

ESTATE RECOVERY PROGRAM DISCLOSURE INSTRUCTIONS

The Estate Recovery Program (ERP) Disclosure form is to be completed for nursing facility Medicaid applicants and Medicaid and COP applicants 55 and over. (This form does NOT need to be completed for Senior Care applicants.)

The long-term care worker is to complete the form with information about the applicant, his/her spouse, and any children that are blind, disabled (as determined by DDB), and under age 21.

Attach a legible copy of the latest property tax bill or a copy of the property deed for any homestead property reported if possible. These documents may give ERP staff the property's legal description.

Completed forms should be sent to ERP, P.O. Box 309, Madison, WI 53701-0309. A copy should be filed in the applicant's (member's) case record.

SECTION I – COUNTY INFORMATION

Date Completed

Enter the date (mm/dd/yy) this form is completed.

Agency Name

Enter the name of the agency.

Worker Name

Enter your name (last, first, MI).

Worker Telephone Number

Enter your telephone number.

SECTION II – APPLICANT INFORMATION

Applicant Name

Enter the name of the long-term care services applicant (last, first, MI).

Address

Enter the long-term care services applicant's address of residence; include street, city, state and zip code.

CARES Case / RFA Number

Enter the CARES case or Request for Assistance (RFA) number for the applicant.

Birthdate

Enter the long-term care services applicant's birthdate. For example, if the applicant was born on October 4, 1972, enter 10/04/72.

Social Security Number (SSN)

Enter applicant Social Security Number. Providing or applying for a SSN is voluntary; however any person who wants Wisconsin Medicaid but does not want to provide their SSN or apply for one will not be eligible for benefits, according to Wisconsin Statutes, 49.82(2). SSN information will be used for administration of the Medicaid program.

SECTION III – SPOUSE INFORMATION

Is spouse an applicant?

Check "Yes" if the spouse is a long-term care services applicant. Check "No" if the spouse is not a long-term care services applicant.

Spouse's Name

Enter the spouse's name (last, first, MI).

Address

Enter the address of residence for the spouse; include street, city, state and zip code.

CARES Case / RFA Number

Enter the CARES case or RFA number for the spouse.

Birthdate

Enter the spouse's birthdate. If the spouse was born on April 3, 1971, enter 04/03/71.

Social Security Number

Enter spouse's Social Security Number. Providing or applying for a SSN is voluntary; however any person who wants Wisconsin Medicaid but does not want to provide their SSN or apply for one will not be eligible for benefits, pursuant to Wisconsin Statutes 49.82(2). SSN information will be used for administration of the Medicaid/COP program.

SECTION IV – FAMILY INFORMATION

Are there any children who are blind, disabled, or under age 21?

Check "Yes" if the long-term care services applicant has children who are blind, disabled or under age 21. Check "No" if there are no children who are blind, disabled or under age 21.

If "Yes" is checked complete the rest of Section IV.

Child's Name

Enter the last name, first name and middle initial of any child or children who are blind, disabled, or under age 21. (Please attach additional sheet of paper, if there is more than one child.)

Birthdate

Enter the birthdate for any child or children who are blind, disabled or under the age 21. (Please attach additional sheet of paper, if there is more than one child.) If the child's birthdate is May 5, 1997, enter 05/05/97.

Address

Enter the address of residence, include street, city, state, zip code, for any child or children who are blind, disabled or under age 21. (Please attach additional sheet of paper, if there is more than one child.)

Disability Explanation

Give a brief description of the child's or children's disability. (Please attach additional sheet of paper, if there is more than one child.)

SECTION V – ASSET INFORMATION

If joint assets are held with someone other than the spouse please disclose. If there is ownership in property indicate the dollar value in the column that describes the applicant's interest and **attach a copy of the property tax bill** for each parcel.

SECTION VI – GUARDIAN OR POWER OF ATTORNEY FOR FINANCE AND PROPERTY INFORMATION

Check the "guardian" or "power of attorney for finance and property" box if the person helping to complete this form is either a guardian or durable power of attorney for finances for the long-term care services applicant.

Telephone Number

Enter the telephone number of the guardian or power of attorney for finance and property, include area code.

Guardian / Power of Attorney for Finance and Property Name

Enter the name of the guardian or power of attorney for finance and property (last, first, MI).

Address

Enter the address of the guardian or power of attorney for finance and property; include street, city, state and zip code.

SECTION VII – SIGNATURE

Signature – Applicant / Guardian / Power of Attorney for Finance and Property

The applicant or his/her guardian or power of attorney for finance and property should sign the form. If the applicant will not sign the form you (the worker) should sign the form at the Signature line.

Date Signed

Enter the date (mm/dd/yy) the document was signed by the applicant, guardian or power of attorney for finance and property

Applicant Agreed to Sign

Check the “Yes” box if the applicant agreed to sign the form or have their guardian or power of attorney for finance and property sign the form. Check “No” if the applicant did not agree to sign the form or have the guardian or power of attorney for finance and property sign the form.

Comments

Explain in this field that you reviewed the data with the applicant or his/her guardian or power of attorney for finance and property. Indicate that the reason why the applicant did not sign the form or have their guardian or power of attorney for finance and property sign the form.