**DEPARTMENT OF HEALTH SERVICES**
Division of Medicaid Services
F-29314 (01/2017)

**STATE OF WISCONSIN**
COP-DIA
Wis. Stats. § 46.27

# DECLARATION OF INCOME AND ASSETS AND STATE RESIDENCY
## COMMUNITY OPTIONS PROGRAM (COP)

(Care Managers: Refer to line-by-line instructions (F-29315) when completing this form.)

| Name – Applicant/Participant | County of Residence |
|---|---|
| | |

**PART I—RESIDENCY** (Complete Part I at application only)
Have you resided in the State of Wisconsin for the past six months? (See instructions F-29315 to determine if this applies)

☐ Yes—Continue ☐ No—**STOP**, individual is not eligible for COP 100% State funding but may be eligible for Medicaid Waivers

**PART II—DIVESTMENT:** As of January 1, 2014, the look back period for ALL divestments is **60 months** from the application date.

Ask the following questions [See instructions F-29315 to determine if a referral to the Income Maintenance (IM) Agency is appropriate]

1. Within the last 60 months have you or your spouse disposed of, given away, or transferred property (such as land, stocks, bonds, cash, etc.) including transfers of property to children, relatives or other persons?
2. Within the last 60 months have you or your spouse purchased a life estate in another person's home?
3. Within the last 60 months have you or your spouse purchased a promissory note, a loan or a mortgage?
4. Within the last 60 months have you or your spouse purchased an annuity?
5. If you or your spouse own any annuities which were purchased prior to 1/1/09, have any of the following transactions occurred (after 1/1/09) to that annuity: additions of principal; elective withdrawals; requests to change the distribution; elections to annuitize the contract; a change in ownership?
6. Within the last 60 months have you or your spouse, set up a trust or have you added funds to a trust? (Exception: Exempt funeral trusts described on page 5 of the instructions to this Declaration, F-29315).

If the answer to ANY of the questions above is "YES" at application or at review, complete form F-20919D and make a referral to Income Maintenance.

**PART III—INCOME AND ASSET INFORMATION FOR SSI RECIPIENTS ONLY:**
Fill in amount on Income line 4 below. For SSI recipients who live at home, go directly to Part V of this Declaration for signature and date. Enter zero on line 9 of COP Cost-Share Worksheet 1 (F-29319). Applicant is eligible without cost sharing. It is not necessary to complete Asset information or information in Part IV. For SSI recipients who live in substitute care, complete this form and then complete applicable COP cost-share worksheet to determine cost-share.

**A. Monthly Earned Income**

| | Applicant | Spouse |
|---|---|---|
| 1. Before-tax wages or salary | | |
| 2. Before-tax income from self-employment | | |
| **Monthly Unearned Income** | | |
| 3. Social Security, SSDI or Railroad Ret. | | |
| 4. SSI | | |
| 5. SSI-E | | |
| 6. Veteran's Pension | | |
| 7. Pension / Annuities | | |
| 8. Interest / Dividend Income if ↑ $20xmo.* | | |
| 9. Other (i.e., estates / trusts, net rental income, farm income, business income, worker's compensation, unemployment compensation, alimony, child support, etc.) | | |
| **A10 Total Monthly Earned & Unearned Income** (Add Lines 1 – 9) | | |

* Consult with IMW for exceptions.

**B. Combined Assets of Applicant and Spouse**

**Do not count** the home, furnishings, one car, or burial trusts under $3000. If the spouse is not applying or is not eligible for COP, do not count his / her IRA.

| | |
|---|---|
| 1. Cash on hand | |
| 2. Savings | |
| 3. Checking | |
| 4. IRA (Do not count ineligible spouse's IRA) | |
| 5. Certificates of Deposit | |
| 6. Money Market | |
| 7. Life Insurance (including riders) if cash value exceeds $1500 | |
| 8. Other, specify (i.e., count the value of burial trusts that is over $3000, other types of trusts, stocks, bonds, money owed to you, etc.) | |
| 9. Value of divested amount, if applicable | |
| **B10 Total Assets** (Add Lines 1 – 9) | |

**PART IV—MONTHLY EXPENSES**

**1. Impairment Related Work Expenses (IRWEs)** (Do not include IRWEs again under # 3 or # 4 below)

**TOTAL** Applicant's Spouse's

**2. Monthly Court-Ordered Expenses Paid by the Applicant(s)**

Child support or family support: Applicant's _____ Spouse's _____

Maintenance or alimony: Applicant's _____ Spouse's _____

Court ordered guardian and guardian ad litem fees: Applicant's _____ Spouse's _____

Court ordered attorney fees: Applicant's _____ Spouse's _____

Other court ordered expenses (specify type): _____ Applicant's _____ Spouse's _____

**TOTALS** Applicant's **Spouse's**

**3. Monthly Out-of-Pocket Medical / Remedial Expenses**

| Applicant's medical / remedial expenses | Cost | If applicable, list spouse's med / remedial expenses | Cost |
|---|---|---|---|
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| | | | |
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| | | | |
| **TOTAL** | | **TOTAL** | |

**4. Non-medically Related Monthly Expenses—County Determined**

Are there other, non-medically related household expenses that impact your household and which are approved under the county's COP Plan? (See F-29315 DIA Instructions)

☐ **YES** ☐ **NO**

| Applicant's other expenses | Cost | If applicable, list spouse's other expenses | Cost |
|---|---|---|---|
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| | | | |
| **TOTAL** | | **TOTAL** | |

**PART V—SIGNATURE AND DATE**

I have provided true and accurate information. I understand that the agency may request more detailed and documented information later. I have received information regarding the Estate Recovery Program.

| **SIGNATURE** – Applicant / Participant | **PRINT** Name – Applicant / Participant | Date Signed |
|---|---|---|
| | | |

If signed by a legal representative, specify legal authority (Guardian, Conservator, DPOA for finances, etc.)