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| **DEPARTMENT OF HEALTH SERVICES**Division of Enterprise ServicesF-80130 (08/2018) | **FINANCIAL RESPONSIBILITY INFORMATION** | **STATE OF WISCONSIN** |
| Providing the information requested on this form meets the provisions of DHS 1.02(6) and 1.03(8), Wisconsin Administrative Code. Failure or refusal to provide the information may result in the full cost of care being charged. Provision of social security numbers is voluntary; however, it is a unique identifier used to ensure proper identification of the individuals listed on this form. Personally identifiable information on this form will be used only for billing and collection purposes as specified in s. 51.30, Wis. Stats. |
| Name – Client (Last, First, Middle) | Birth Date | Social Security No. | Client No. | Facility (Abbreviate) |
|       |       |       |       |       |
| Family Address – Street | City | State | Zip Code | Primary Phone Number |
|       |       |    |       |       |
| Supplemental Security Income (SSI) / Medical Assistance (MA) Recipient | [ ]  SSI [ ]  MA | Service From – Date |
|       |
| **PART 1** – THIRD PARTY PAYERS – INSURANCE |
| Medical Assistance Number | M.A. Eligibility Dates | Medicare Number | Veteran Coverage Number (TRICARE, etc.) |
|       | From:       | To:       |       |       |
| Name – Insurance Carrier | Name of Policy Holder | Subscriber Number |
|       |       |       |
| Insurance Carrier’s Address – Street | City | State | Zip Code | Group Number |
|       |       |    |       |       |
| Name – Insurance Carrier      | Name of Policy Holder      | Subscriber Number      |
| Insurance Carrier’s Address – Street | City | State | Zip Code | Group Number |
|       |       |    |       |       |
| If client is a recipient of SSI or MA - | stop | **STOP** HERE - DO **NOT** COMPLETE PARTS 2-4, BELOW |
| **PART 2** – FAMILY INCOME INFORMATION |
|  |  | **GROSS AVERAGE MONTHLY INCOME** |
| Client | (If client lives in substitute care facility, do not enter client income.) |
| Name – Employer | Work Phone Number | 1 |
|       |       |       |
| Work Address – Street | City | State | Zip Code |  |
|       |       |    |       |  |
| Spouse of Client |  |  |  |  |  |
| Name | Social Security No. | Birth Date | Date Married | 2 |
|       |       |       |       |       |
| Home Address (if different from Client) – Street | City | State | Zip Code |  |
|       |       |    |       |
| Home Telephone No. | Employer – Name and City |  |
|       |       |  |
| Father of Minor Client | (Enter Stepfather information in line 5.) |
| Name      | Social Security No.      | Birth Date      | 3      |
| Home Address (if different from Client) – Street | City | State | Zip Code |  |
|       |       |    |       |  |
| Home Telephone No.      | Employer – Name and City      |  |
| Mother of Minor Client | (Enter Stepmother information in lines line 5.) |
| Name      | Social Security No.      | Birth Date      | 4      |
| Home Address (if different from Client) – Street | City | State | Zip Code |  |
|       |       |    |       |
| Home Telephone No.      | Employer – Name and City      |  |
| Others in Family | Is there income in lines 1 through 4? [ ]  Yes, CONTINUE. [ ]  No, Skip to line 15 & enter 0. |
| Relatives in the home who are federal tax exemptions (siblings, stepparents, etc.)● Enter earnings for all persons except children in school. ● Enter income for all persons. |
| Name | Relationship to Client | Birth Date | Social Security No. |  |
|                         |       |       |       | 5      |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
| TOTAL MONTHLY INCOME: Find the total of lines 1 through 5 and enter the result. | 6      |

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| Total Monthly Income carried forward from line 6. | 7      |
| Court Ordered Obligations paid monthly. | 8      |
| Total Income after court ordered obligations.Subtract Line 8 from line 7. | 9      |
| **PART 3** – MAXIMUM MONTHLY PAYMENT AND ADJUSTMENTS |
| Total Number of Persons Dependent on Family income for support.Exclude persons for whom court ordered support is paid and persons living in care facilities. | 10      |
| MAXIMUM MONTHLY PAYMENT FROM MAXIMUM MONTHLY PAYMENT SCHEDULE TABLE.Use the values in line 9 and line 10. | 11      |
| ADJUSTMENT TO MAXIMUM MONTHLY PAYMENT for income from non-liable parties. |  |
| Is there income reported on line 5?(That is, from a person other than client, spouse, father, or mother?) [ ]  No – Copy the amount from line 11 to line 15. Skip lines 12 through 14. [ ]  Yes – Complete lines 12 through 14. |  |
| Total Average Income of the Client, Spouse, Father and Mother. (This is, the total of lines 1, 2, 3 and 4.) Exclude client’s income in out of home placements. | 12      |
| ALLOWANCES FOR WORK-RELATED EXPENSES. | 1a       |  |
| For each line in this workspace, enter the lesser of the amount in each earning line or $90. | 2a       |  |
| (For example if line 1a is $50, enter $50; if line 1a is $100, enter $90.) | 3a       |  |
|  | 4a       |  |
| Find the total of the allowances. | 13      |
| Subtract line 13 from line 12. Enter the result.THE MAXIMUM MONTHLY PAYMENT MUST NOT EXCEED THIS AMOUNT. | 14      |
| ADJUSTED MAXIMUM MONTHLY PAYMENT: Enter the lesser of line 14 or line 11 if income is contributed by someone other than the client, spouse, father, or mother. In all other cases, enter the amount from line 11. | 15      |
| **PART 4** – OTHER INFORMATION |
| OTHER SERVICE: Is the family currently being billed for STATE OR COUNTY FUNDED service relating to the mental hygiene, alcohol and other drug abuse, developmental disabilities, social services, youth corrections services? [ ]  Yes - Indicate payment amounts and agencies in comments section below. It may be necessary to coordinate billings and payment application. [ ]  No - Continue |
| SPECIAL PAYMENT ARRANGEMENT: If the family requests an extended or delayed payment privilege, indicate reasons for the request in the comments section below. Include information on current payments and expenses. |
| Comments      |
| **PART 5** – SIGNATURE ACKNOWLEDGMENT |
| Name – Applicant (Print or Type)      | I understand that the statements made in this application must be, and are to the best of knowledge true and correct. |
| Interviewed by | I also understand these statements may be verified. |
| Name Date Interviewed            | **SIGNATURE** – Applicant |
| Annual or Periodic ReviewName – Reviewer Date Reviewed Action            [ ]  No Change [ ]  Change Notes [ ]  Updated F-80130 Prepared            [ ]  No Change [ ]  Change Notes [ ]  Updated F-80130 Prepared            [ ]  No Change [ ]  Change Notes [ ]  Updated F-80130 Prepared |