DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-10112 (04/2024)

MADA

MEDICAID – DISABILITY APPLICATION

Instructions: You must return all pages of this application form. This form needs to be completed for persons who require a disability determination in the Medicaid application process. This form must be completed by the applicant or their representative. If you are completing this application for someone else, complete the Appoint, Change, or Remove an Authorized Representative (F-10126) form, or attach legal documentation authorizing you to be that person's appointed guardian or durable power of attorney for finances. Information provided on this application should be about the applicant, not the representative. You must complete and include a signed copy of the Authorization to Disclose Information to Disability Determination Bureau (F-14014).

Return this completed application, the Authorization to Disclose Information to Disability Determination Bureau (F-14014) form and if applicable, the Appoint, Change, or Remove an Authorized Representative (F-10126) to the local county/tribal agency. To get these forms, contact your local county/tribal agency or visit the Wisconsin Department of Health Services website at dhs.wi.gov/em/customerhelp. Do not use this form for reconsiderations/fair hearings or redetermination cases.

Personally identifiable information will be used only for the direct administration of the Medicaid program.

Providing or applying for a Social Security number (SSN) is voluntary; however, any person who wants Wisconsin Medicaid but does not want to provide their SSN or apply for one will not be eligible for benefits, pursuant to Wis. Stats. § 49.82(2). SSN information will be used for the administration of the Wisconsin Medicaid Program. An applicant's SSN permits a computer check of the applicant's information with government agencies such as the Internal Revenue Service (IRS), Social Security Administration (SSA), and the Department of Workforce Development. In addition, the Department will match the applicant's name and SSN with information provided by health insurance carriers to determine if the applicant has other health insurance. The applicant's SSN will not be shared with the United States Citizenship and Immigration Services (USCIS).

SECTION I – APPLICANT INFORMATION

Applicant Name (last, first, MI)	Social Security Number	Birthdate	Age	Sex ☐ Female ☐ Male
Address (street, city, state, ZIP code)		County of Residence		
Phone Number (include area code)	If Married, Name of Spouse (last, first, MI)	Medicaid Application Date (agency must write in this date)		

List the name of a friend or relative that we can contact (other than your doctors) who knows about your illnesses, injuries, or conditions and can help you with your claim.

Name (last, first, MI)	Relationship to Applicant
Address (street, city, state, ZIP code)	Daytime Phone Number (include area code)

SECTION II – DISABILITY INFORMATION

1. What is your disability?

2. What is the date the disability first prevented you from working? (mm/dd/yyyy)

3. How does the disability affect your ability to perform normal daily activities?

4. Have you applied for Social Security Disability (SSD) or Supplemental Security Income (SSI) benefits?

☐ Yes ☐ No If yes, on what date was the most recent application filed?

At which Social Security office (street address, city, state, ZIP code) was the most recent application filed?

Was that claim: ☐ Allowed ☐ Denied ☐ Still pending

SECTION III – MEDICAL RECORDS INFORMATION

5a. List the name, address, and phone number of the doctor and clinic which have the most recent medical records about your disability. (If you need more space, list additional doctor and clinic information in 5b.)

Name of Doctor (last, first)	Business Phone Number (including area code)
Business Address (street, city, state, ZIP code)	
Clinic Name	How often do you see this doctor?
Date you first saw this doctor (mm/dd/yyyy)	Date you last saw this doctor (mm/dd/yyyy)
Reason for the visit(s)	
Type of treatment, surgery, or medicine(s) received.	

5b. Have you been seen by any other doctor or clinic in the last two years?
☐ Yes ☐ No

If yes, list the name, address, and phone numbers of any other doctors and clinics you have seen within the last two years for the disabling condition. (If you need more space, go to the Additional Information Section or you can use an additional sheet of paper.)

Name of Doctor (last, first)	Business Phone Number (including area code)
Business Address (street, city, state, ZIP code)	
Clinic Name	How often did you see this doctor?
Date the applicant first saw this doctor (mm/dd/yyyy)	Date the applicant last saw this doctor (mm/dd/yyyy)
Reason for the visit(s)	

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Type of treatment, surgery or medicine(s) received.

Name of Doctor (last, first)	Business Phone Number (including area code)
Business Address (street, city, state, ZIP code)	
Clinic Name	How often did you see this doctor?
Date the applicant first saw this doctor (mm/dd/yyyy)	Date the applicant last saw this doctor (mm/dd/yyyy)
Reason for the visit(s)	
Type of treatment, surgery, or medicine(s) received.	

6a. Have you been treated at a hospital for this disability within the past two years? ☐ Yes ☐ No

If yes, list details of the most recent hospitalization below.

Name of Hospital	Patient Number	
Address (street, city, state, ZIP code)		
Were you an inpatient (stayed at least overnight)? ☐ Yes ☐ No	Date of Admission (mm/dd/yyyy)	Date of Discharge (mm/dd/yyyy)
Were you an outpatient? ☐ Yes ☐ No	Dates of outpatient visits (mm/dd/yyyy)	
Reason for your hospitalization visits		
Type of treatment or medicines received (such as surgery, chemotherapy, radiation)		

6b. Have you been in any other hospital within the past two years for the disability? ☐ Yes ☐ No

If yes, identify the hospital below. (If you need more space, go to Additional Information Section or you can use an additional sheet of paper.).

Name of Hospital	Patient Number
Address (street, city, state, ZIP code)	

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Were you an inpatient (stayed at least overnight)? ☐ Yes ☐ No	Date of Admission (mm/dd/yyyy)	Date of Discharge (mm/dd/yyyy)
Were you an outpatient? ☐ Yes ☐ No	Dates of outpatient visits (mm/dd/yyyy)	

Reason for your hospitalization visits

Type of treatment or medicines received (such as surgery, chemotherapy, radiation)

7. Have you had any of the following tests in the past year?

Test		Date Completed	Test Location
Electrocardiogram (EKG) or Treadmill (Exercise)	☐ Yes ☐ No		
Echocardiogram or Cardiac Catheterization	☐ Yes ☐ No		
MRI/ X-ray/CT Scan Which body part:	☐ Yes ☐ No		
Breathing Tests	☐ Yes ☐ No		
Blood Tests	☐ Yes ☐ No		
Other Tests Specify:	☐ Yes ☐ No		

8. Have you been seen by other agencies for your disabling condition? (For example, Veterans Administration, Worker's Compensation, Vocational Rehabilitation, Social Service Agencies, Probation or Parole, etc.) ☐ Yes ☐ No

If yes, provide the following information.

Name of Agency	Claim Number

Address (street, city, state, ZIP code)

Dates of Visits (mm/dd/yyyy)

Types of treatment, exam, medicine, or services received.

9a. Information about your activities.

Has your doctor told you to cut back or limit activities in any way? ☐ Yes ☐ No
If yes, give the name of the doctor below and the doctor's instructions about cutting back or limiting activities.

9b. Describe your daily activities in the following areas and state what, how much, and how often each is done.

Household Maintenance (including cooking, cleaning, shopping and other jobs around the house, as well as similar activities)

Recreational Activities and Hobbies (hunting, fishing, bowling, hiking, musical activities, etc.)

Social Contact (visits with friends, relatives, neighbors)

Other (drive a car or motorcycle, ride bus, etc.).

SECTION IV – EDUCATION INFORMATION

10. Education Information

What is the highest grade level you completed?	Did you attend special education classes? ☐ Yes ☐ No	Have you attended trade/vocational school or had any other training? ☐ Yes ☐ No

Type of trade or vocational schooling or training?

Approximate dates you attended (mm/dd/yyyy)

SECTION V – WORK HISTORY

11. Work History

Are you currently working? ☐ Yes ☐ No If yes, complete the following.

Name of Employer

Address (street, city, state, ZIP code)

Date Started (mm/dd/yyyy)	Hours Per Week	Rate of Pay (per hour)

12a. List all jobs you have had within the last 15 years beginning with the current or most recent job.

Job Title	Name of Employer/Type of Business	Dates Worked		Hours Per Week	Rate of Pay
		From	To		

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12b. Complete sections 12b through 12g using the information from the job you held the longest in the last 15 years. In the job you held the longest within the last 15 years, did you:

Use machines, tools or equipment of any kind? ☐ Yes ☐ No	Use technical knowledge or skills? ☐ Yes ☐ No
Do any writing, complete reports, or perform similar duties? ☐ Yes ☐ No	Have supervisory responsibilities? ☐ Yes ☐ No

12c. What were the job duties?

12d. How many total hours each day, did you do the following:

Activity	Hours	Activity	Hours
Walk		Kneel (bend legs to rest on knees)	
Stand		Crouch (bend legs and back down and forward)	
Sit		Crawl (move on hands and knees)	
Climb		Handle, grab or grasp big objects	
Stoop (bend down and forward at waist)		Write, type or handle small objects	

12e. Lifting and Carrying (Explain what you lifted in this job, how far it was carried and how often it was lifted)

12f. Check the heaviest weight lifted in this job.

☐ Less than 10 lbs. ☐ 10 lbs. ☐ 20 lbs. ☐ 50 lbs. ☐ 100 lbs. or more ☐ Other (enter amount): _____

12g. Check weight frequently lifted in this job (by frequently, we mean from 1/3 to 2/3 of the workday).

☐ Less than 10 lbs. ☐ 10 lbs. ☐ 25 lbs. ☐ 50 lbs. or more ☐ Other (enter amount): _____

SECTION VI – ADDITIONAL INFORMATION

Use this section for additional space to answer any previous question or to give any additional information that you think will be helpful in making a decision about your disability claim (such as information about other illnesses or injuries not shown, information about additional doctors seen or places or dates of hospitalizations). Refer to previous items by section number when responding. If more room is needed, use an additional sheet of paper.

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SECTION VII – COMPLETION ASSISTANCE

This section should be completed if the applicant needed help completing this application. The person who helped the applicant must **complete the following section.**

Did the applicant need help completing this application? ☐ Yes ☐ No

If yes, list name, address, and telephone number of the person who helped the applicant.

Name (last, first, MI) (please print)	Relationship/Title
Address (street, city, state, ZIP code)	Phone Number (including area code)

Can the applicant speak English? ☐ Yes ☐ No	If the applicant cannot speak English, what language does the applicant speak?
Can the applicant read English? ☐ Yes ☐ No	Can the applicant write English (other than their name)? ☐ Yes ☐ No

If the applicant cannot speak English, list the name of someone who may be contacted who speaks English and will give the applicant messages.

Name (last, first, MI) (please print)	Relationship to Applicant
Address (street, city, state, ZIP code)	Phone Number (including area code)

SIGNATURE — Person who helped applicant	Name	Date Signed

SECTION VIII – SIGNATURE

I understand the questions and statements on this application form. I understand the penalties for giving false information or breaking rules. I certify, under penalty of false swearing, that all my answers are complete to the best of my knowledge. I understand that the agency may contact other persons or organizations to obtain the necessary proof of my eligibility and level of benefits. The applicant's signature must be witnessed by two people if signed with an "X". If you are an Authorized Representative and completed this form on behalf of the applicant, you must attach a completed Medicaid/FoodShare Wisconsin Authorization of Representative form (F-10126).

SIGNATURE — Applicant or Authorized Representative	Name	Date Signed
SIGNATURE — Witness (Required if signed with an X.)	Name	Date Signed
SIGNATURE — Witness (Required if signed with an X.)	Name	Date Signed