DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-22571 (11/2023)

CARETAKER SUPPLEMENT APPLICATION

Before completing this form, read the instructions (F-22571A) also available on the Department of Health Services website at dhs.wisconsin.gov/library/collection/F-22571. Type into the form or print and fill in using black or blue ink. Use additional paper if needed.

SECTION 1 – CLIENT INFORMATION

Name of Person Applying for Caretaker Supplement (Last, First, MI)	Phone Number (Include area code)

Address of Person Applying for Caretaker Supplement (Street, City, State, ZIP Code)	Mailing Address (Only if different from residence)

SECTION 2 – GENERAL INFORMATION

You will need to refer to the form instructions to complete the columns below asking for marital status and race or ethnic codes.

Name of Each Family Member Living in Your Household (Last, First, MI) (Enter one per line.)	Social Security * Number (SSN) (Applicant Only)	Date of Birth (mm/dd/yyyy)	Gender	Marital Status Code	US Citizen (Applicant Only)	Ethnicity or Race Code (Optional)	Relationship to Applicant
			☐ M ☐ F		☐ Yes ☐ No		Self/Applicant
			☐ M ☐ F		☐ Yes ☐ No		
			☐ M ☐ F		☐ Yes ☐ No		
			☐ M ☐ F		☐ Yes ☐ No		
			☐ M ☐ F		☐ Yes ☐ No		
			☐ M ☐ F		☐ Yes ☐ No		
			☐ M ☐ F		☐ Yes ☐ No		
			☐ M ☐ F		☐ Yes ☐ No		
			☐ M ☐ F		☐ Yes ☐ No		

* Providing or applying for a Social Security number (SSN) is voluntary; however, any person who does not provide their SSN or apply for one, will not be eligible for Caretaker Supplement benefits, pursuant to Wis. Stats. sec. 49.82(2).

SECTION 3 – ABSENT PARENT INFORMATION

Do any children in the applicant's household have a biological or adoptive mother or father who is not living at home? ☐ Yes ☐ No

If "Yes," fill out the section below. If "No," go to Section 4.

Name of Parent (Last, First, MI)	Social Security Number	Date of Birth (mm/dd/yyyy)	Name(s) of Child(ren)	Relationship to Child

Reason for Parent's Absence	Date Parent Left Household	Date Last Contact with Parent	Court Order of Divorce/Paternity		
			Case Number	County	State

SECTION 4 – EMPLOYMENT

Are you or any household members working (but not self-employed)? ☐ Yes ☐ No

If you answered "Yes," complete below. If "No," go to Section 5.

Is anyone listed below a migrant worker? ☐ Yes ☐ No

1. Name of Working Person | Name of Employer

Address of Employer (Street, City, State, Zip Code) | Employer's Telephone Number

Date Employment Began (mm/dd/yyyy) | Gross Monthly Earnings Expected This Month (Before taxes and deductions) | Gross Monthly Earnings Expected Next Month (Before taxes and deductions)

2. Name of Working Person | Name of Employer

Address of Employer (Street, City, State, Zip Code) | Employer's Telephone Number

Date Employment Began (mm/dd/yyyy) | Gross Monthly Earnings Expected This Month (Before taxes and deductions) | Gross Monthly Earnings Expected Next Month (Before taxes and deductions)

SECTION 5 – SELF-EMPLOYMENT

Are you or any other household members self-employed? ☐ Yes ☐ No

If "Yes," fill out the section below. If "No," go to Section 6.

1.	Name (Last, First, MI)	Name of Business	
	Address of Business (Street, City, State, Zip Code)	Type of Business	
	Net Annual Income $	Depreciation Amount Claimed $	Income You Expect to Earn This Year $
2.	Name (Last, First, MI)	Name of Business	
	Address of Business (Street, City, State, Zip Code)	Type of Business	
	Net Annual Income $	Depreciation Amount Claimed $	Income You Expect to Earn This Year $

SECTION 6 – UNEARNED INCOME

Refer to instructions (https://www.dhs.wisconsin.gov/library/collection/F-22571) to complete this section.

Does anyone in your household receive unearned income? ☐ Yes ☐ No

If "Yes," complete section below for each income type. If "No," go to Section 7.

Type of Income	Yes/No	Name of Person(s) Receiving Unearned Income	Gross Monthly Amount
Social Security/Supplemental Security Income (SSI)	☐ Yes ☐ No		$
Maintenance/Child Support	☐ Yes ☐ No		$
Workers Compensation	☐ Yes ☐ No		$
Unemployment Insurance	☐ Yes ☐ No		$
Disability/Sick Pay	☐ Yes ☐ No		$
Interest/Dividends	☐ Yes ☐ No		$
Veterans Benefits	☐ Yes ☐ No		$
***Other Income – List type(s) below:**			
	☐ Yes ☐ No		$
	☐ Yes ☐ No		$
	☐ Yes ☐ No		$

SECTION 7 – ASSETS

List all assets owned by the applicant(s), except vehicles. Include assets owned jointly. Do not include personal household belongings, unless of unusual value. Do **not** include assets of any household member who is receiving SSI. List vehicles in Section 8.

	Type of Asset	Name of Owner(s)	Current Value	Description (e.g., Bank / Financial Institution Name, Account Number)
1.	Cash		$	
	Cash		$	
2.	Checking Account		$	
	Checking Account		$	
3.	Savings Account		$	
	Savings Account		$	
4.	Real Estate/Property		$	
	Real Estate/Property		$	
5.	Burial Assets/Burial Insurance		$	
	Burial Assets/Burial Insurance		$	
6.	Life Insurance		$	
	Life Insurance		$	
***Other Asset Type – List**				
7.			$	
			$	

***OTHER ASSET TYPES:** Certificates of deposit, trust funds or life estates, stocks, bonds, IRAs, Keogh Plans or other tax shelters, farm equipment, livestock, personal property of exceptional value (art collections, coin collections, jewelry, etc.), land contracts and mortgages, etc.

ASSETS SOLD OR GIVEN AWAY: Has anyone in your household sold or given away assets (including vehicles) for less than fair market value* in the last **two years**? ☐ Yes ☐ No

* By fair market value, we mean the amount that you would get if you sold it on the open market.

SECTION 8 – VEHICLE INFORMATION

List all vehicles owned by applicant(s). Include vehicles owned jointly with another person.

1.	Vehicle Type	Vehicle Year, Make and Model	Name of the Owner(s)
	Amount Still Owed on This Vehicle $	Vehicle is Used to Get to Medical Appointments ☐ Yes ☐ No	Vehicle is Used for Employment, Training, School or Farming ☐ Yes ☐ No
2.	Vehicle Type	Vehicle Year, Make and Model	Name of the Owner(s)
	Amount Still Owed on This Vehicle $	Vehicle is Used to Get to Medical Appointments ☐ Yes ☐ No	Vehicle is Used for Employment, Training, School or Farming ☐ Yes ☐ No

SECTION 9 – PREGNANCY

Are any Members of Your Household Pregnant? ☐ Yes ☐ No	Name(s) of Anyone who is Pregnant
Due Date(s) (mm/dd/yyyy)	

SECTION 10 – RIGHTS AND RESPONSIBILITIES

Read the Important Information and Rights and Responsibilities sections in the instructions (dhs.wisconsin.gov/library/collection/F-22571) before signing this form.

☐ I understand the questions and statements on this application form.

☐ I understand the penalties for giving false information or breaking the rules.

☐ I certify, under penalty of false swearing, that all my answers are correct and complete to the best of my knowledge, including information provided about the citizenship status of each household member applying for benefits.

☐ 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 level of benefits.

☐ I understand that by signing this application for Caretaker Supplement, I am giving the State the right to collect court-ordered child support or family support.

_____ _____

SIGNATURE – Applicant or Authorized Representative | Date Signed