

Scott Walker  
Governor

**State of Wisconsin**  
Department of Health Services

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DATE: March 1, 2016

TO: All Wisconsin Chronic Disease Program (WCDP) Members  
Adult Cystic Fibrosis (ACF) Program

FROM: WCDP

Please complete the enclosed *Financial Need Statement* [F-01188 (02/16)] and return it to WCDP before **May 31, 2016**.

**IMPORTANT: Please do NOT throw out your current ForwardHealth ID card. You will NOT receive another card after you send in your new financial needs information. However, you must provide all information requested.** We will return incomplete forms to you. *If you do not return the completed Financial Need Statement, claims for WCDP services after **June 30, 2016**, will not be paid.*

Please pay particular attention to the following items. If necessary, staff at your treatment center will be able to assess your particular case and advise you in completing and mailing this form.

**SECTION 5. INSURANCE INFORMATION** – You must provide accurate, current insurance information. If your insurance has changed, please indicate the date your old insurance terminated and your new insurance began. If you have more than one insurance policy, list the second insurance company under Insurance 2. Please attach additional sheet(s) of paper with your insurance information if needed. Incomplete insurance information may cause your claims to be rejected.

**SECTION 6. FINANCIAL INFORMATION.**

**Item 21. CURRENT MONTHLY/YEARLY FAMILY INCOME** – Your eligibility will be determined by *current monthly or annual family income*. You must report all items (a. through l.) for all your immediate family to determine your total family income.

**SUBMIT ADDITIONAL INFORMATION.**

You will need to submit the following items with the Financial Need Statement:

- Copy of last year's Wisconsin Income Tax return with all attachments.
- Copy of the most recent rental agreement OR property tax bill.
- 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).
- Copy of your alien registration card issued by the United States Citizenship and Immigration Services (USCIS) if you are not a U.S. citizen.

Please send your completed materials to:

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

If you have questions, you may call 800-362-3002.