DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-01186 (09/2019)

STATE OF WISCONSIN
Wis. Stat. § 49.58

WISCONSIN CHRONIC RENAL DISEASE PROGRAM APPLICATION

Read instructions (F-01186A) carefully before completing this form.

SECTION 1. APPLICANT INFORMATION

1. Name – Applicant (Last, First MI)			2. Social Security Number (SSN, optional)
3. Street Address			4. Home Phone
5. City	State	Zip Code	6. County of Residence

7a. Email Address (optional, only to be used if issues with application)	7b. Is email your preferred method of contact? ☐ Yes ☐ No

8. Are you currently receiving veteran health care benefits?	9. Sex ☐ Male ☐ Female	10.Date of Birth

11. Do you have any dependent family members who are also members of the Wisconsin Chronic Disease Program (WCDP)? If Yes, indicate the names and SSNs of all dependent family members who are members of the Chronic Disease program.

☐ Yes ☐ No

Name – Dependent Family Member	SSN
Name – Dependent Family Member	SSN

12. Race / Ethnicity (optional)

☐ American Indian or Alaska Native ☐ Asian or Pacific Islander

☐ Hispanic (Mexican, Puerto Rican, Cuban, or other Hispanic culture) ☐ White (not of Hispanic origin)

13. Current Medical Status	Date Status Began
☐ In-center hemodialysis ☐ Home hemodialysis ☐ In-center peritoneal dialysis ☐ Home peritoneal or central auditory processing disorder	

SECTION 2. RESIDENCY INFORMATION

14. Have you lived in Wisconsin for the last two years? ☐ Yes ☐ No	If No, indicate the date you moved to Wisconsin.

15a. Applicants **age 19 and over** should provide copies of the following documents:	15b. Applicants **under the age of 19** should provide copies of the following documents:
• Last year's Wisconsin Income Tax return with all attachments • The most recent rental agreement or property tax bill • Wisconsin driver's license with current address OR state identification with current address • Alien registration card issued by the INS if you are not a U.S. citizen • A copy of your Medicare card unless you are exempt	• Parent or guardian's Wisconsin Income Tax return with all attachments for the last year • Parent or guardian's most recent rental agreement or property tax bill • Wisconsin driver's license with current address OR state identification with current address OR school identification • Alien registration card issued by INS if you are not a U.S. citizen

16. If you do not have these documents, explain why.

SECTION 3. MEDICARE, WISCONSIN MEDICAID, BADGERCARE PLUS, AND SENIORCARE INFORMATION

17. Do you currently have or have you had Medicare coverage?

☐ Yes ☐ No

If Yes, indicate your Medicare eligibility dates below.

Part A Begin Date	Part B Begin Date	Part D Begin Date
Part A End Date	Part B End Date	Part D End Date

- If you are currently eligible for Medicare, attach a copy of your Medicare card.
- If you are not eligible for Medicare, attach the letter of denial from the Social Security Administration stating the reason you are not eligible for Medicare. You may disregard this if your transplant was more than three years ago.

18. Were you eligible for Medicare when you received your kidney transplant?

☐ Yes ☐ No ☐ N/A

19. Wisconsin law requires applicants must first complete applications for other health care programs if they may be reasonably eligible given their financial and nonfinancial circumstances before applying to WCDP.

Are you currently enrolled in Wisconsin Medicaid, BadgerCare Plus (medical assistance, MA, Title 19, T-19), or SeniorCare?

☐ Yes ☐ No

If Yes, indicate your Medicaid, BadgerCare Plus, or SeniorCare identification number here.

20. If No, have you applied for any of these programs in the past year?

☐ Yes ☐ No

If Yes and you were denied eligibility for these programs, explain why.

SECTION 4. SOCIAL WORKER SIGNOFF

This section is to be completed by the social worker if the applicant is **not** enrolled in Wisconsin Medicaid, BadgerCare Plus, or SeniorCare.

21. Based on my knowledge of _____, I attest that he/she is not eligible for the programs listed above. Explain in the space provided why the applicant would be denied eligibility where applicable.

Medicaid

BadgerCare Plus

SeniorCare

SIGNATURE – Social Worker	Date Signed

Name – Facility

SECTION 5. INSURANCE INFORMATION

22. In the last two years, have you had or do you currently have private, group, Health Insurance Risk-Sharing Plan, or other health insurance coverage for medical expenses? (Do not include Medicare, Wisconsin Medicaid, BadgerCare Plus, or SeniorCare information here.)

☐ Yes ☐ No

If Yes, complete the following information. If you have more than one insurance company, list the second company under Insurance 2. Attach additional information if needed for current and past insurance for the last two years.

Insurance 1		Insurance 2	
a. Name – Insurance Company	b. Phone Number	a. Name – Insurance Company	b. Phone Number
c. Name – Policy Holder	d. Relationship of Policy Holder	c. Name – Policy Holder	d. Relationship of Policy Holder
e. Policy Number	f. Group Policy Number	e. Policy Number	f. Group Policy Number
g. Coverage Begin Date	h. Coverage Termination Date	g. Coverage Begin Date	h. Coverage Termination Date

Indicate whether this insurance covers these services by answering each question.		Indicate whether this insurance covers these services by answering each question.	
i. Inpatient hospital service	☐ Yes ☐ No	i. Inpatient hospital service	☐ Yes ☐ No
j. Outpatient hospital service	☐ Yes ☐ No	j. Outpatient hospital service	☐ Yes ☐ No
k. Physician services	☐ Yes ☐ No	k. Physician services	☐ Yes ☐ No
l. Radiology services	☐ Yes ☐ No	l. Radiology services	☐ Yes ☐ No
m. Laboratory services	☐ Yes ☐ No	m. Laboratory services	☐ Yes ☐ No
n. Home dialysis supplies	☐ Yes ☐ No	n. Home dialysis supplies	☐ Yes ☐ No
o. Prescription drugs	☐ Yes ☐ No	o. Prescription drugs	☐ Yes ☐ No

23. If you are enrolled in Wisconsin Medicaid, BadgerCare Plus, SeniorCare, or Medicare Part D, you may skip this question and go to question 24. WCDP is trying to determine if you have insurance that covers drugs that meets Medicare Part D's definition of "creditable coverage."

If you currently have private, group, or other health insurance coverage for medical expenses, does it do the following:

a. Provide coverage for brand and generic prescriptions ☐ Yes ☐ No

b. Provide reasonable access to retail providers and optionally for mail order coverage ☐ Yes ☐ No

c. Pay on average at least 60 percent of your prescription drug expenses ☐ Yes ☐ No

d. Satisfy at least one of the following criteria below: ☐ Yes ☐ No

1. The prescription drug coverage has no annual benefit maximum benefit or a maximum annual benefit payable by the plan of at least $25,000
2. The prescription drug coverage has an actuarial expectation that the amount payable by the plan will be at least $2,000 per Medicare eligible in 2013
3. For plans that have integrated supplemental coverage directly through a specific Part D plan, the integrated health plan has no more than a $250 deductible per year, has no annual benefit maximum payable by the plan of at least $25,000 and has not less than a $1,000,000 life time combined benefit maximum.

SECTION 6. FINANCIAL INFORMATION

24. Indicate the number of dependent family members; including yourself if you are a dependent family member.

25. Indicate your current total income by completing items a.–m. either by **monthly OR annual totals**.	Average Monthly Totals		Annual Totals
	Month	Year	Year
a. Gross wages, salaries, tips, etc.	$		$
b. Net income from nonfarm self-employment	$		$
c. Net income from farm self-employment	$		$
d. Social Security and/or Supplemental Security benefits	$		$
e. Dividends and interest income	$		$
f. Total of estate or trust income, net rental income and royalties	$		$
g. Cash public benefits (for example, W-2 payments)	$		$
h. Pensions, annuities, and/or veteran pension	$		$
i. Unemployment compensation and/or worker's compensation	$		$
j. Maintenance, alimony, and/or child support	$		$
k. Nontaxable interest (federal, state, or municipal bonds)	$		$
l. Nontaxable deferred compensation	$		$
m. **Total Monthly OR Yearly Income**	**$**		**$**

26. Do you expect this income to change significantly from month to month or in the next year?
☐ Yes ☐ No

27. If Yes, will your income be less or more than the total above?
☐ Yes ☐ No

Explain.

28. On last year's Wisconsin Income Tax return, what was your total gross family income before taxes?
$

SECTION 7. AGREEMENT AND SIGNATURES FOR CHRONIC RENAL DISEASE PROGRAM APPLICANTS

Eligibility for state reimbursement exists only insofar as certified by the Department of Health Services (DHS) or its fiscal agent upon: (a) determination of the member's Wisconsin residency; (b) payment of Medicare part B premiums if eligible for Medicare; and (c) receipt of a completed application, including verification by a nephrologist or transplant surgeon from an approved facility of having end stage renal disease. End stage renal disease is defined in Wis. Admin. Code ch. 152 as: "that stage of renal impairment which is virtually irreversible and requires a regular course of dialysis or kidney transplantation to maintain life."

Pursuant to the authority of Wis. Stat. §§ 49.68 and 49.687 and the rules promulgated thereunder, DHS or its fiscal agent will, subject to the conditions named, reimburse an approved dialysis or transplant facility in the state or a dialysis or transplant center, which is approved as such in a contiguous state, on behalf of the member, for part of the cost of medical treatment specifically relating to chronic renal disease. Reimbursement will be made only for that portion of the allowable cost of medical services and medication remaining after all payment from other state programs, federal programs, and private health insurance coverage that have been received and the member's liability and deductibles have been determined. The member's liability and deductibles will be based on income and family size.

If insufficient aid is available from other sources, the state shall pay the difference between the allowable cost and the sum of payment received and member liability and deductibles. State payment shall be appropriately reduced if federal, state, private, or other health insurance becomes available during the benefit period. The member must inform DHS or its fiscal agent of all health insurance coverage and eligibility date.

DHS, the State of Wisconsin, and its officers or agents are released and discharged of, and from all manner of action and actions, cause and causes of actions, suits, sums of money, judgment, claims, and demands whatsoever in law or in equity which the claimant, or his/her heirs, executors or assignees might have, or may hereinafter have, by reason of any injury or worsening of condition or death of the member due to chronic renal disease, treatment or lack of treatment.

In order to establish my eligibility for state benefits, I authorize the medical facility (29.) _____ to disclose information relating to my health condition or payment made for my health care to the Chronic Renal Disease Program.

I certify, to the best of my knowledge, all information provided on this form is true, correct, and complete. I understand that I will be denied reimbursement if I withhold information, provide inaccurate information, or refuse to provide information. I authorize release of any medical and financial information including certification for General Assistance, Wisconsin Medicaid, BadgerCare Plus, SeniorCare, or Medicare to the Wisconsin Chronic Disease Program necessary for processing claims and verifying services under the program. I agree to notify DHS or its fiscal agent in writing within 30 days of any change in name, address, income by more than 10 percent, insurance coverage, or family size. I agree to accept responsibility for the program's copayments and deductibles. I have read and consent to the above.

I understand that if I have not had a kidney transplant and I no longer require a regular course of dialysis to maintain life, I will not be eligible for benefits of the Wisconsin Chronic Renal Disease Program as of the date of my last dialysis. I will not be eligible for benefits until such time that I receive a kidney transplant or require a regular course of dialysis to maintain life. I also understand that if I am eligible for Medicare Part B, I must continue to pay Part B premiums in order to remain eligible for the Chronic Renal Disease Program.

I understand that benefits issued through the Wisconsin Chronic Disease Program are eligible for estate recovery as defined in Wis. Admin. Code § DHS 152.065(7). I understand that only Wisconsin residents are eligible for the Chronic Disease Program. By signing this form, I am attesting that I am a Wisconsin resident as set forth in Wis. Admin. Code § DHS 152.02(25).

30. **SIGNATURE** – Applicant (or applicant's representative if applicant is a minor)	Date Signed

SECTION 8. CHRONIC RENAL DISEASE PATIENT MEDICAL INFORMATION

Section 8 is to be completed by a nephrologist or transplant surgeon at an approved facility.

31. Name – Patient (Last, First MI)	32. Patient's Primary Diagnosis (use ICD-10 CM Code)

33. Date Patient Started on Regular Course of Chronic Maintenance Dialysis

34. For the above patient, indicate dates of hospitalization for initial diagnosis of chronic renal disease (if applicable) and all types of treatments and dates of each treatment. Treatments may include disease transplant, home peritoneal dialysis, home hemodialysis, in-center peritoneal dialysis, or in-center hemodialysis.

Hospitalization for Initial Diagnosis or Type of Treatment	Date Treatment Began (Date should correspond with item 30.)	Date Treatment Terminated

35. Name – Treating Facility

36. Wisconsin Medicaid or BadgerCare Plus Provider Identification Number of Facility

37. Street Address – Treating Facility

City	State	Zip Code

I certify that the above patient has been diagnosed to have end stage renal disease as defined in the Wisconsin Administrative Code as "that stage of renal impairment which is virtually irreversible, and requires a regular course of dialysis or kidney transplantation to maintain life." I have read and determined that the dates in items 31 and 32 as well as other information on this page is true and correct.

38. **SIGNATURE** – Nephrologist or Transplant Surgeon	Date Signed

Send completed application to:

Wisconsin Chronic Disease Program
Attn: Eligibility Unit
PO Box 6410
Madison, WI 53716-0410

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