DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-01145 (05/2025)

STATE OF WISCONSIN
Wis. Stat. § 49.685

WISCONSIN HEMOPHILIA HOME CARE PROGRAM
RESIDENCY VERIFICATION

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

Failure to provide the information requested on this form may result in a denial of WCDP eligibility.

Note: 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.

SOCIAL WORKER / FINANCIAL COUNSELOR INFORMATION	
1. Name – Social Worker / Financial Counselor	2. Phone Number – Social Worker / Financial Counselor
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 Admin. Code § 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. Code § DHS 153.02 (17).

SIGNATURE – Social Worker / Financial Counselor	Date Signed