DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-01144 (05/2025)

STATE OF WISCONSIN
Wis. Stat. § 49.683

WISCONSIN ADULT CYSTIC FIBROSIS PROGRAM
RESIDENCY AND HEALTH CARE BENEFITS VERIFICATION

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

- A copy of his or her most recent rental agreement OR property tax bill.
- A copy of his or her Wisconsin driver's license with current address OR state identification with current address OR student ID (only for applicants under age 19).

This form should be completed and signed by a county or facility social worker or clinic financial counselor. The member should include this form with his or her completed Financial Need Statement if the member is unable to provide a copy of the documents listed above and send it to WCDP. Failure to provide the information requested on this form may result in denial of WCDP eligibility.

Note: It is the member's responsibility to ensure 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 or financial counselor.

Provision of a Social Security Number (SSN) is voluntary but highly recommended. Information provided in this form is held confidential and solely used for WCDP administration purposes only.

Contact your treatment center if you need information about your social worker.

SECTION 1. SOCIAL WORKER / FINANCIAL COUNSELOR INFORMATION

1. Name – Social Worker / Financial Counselor	2. Phone – Social Worker / Financial Counselor
3. Facility Name	
4. Facility Street Address	5. City, State, Zip Code

SECTION 2. MEMBER INFORMATION

6. Name – Applicant	7. SSN or WCDP Identification Card Number

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 to first complete applications for other health care programs, if they may be reasonably eligible given their financial and nonfinancial 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 below.

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 why:

SECTION 4. SOCIAL WORKER / FINANCIAL COUNSELOR SIGNOFF

This section is to be completed by a county or facility social worker or clinic 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 or she is not eligible for the programs listed above. Explain in the space provided below, where applicable, why the applicant would be denied eligibility.

Medicaid or BadgerCare Plus

SeniorCare

SIGNATURE – Social Worker / Financial Counselor	Facility Name	Date Signed

Wisconsin Admin. Code § DHS 154.03 (1) specifies that 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 or her home address is in Wisconsin.

By signing this form, I am attesting the member is a Wisconsin resident as set forth in Wis. Admin. Code § DHS 154.02 (16).

SIGNATURE – Social Worker / Financial Counselor	Date Signed