

WISCONSIN ADULT CYSTIC FIBROSIS 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 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 sections 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.

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

8. Do you currently have or have you had Medicare coverage? Yes No
If yes, indicate your Medicare eligibility dates below.
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. 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 _____.

10. 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:

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.

11. 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
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Wisconsin Administrative Code 154.03(1) specifies in order to be eligible for the Adult Cystic Fibrosis 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 this form I am attesting the member is a Wisconsin resident as set forth in 154.02(16).

SIGNATURE- Social Worker	Date Signed
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