DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-10076 (03/2017)

¿Prefiere las notificaciones en español? ◯ Yes ◯ No

SENIORCARE® Rx
Prescription Drugs for Wisconsin Seniors

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STATE OF WISCONSIN
Wis. Stat. § 49.688

APPLICATION

Select One: ◯ New Application ◯ Add Spouse ◯ Reapplication

SECTION I – APPLICANT INFORMATION

Are you requesting SeniorCare? ◯ Yes ◯ No Wisconsin Resident? ◯ Yes ◯ No U.S. Citizen? ◯ Yes ◯ No Gender? ◯ Male ◯ Female

Race/Ethnicity (Optional) ***Choose all that apply***
◯ American Indian/Alaskan Native ◯ Hawaiian/Other Pacific Islander ◯ Black/African American
◯ White ◯ Asian ◯ Hispanic Ethnicity

Current Marital Status:
◯ Married ◯ Divorced
◯ Widowed ◯ Separated
◯ Single

If married or separated, are you
◯ Living with spouse
◯ Not living with spouse

Last Name:

First Name: **Middle Initial:**

Birth Date: / / **Soc. Sec. No.** - -

SECTION II – SPOUSE INFORMATION (IF LIVING WITH APPLICANT)

Are you requesting SeniorCare? ◯ Yes ◯ No Wisconsin Resident? ◯ Yes ◯ No U.S. Citizen? ◯ Yes ◯ No Gender? ◯ Male ◯ Female

Race/Ethnicity (Optional) ***Choose all that apply***
◯ American Indian/Alaskan Native ◯ Hawaiian/Other Pacific Islander ◯ Black/African American
◯ White ◯ Asian ◯ Hispanic Ethnicity

Last Name:

First Name: **Middle Initial:**

Birth Date: / / **Soc. Sec. No.** - -

SECTION III – MAILING ADDRESS

Street: **Apartment:**

City: **State:** **Zip Code:**

Phone: - -

Address is: ◯ Same as residence ◯ Different than residence ◯ Your Authorized Representative's / Legal Guardian's / Power of Attorney's address

SECTION IV – EXPECTED ANNUAL INCOME (Required)

For each item below, enter the total gross (before deductions) expected ANNUAL income for you and your spouse for the next 12 months.
ROUND INCOME TO THE NEAREST DOLLAR – DO NOT INCLUDE CENTS

	APPLICANT	SPOUSE (If Living with Applicant)
Gross Social Security	$ ___,___	$ ___,___
Gross Wages	$ ___,___	$ ___,___
Interest, Dividends, and Capital Gains	$ ___,___	$ ___,___
Net Self-Employment Income	$ ___,___	$ ___,___
Retirement Income	$ ___,___	$ ___,___
Other Income	$ ___,___	$ ___,___
Grand Total	$ ___,___	$ ___,___

SECTION V – SIGNATURE (Required)

I understand the questions and statements on this application form. I understand the penalties for giving false information or breaking the rules as outlined in the rights and responsibilities section of the SeniorCare application instructions. I certify, under penalty of perjury and false swearing, that all my answers are correct and complete to the best of my knowledge, including information provided about the citizenship or immigration status of my spouse and myself. I understand and agree to provide documents to prove what I have said. I understand that the agency may contact other persons or organizations to obtain the necessary proof of my eligibility and benefits.

SIGNATURE – Applicant or Representative	**PRINTED NAME** – Applicant or Representative

Signature of: ◯ Applicant ◯ Authorized Representative ◯ Legal Guardian ◯ Power of Attorney / Durable Power of Attorney

Two witness signatures are required only if you sign with an "X."

Witness 1	Witness 2

SECTION VI – ENROLLMENT FEE (Required)

Enrollment Fee Enclosed ◯ $30 – One Applicant
◯ $60 – Two Applicants

Make check or money order payable to: State of Wisconsin
(Include names of all applicants on payment.)

Return completed application form and fee to:
SeniorCare
PO Box 6710
Madison, WI 53716-0710

OFFICE USE ONLY

◯ None
◯ Other ___.___

If you have questions, contact SeniorCare Customer Service Hotline at 1-800-657-2038.