DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-01187 (02/2018)

STATE OF WISCONSIN
Wis. Stat. § 49.685

WISCONSIN HEMOPHILIA HOME CARE PROGRAM
FINANCIAL NEED STATEMENT

READ INSTRUCTIONS (F-01187A) CAREFULLY BEFORE COMPLETING THIS FORM

SECTION 1. APPLICANT INFORMATION

1. Name – Applicant (Last, First MI)	2. Social Security Number (SSN) – optional
3. Street Address – Applicant	4. Home Phone Number
5. City, State, Zip Code	6. County of Residence
7a. Email Address (only to be used if issues with application)	7b. Is email your preferred method of contact? ☐ Yes ☐ No
8. Sex ☐ Male ☐ Female	9. Date of Birth

10. Do you have any dependent family members who are also members of the Wisconsin Chronic Disease Program (WCDP)? ☐ Yes ☐ No

If Yes, indicate the names and SSNs of all dependent family members who are members of WCDP.

Name – Dependent Family Member	SSN / WCDP Identification Card Number

11. Race / Ethnicity (Optional)

☐ American Indian or Alaska Native
☐ Asian or Pacific Islander
☐ Hispanic (Mexican, Puerto Rican, Cuban, or other Hispanic Culture)
☐ Black (Not of Hispanic Origin)
☐ White (Not of Hispanic Origin)

SECTION 2. RESIDENCY INFORMATION

12. Have you lived in Wisconsin for the last two years? ☐ Yes ☐ No

If no, indicate the date you moved to Wisconsin: _____

13a. Applicants age 19 and over 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 United States Citizenship and Immigration Services (USCIS) if you are not a U.S. citizen.

Note: If you are unable to provide either of the following documents, you must have your treatment facility social worker sign the residency verification:

- A copy of the most recent rental agreement or property tax bill.
- A copy of your Wisconsin driver's license with current address OR state identification with current address.

13b. Applicants under the age of 19 should provide copies of the following documents:

- 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 student ID.
- Alien registration card issued by USCIS if you are not a U.S. citizen.

Note: If you are unable to provide either of the following documents, you must have your treatment facility social worker sign the residency verification.

- A copy of the most recent rental agreement or property tax bill.
- A copy of your Wisconsin driver's license with current address OR state identification with current address OR student ID.

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

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

15. 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

16. Wisconsin law requires applicants to 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 eligible for 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 below.

17. 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.

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

Medicaid or BadgerCare Plus

SeniorCare

SIGNATURE – Social Worker	Facility Name	Date Signed

SECTION 5. INSURANCE INFORMATION

19. In the last two years, have you had or do you currently have private, group, the Wisconsin Health Insurance Risk Sharing Plan (HIRSP), or other health insurance coverage for medical expenses? (Do not include Medicare, 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. Telephone Number	a. Name – Insurance Company	b. Telephone 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 the services listed below.		Indicate whether this insurance covers the services listed below.	
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. Hemophilia Home Care Products and Supplies ☐ Yes ☐ No		n. Hemophilia Home Care Products and Supplies ☐ Yes ☐ No	
o. Prescription Drugs ☐ Yes ☐ No		o. Prescription Drugs ☐ Yes ☐ No	

SECTION 6. FINANCIAL INFORMATION

20. Indicate the number of dependent family members; include yourself if you are a dependent family member.

21. Indicate your current total income by completing items a. through m. either by **monthly OR annual totals**.	Month / Year	Year
	Average Monthly Totals	**Annual Totals**
a. Gross wages, salaries, tips, etc.	$	$
b. Net income from non-farm self-employment	$	$
c. Net income from farm self-employment	$	$
d. Social Security and/or Supplemental Security Income Benefits	$	$
e. Dividends and interest income	$	$
f. Total of estate or trust income, net rental income, and royalties	$	$
g. Cash public benefits (e.g., W-2 payments)	$	$
h. Pensions, annuities, and/or Veterans Pension	$	$

	Average Monthly Totals	Annual Totals
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**	$	$

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

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

Explain why.

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

SECTION 7. AGREEMENT AND SIGNATURES FOR HEMOPHILIA HOME CARE APPLICANTS

Eligibility for state reimbursement exists only insofar as certified by the Department of Health Services (herein called the Department) or its fiscal agent upon: (a) receipt of completed application, including verification by the physician director of the member's successful participation in a hemophilia home care or self-infusion training program and maintenance program; and (b) existence of a written agreement, as designated by the Department or its fiscal agent, between the patient and a certified comprehensive treatment center for compliance with the maintenance program.

Pursuant to the authority of Wis. Stat. §§ 49.685 and 49.687 and the rules promulgated thereunder, the Department or its fiscal agent will, subject to the conditions named, reimburse a certified comprehensive hemophilia treatment center or an approved source, on behalf of the member, for part of the cost of hemophilia home care blood products and infusion supplies. Reimbursement will be made only for that portion of the allowable cost of home care blood products and infusion supplies remaining after all payment from other state programs, federal programs, and private health insurance coverage has 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.

Wisconsin Administrative Code ch. DHS 153 specifies the methodology for provider reimbursement. **Charges in excess of what the Hemophilia Home Care Program allows are the individual responsibility of the member.**

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 the Department or its fiscal agent of all health insurance coverage and eligibility date.

The Department, 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 or 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 treatment of hemophilia or lack of treatment.

In order to establish my eligibility for state benefits, I authorize the medical facility

(25) _____ to disclose information relating to my health condition or payment made for my health care to the Hemophilia Home Care 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 the Department 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 benefits issued through the Wisconsin Chronic Disease Program are eligible for estate recovery as defined in Wis. Admin. Rule DHS 153.07 (5). 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. Rule DHS 153.02 (17).

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