Number is one of the unique identifiers used to identify you as a unique person in our claim system. Personally identifiable information is confidential and is used for purposes directly related to WCDP administration.

If you are a dialysis patient and do not know who your social worker is, you may contact your treatment facility. If you are a transplant patient and do not know who your social worker is, see the contact information provided below.

St. Lukes Hospital  
Financial Coordinator  
(414) 385-1875  
(800) 636-2393 ext. 1875

University of Wisconsin Hospital and Clinics  
Emily Niemeyer, MSW  
(608) 890-9891

Froedert Hospital  
Transplant Clinic  
(414) 805-3100

---

### SECTION 1. SOCIAL WORKER / FINANCIAL COUNSELOR INFORMATION

1. Name - Social Worker / Financial Counselor	2. Telephone - Social Worker / Financial Counselor
3. Facility Name	
4. Facility Street Address	5. City, State, ZIP Code

---

### SECTION 2. MEMBER INFORMATION

6. Name - Applicant	7. Social Security Number (SSN) or WCDP Identification Card Number
---------------------	--

---

**SECTION 3. MEDICARE, MEDICAID, BADGERCARE PLUS, AND SENIORCARE INFORMATION**

8. Do you currently have or have you had Medicare coverage?  Yes  No

Part A Begin Date \_\_\_\_\_ Part B Begin Date \_\_\_\_\_ Part D Begin Date \_\_\_\_\_

Part A End Date \_\_\_\_\_ Part B End Date \_\_\_\_\_ Part D End Date \_\_\_\_\_

9. Were you eligible for Medicare when you received your kidney transplant?  Yes  No  N/A

10. Wisconsin law requires applicants must first complete applications for other health care programs, if they may be reasonably eligible given their financial and non-financial circumstances, before applying to WCDP.

Are you currently eligible for Wisconsin Medicaid, BadgerCare Plus (Medical Assistance, MA, Title 19, T-19), or SeniorCare?

Yes  No

If yes, indicate your Medicaid, BadgerCare Plus, or SeniorCare identification number here \_\_\_\_\_.

11. If no, have you applied for any of these programs in the past year?  Yes  No

If yes, and you were denied eligibility for these programs, explain why \_\_\_\_\_.

**SECTION 4. SOCIAL WORKER / FINANCIAL COUNSELOR SIGN OFF**

This section is to be completed by a county/facility social worker or financial counselor if the applicant is **not** enrolled in Wisconsin Medicaid, BadgerCare Plus, or SeniorCare.

12. Based on my knowledge of \_\_\_\_\_, I attest that he/she is not eligible for the programs listed above. Explain in the space provided why the applicant would be denied eligibility, where applicable.

Medicaid or BadgerCare Plus \_\_\_\_\_.

SeniorCare \_\_\_\_\_.

SIGNATURE – Social Worker	Facility Name	Date Signed
---------------------------	---------------	-------------

Wisconsin Administrative Code 152.03(1)(a) specifies in order to be eligible for the Chronic Renal Disease Program the applicant must be a resident of Wisconsin.

Based on my knowledge, I attest that \_\_\_\_\_ is a resident of Wisconsin. I have verified that his home address is in Wisconsin.

By signing below I am attesting the member is a Wisconsin resident as set forth in 152.02(25).

SIGNATURE- Social Worker	Date Signed
--------------------------	-------------