

WISCONSIN ADULT CYSTIC FIBROSIS PROGRAM FINANCIAL NEED STATEMENT INSTRUCTIONS

The Wisconsin Chronic Disease Program (WCDP) is a state-funded program whose purpose is to provide payment for chronic renal disease services, adult cystic fibrosis services, and hemophilia home care supplies. The WCDP provides payment after all other payment sources have been used.

The Department of Health Services has the authority to collect personally identifiable information necessary to determine continued eligibility and benefits for WCDP. Information provided in the application form is held confidential and solely used to determine continued eligibility and benefits for WCDP.

Upon determination that an applicant is eligible for WCDP benefits, the applicant receives a letter of notification and a WCDP identification card. WCDP members are required to inform WCDP in writing within 30 days of any qualifying changes, such as change in address, eligibility, mode of treatment, health insurance coverage, or Medicare coverage; an up or down income change of more than 10 percent; or change in family size. WCDP members may be responsible for income deductibles, inpatient/outpatient deductibles, drug copayments, and coinsurance.

INSTRUCTIONS: Print clearly and follow these instructions carefully. Incomplete or illegible Financial Need Statements will be returned and delay determination of your eligibility. If you are an applicant's representative, provide the applicant's information. Make a copy of the completed Financial Need Statement for your records.

SECTION 1. APPLICANT INFORMATION

- Item 1. Print your last name, first name, and middle initial.
- Item 2. Indicate your SSN.
- Item 3. Indicate your street address. You must indicate the physical residential address. A post office box alone is not acceptable.
- Item 4. Indicate your home phone number, including the area code. If you do not have a phone, indicate "None."
- Item 5. Indicate your city, state, and zip code.
- Item 6. Indicate the county where you live.
- Item 7a. Indicate your email address (optional)
- Item 7b. Check if email is your preferred method of contact.
- Item 8. Check "Male" or "Female."
- Item 9. Indicate the month, date, and year of birth.
- Item 10. Answer "Yes" if you have dependent family members who are members of WCDP.
If you answered "Yes," indicate the name(s) and SSNs or WCDP identification card number(s) of all dependent family members currently eligible for benefits from WCDP.
- Item 11. Indicate your race/ethnicity by checking the appropriate box. This information will be used for statistical purposes only.

SECTION 2. RESIDENCY INFORMATION

- Item 12. Check "Yes" or "No."
If you answered "No," indicate the month, date, and year you moved to Wisconsin.
- Item 13a. Applicants age 19 and over should provide copies of the following documents:
 - Last year's Wisconsin Income Tax return with all attachments.

- The most recent rental agreement or property tax bill.
- Wisconsin driver's license with current address **OR** state identification with current address.
- Alien registration card issued by the United States Citizenship and Immigration Services (USCIS) if you are not a U.S. citizen.

Item 13b. Applicants under the age of 19 should provide copies of the following documents.

- Parent or guardian's Wisconsin Income Tax return with all attachments for the last year.
- Parent or guardian's most recent rental agreement or property tax bill.
- Wisconsin driver's license with current address **OR** state identification with current address **OR** student ID.
- Alien registration card issued by USCIS if you are not a U.S. citizen.

If you are unable to provide either of the following documents, you must have your treatment facility social worker sign the residency verification.

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

Item 14. If you do not have these documents, explain why. Attach additional pages if necessary.

SECTION 3. MEDICARE, MEDICAID, BADGERCARE PLUS, AND SENIORCARE INFORMATION

Item 15. Check "Yes" or "No."

If you answered "Yes," indicate your Medicare Part A (hospital insurance), Part B (medical insurance), and Part D (drugs) begin date(s). If your coverage has ended, indicate the end date(s). *If you currently have Medicare coverage, do not indicate a Medicare end date.*

If you answered "No," proceed to item 16.

Item 16. Check "Yes" or "No." If you answered "Yes," indicate your Wisconsin Medicaid, BadgerCare Plus, or SeniorCare identification number. Wisconsin Medicaid and BadgerCare Plus may also be called Medical Assistance, MA, Title 19 or T-19.

Item 17. Check "Yes" or "No" to indicate whether you have applied for Wisconsin Medicaid, BadgerCare Plus, or SeniorCare in the past year if you answered no in item 16.

If you answered "Yes," explain why you were denied eligibility for Wisconsin Medicaid, BadgerCare Plus, or SeniorCare.

Wisconsin law requires applicants must first complete applications for other health care programs if they may be reasonably eligible given their financial and nonfinancial circumstances before applying to WCDP.

SECTION 4. SOCIAL WORKER SIGNOFF

Item 18. This section should be completed by the treatment facility social worker if the applicant is not enrolled in Wisconsin Medicaid, BadgerCare Plus, or SeniorCare.

SECTION 5. INSURANCE INFORMATION

Item 19. Check "Yes" or "No" to indicate whether you have private, group, HIRSP (Health Insurance Risk Sharing Plan), or other health insurance coverage for medical expenses. Do not include Medicare, Medicaid, BadgerCare Plus, SeniorCare, or WCDP here.

If “Yes,” complete items 19a through 19n.

- a. Indicate the name of the company through which you have health insurance coverage.
- b. Indicate the phone number, including the area code, of the insurance company.
- c. Indicate the name of the policyholder.
- d. Indicate the relationship of the policyholder to you (for example, wife, husband, self).
- e. Indicate the policy number.
- f. Indicate the group policy number.
- g. Indicate the date the coverage began.
- h. Indicate the date the coverage ended if you no longer have the coverage. If the coverage is still in effect, leave the coverage termination date blank.
- i-n. Check “Yes” or “No” for each question. Refer to your insurance policy or contact your insurance company or representative for more information on your coverage.

If you have more than one insurance company, list the second insurance under “Insurance 2.” Attach additional information if needed for current and past insurance for the last two years.

SECTION 6. FINANCIAL INFORMATION.

Item 20. Indicate the number of dependent family members; include yourself if you are a dependent family member. Include all family members who may be claimed as dependents by the applicant for the purpose of filing a federal income tax return. This information is needed to determine your deductible for the Wisconsin Adult Cystic Fibrosis Program.

Item 21. Indicate your average total income by completing items a. through l. Choose to complete either the average monthly totals OR annual totals.

If you are completing the “Average Monthly Totals” column, indicate the income received during a month in the most recent 12-month period. Do not use the highest or lowest monthly totals for income; use a monthly total that reflects an average amount of income. Indicate the month and year of this income (for example, March 2019). If you are completing the “Annual Totals” column, indicate the income for the most recently completed calendar year. Indicate the calendar year of this income (for example, 2018).

- **If you are claimed as a dependent on someone else’s income tax return**, enter the current total monthly or annual income from that person’s paycheck stub and all federal Social Security payments, dividends, interest income, estate or trust income, net rental income, royalties, cash public benefits (for example, W-2 payments), pensions, annuities, veterans benefits, unemployment compensation, worker’s compensation, maintenance payments, alimony, child support, nontaxable interest, and nontaxable deferred compensation received by that person. **Also include any of these same types of payments or income received by you and everyone included in Item 20.**
- **If you are not claimed as a dependent by anyone else on their income tax return but file your own income tax return and claim yourself as an exemption**, enter the current total monthly or annual income from your paycheck stub and enter all federal Social Security payments, dividends, interest income, estate or trust income, net rental income, royalties, cash public benefits (for example, W-2 payments), pensions, annuities, veterans benefits, unemployment compensation, worker’s compensation, maintenance payments, alimony, child support, nontaxable interest, and nontaxable deferred compensation **received by you and everyone included in Item 20.**
- **If you are not claimed as a dependent by anyone else on their income tax return and you do not file an income tax return of your own**, enter the current total monthly or annual income from your paycheck stub, all federal Social Security payments, dividends, interest income, estate or trust income, net rental income, royalties, cash public benefits (for example, W-2 payments), pensions, annuities, veterans benefits, unemployment compensation, worker’s compensation, maintenance payments, alimony, child support,

nontaxable interest, and nontaxable deferred compensation **received by you and everyone included in Item 20.**

Add up the amounts in items 21a. through 21l. and indicate the current total monthly or annual income under 21m.

Item 22. Indicate whether you anticipate your monthly income to increase or decrease more than 10 percent. If your monthly or annual income increases or decreases more than 10 percent, you must notify WCDP in writing of the change within 30 days.

Item 23. If you answered “Yes” in item 22, explain why.

Item 24. Indicate your total gross family income based on last year’s Wisconsin Income Tax return. If you did not file a state tax return, leave this area blank.

SECTION 7. AGREEMENT AND SIGNATURES

Item 25. Indicate the medical facility from which you are receiving treatment.

Item 26. Applicant (or applicant’s representative if applicant is a minor) signs and dates the form.

Send the completed form to:

Wisconsin Chronic Disease Program
Attention: Eligibility Unit
P.O. Box 6410
Madison, WI 53716-0410

Fax: 608-224-6318

If you have questions regarding the completion of the Financial Need Statement, please contact your treatment center social worker or call WCDP at 800-362-3002.

Remember to:

- Sign and date the application.
- Include a copy of last year’s Wisconsin Income Tax return with all attachments.
- Include a copy of the most recent rental agreement OR property tax bill.
- Include a copy of your Wisconsin driver’s license with current address OR state identification with current address OR student ID (only for applicants under age 19).
- Include a copy of your alien registration card issued by USCIS if you are not a U.S. citizen.

Note: If you are unable to provide either of the following documents, you must have your treatment facility social worker sign the residency verification.

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

CAUTION: Failure to fully complete your application and provide the requested documentation may result in delayed processing and eligibility determination.