**DEPARTMENT OF HEALTH SERVICES**
Division of Health Care Access and Accountability
F-01145 (02/2016)

**STATE OF WISCONSIN**
Wis. Stat. § 49.685

# WISCONSIN HEMOPHILIA HOME CARE PROGRAM
# RESIDENCY VERIFICATION

Wisconsin Chronic Disease Program (WCDP) requires the information requested in this form to enable WCDP to determine member eligibility 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).

The use of this form is mandatory if the member is unable to supply the requested documents listed above. Failure to supply the information requested on this form may result in a denial of WCDP eligibility. Provision of your Social Security Number (SSN) is voluntary; however, your SSN 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.

**SOCIAL WORKER INFORMATION**

| 1. Name – Social Worker | 2. Telephone Number – Social Worker |
|---|---|
| 3. Facility Name | |
| 4. Facility Street Address | 5. City, State, Zip Code |

**MEMBER INFORMATION**

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

Wisconsin Administrative Rule DHS 153.03 (1) specifies that in order to be eligible for the Hemophilia Home Care 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. Rule DHS 153.02 (17).

| **SIGNATURE** – Social Worker | Date Signed |
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