

CARETAKER SUPPLEMENT APPLICATION

Before completing this form, read the instructions ([F-22571A](#)) also available on the Department of Health Services website at www.dhs.wisconsin.gov/forms/f2/f22571a.pdf. 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)	Telephone 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
			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No		Self/Applicant
			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No		
			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No		
			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No		
			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No		
			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No		
			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No		
			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No		
			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> 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](#) 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)	<input type="checkbox"/> Yes <input type="checkbox"/> No		\$
Maintenance/Child Support	<input type="checkbox"/> Yes <input type="checkbox"/> No		\$
Workers Compensation	<input type="checkbox"/> Yes <input type="checkbox"/> No		\$
Unemployment Insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No		\$
Disability/Sick Pay	<input type="checkbox"/> Yes <input type="checkbox"/> No		\$
Interest/Dividends	<input type="checkbox"/> Yes <input type="checkbox"/> No		\$
Veterans Benefits	<input type="checkbox"/> Yes <input type="checkbox"/> No		\$

***Other Income - List type(s) below:**

	<input type="checkbox"/> Yes <input type="checkbox"/> No		\$
	<input type="checkbox"/> Yes <input type="checkbox"/> No		\$
	<input type="checkbox"/> Yes <input type="checkbox"/> 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.

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 <input type="checkbox"/> Yes <input type="checkbox"/> No	Vehicle is Used for Employment, Training, School or Farming <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No	Vehicle is Used for Employment, Training, School or Farming <input type="checkbox"/> Yes <input type="checkbox"/> No	

SECTION 9 - PREGNANCY

Are any Members of Your Household Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> 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 (also available [online](#)) 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