WISCONSIN DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-00407 (05/2019)

BNK

FINANCIAL RECORDS REQUEST

INSTRUCTIONS: Under Wis. Stat. § 49.22 (2m), the Wisconsin Department of Health Services (DHS) may request from any person in this state information it determines appropriate and necessary for the administration of Wisconsin's Medicaid program under Wis. Stat. §§ 49.22, 49.141 to 49.161, 49.19, 49.46, 49.468, 49.47, and 49.471 and programs carrying out the purposes of 7 USC 2011 to 2019. Unless access is prohibited or restricted by law or unless the financial institution has good cause, as determined by DHS in accordance with federal law and regulations, for refusing to cooperate, the financial institution shall make a good faith effort to provide this information within seven days after receiving this request.

Complete this form and return it within seven days. This form will be due on _____.

- If the customer has more than three accounts, attach a separate document with information on those accounts. You may submit copies of account records or complete the information requested for each month listed.
- A representative from your financial institution **must** sign this form.
- If the customer does not have an account with your financial institution, check the box in Section 2 indicating that.

Form Submission
Submit the completed form in one of the following ways:

Fax

- If the customer lives in Milwaukee County, fax the form to 888-409-1979.
- If the customer does not live in Milwaukee County, fax the form to 855-293-1822.

Mail

If the customer lives in **Milwaukee County**, mail the form to:

MDPU
PO Box 05676
Milwaukee, WI 53205

If the customer does **not** live in Milwaukee County, mail the form to:

CDPU
PO Box 5234
Janesville, WI 53547

SECTION 1 Information About Financial Institution and Customer

Name – Financial Institution		
Street Address		
City	State	Zip Code
The financial institution is requested to provide information for the period of:		
Name – Customer	Social Security Number	

I certify that the applicable provisions of the Right to Financial Privacy Act of 1978 (12 U.S.C. 3401–3422) have been complied with in this request. Pursuant to the Right to Financial Privacy Act of 1978, good faith reliance up in this certification relieves your institution and its employees and agents of any possible liability to the customer in connection with the disclosure of these financial records.

SIGNATURE – Income Maintenance Worker Requesting Information	Date Signed
Phone Number (include area code)	

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SECTION 2 Account Information

List the type of account (checking, savings, time/certificate of deposit, Keogh, trust, etc.), account number, and the name(s) on and exact account designation. Make copies of this page if there are more than three accounts.

Account 1 – Type	Account Number
Name(s) On and Exact Account Designation	
Account 2 – Type	Account Number
Name(s) On and Exact Account Designation	
Account 3 – Type	Account Number
Name(s) On and Exact Account Designation	

☐ No accounts were located for this customer.

SECTION 3 Account Details

☐ Opening balance(s) as of the first day of the month for each account (or balance on the close of business of the last day of the previous month)

☐ The amount of interest paid or credited during each month

	Account 1		Account 2		Account 3	
Date	**Balance**	**Interest Paid**	**Balance**	**Interest Paid**	**Balance**	**Interest Paid**
	$	$	$	$	$	$
	$	$	$	$	$	$
	$	$	$	$	$	$
	$	$	$	$	$	$
	$	$	$	$	$	$
	$	$	$	$	$	$

SIGNATURE – Financial Institution Representative	Date Signed
Print First and Last Name of Financial Institution Representative	Phone Number (with area code)

RESET FORM