STATE OF WISCONSIN
DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-10141 (05/2022)

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WISCONSIN FUNERAL AND CEMETERY AIDS PROGRAM APPLICATION

This form must be completed by the provider, signed, and dated to receive consideration for Wisconsin Funeral and Cemetery Aids Program (WFCAP) payment. Return the completed WFCAP application with all other verifying documentation to:

Wisconsin Department of Health Services
Wisconsin Funeral and Cemetery Aids Program
PO Box 309
Madison, WI 53701

Phone: 888-859-0611
Fax: 608-710-6712

Email: dhswfcapapplications@wi.gov

Refer to the WFCAP manual at www.emhandbooks.wisconsin.gov/wfcap/fcap.htm for program guidelines.

Note: Any suspected fraud will be referred to the Office of the Inspector General. Findings of fraud can remove a provider from program participation.

SECTION 1 – Decedent Information

Name – Decedent	Stillborn ☐ Live Birth ☐	If Stillborn, Mother's Full Name and Date of Birth
Social Security Number	Date of Birth	Date of Death

Date(s) Services Provided (a date of service is required for **each** category of services listed on this application)

Street Address – Last Known

City	State	Zip Code

County of Residence

Personally identifiable information and Social Security numbers are used only for the direct administration of the Wisconsin Funeral and Cemetery Aids Program. Disclosure of Social Security numbers is required under Wis. Stat. § 49.78. Failure to provide the Social Security number will result in a denial.

SECTION 2 – Funeral Home Service Provider Information

Name – Funeral Home (where the services took place)	Tax ID Number

Street Address

City	State	Zip Code

Phone Number	Fax
Email	Type of Provider ☐ Funeral Home ☐ Crematory Operated by Funeral Home

Note: Provide a signed Final Itemized Funeral Home Billing Statement with Payment Sources.

SECTION 3 – Cemetery Service Provider Information

Name – Cemetery (where the services took place)		Tax ID Number
Street Address		
City	State	Zip Code
Phone Number	Fax	
Email		

Did the funeral home cash advance any charges? If yes, provide receipts. ☐ Yes ☐ No

Is a qualified payment being requested? If yes, complete attached Qualified Payment Form. ☐ Yes ☐ No

Note: Provide a signed Final Itemized Cemetery Statement with Payment Sources.

SECTION 4 – Crematory Service Provider Information (if you are a crematory operated by a funeral home, complete Section 2 also)

Name – Crematory (where the services took place)		Tax ID Number
Street Address		
City	State	Zip Code
Phone Number	Fax	
Email		

Did the funeral home cash advance any charges? If yes, provide receipts. ☐ Yes ☐ No

Note: Provide a signed Final Itemized Crematory Billing Statement with Payment Sources.

SECTION 5 – Life Insurance Assets and Values

Under Wis. Stat. § 49.785(1m)(d), if the decedent, the decedent's spouse, or another person owns a life insurance policy insuring the decedent's life, and the death benefit of the policy is more than $3,000, any WFCAP amount that the Department of Health Services (DHS) would be obligated to pay shall be reduced by one dollar for every dollar by which the death benefit of the policy payment exceeds $3,000.

Indicate below all life insurance policies insuring the decedent's life. If more space is needed, attach additional sheet(s). **Verifying documentation of the policy must be submitted with this application, or processing of your WFCAP application will be delayed.** Documentation must include a copy of the life insurance policy, documentation showing the death benefit amount, insurance company name, issue date, and policy number.

Name – Insurance Company	Life Insurance Death Benefit Amount $
Issue Date	Policy Number
Name – Insurance Company	Life Insurance Death Benefit Amount $
Issue Date	Policy Number

SECTION 6 – Special Circumstances

Payment under Wis. Stat. § 49.785 is available **only** when the estate of the decedent is insufficient to pay for his or her funeral, burial, cemetery, and crematory expenses and there are no other sources of payment.

WFCAP payment is limited to the lesser of $1,500 or the funeral and burial expenses not paid by the estate of the decedent and other sources. If the total funeral and burial expenses for the decedent exceed $4,500, WFCAP is not required to make a payment for funeral and burial expenses. Please note: special circumstances will be capped at $500.

Are you requesting consideration for special circumstances? If yes, please attach verifying documentation to this application. ☐ Yes ☐ No

If special circumstances exist that may justify exceeding the total expense limit or the payment limit under Wis. Stat. § 49.785, describe those circumstances in detail on an additional sheet and submit as an attachment to this application.

SECTION 7 – Burial Trusts/Burial Insurance

All burial trusts and/or burial insurance must be accounted for.

Indicate below all burial trusts/burial insurance that are funding the decedent's funeral, cemetery, and/or crematory expenses. If more space is needed, attach additional sheets. **Verifying documentation of the burial trusts/burial insurance must be submitted with this application, or processing of your WFCAP application will be delayed.** Documentation must include a copy of the pre-need and a copy of the check or verification showing the amount(s) received from the burial trust/burial insurance.

Name – Burial Trust/Burial Insurance	Amount Received $
Name – Burial Trust/Burial Insurance	Amount Received $
Name – Burial Trust/Burial Insurance	Amount Received $

SECTION 8 – Total Funeral, Cemetery, and Crematory Expenses and Payments

Total Funeral Expenses
Indicate the total actual expenses for all funeral goods and services provided, including any third party cash advances (third party cash advances are counted toward the total funeral expense limit after $500). Total funeral expenses are defined as actual goods and services provided prior to any price reductions or payments. Estimates will not be considered and will delay the application review process. Any price reductions will be counted toward the total funeral expenses.

Total Cemetery and/or Crematory Expenses
Indicate the total actual expenses for all cemetery and/or crematory goods and services provided before or after death. Total cemetery and/or crematory expenses are defined as actual goods and services provided prior to any price reductions or payments. Estimates will not be considered and will delay the application review process. Any price reductions will be counted toward the total cemetery and/or crematory expenses.

Amount Available from Estate and Other Sources
For each category, indicate the total funds available from the estate and other funding sources to cover funeral, cemetery, and crematory expenses of the decedent. This amount must include, but is not limited to: burial trusts, burial insurance, life insurance-funded burial contracts, etc. In addition, if the decedent is named as the insured on a life insurance policy with a death benefit of more than $3,000, the amount exceeding $3,000 must be used to pay for the decedent's funeral, cemetery, and crematory expenses.

Payment Request from WFCAP
For each category, subtract amounts paid by the estate and other sources from the total expenses, then indicate the amount of your WFCAP payment on the lines for "Payment Request from WFCAP."

Note: Any suspected fraud will be referred to the Office of the Inspector General. Findings of fraud can remove a provider from program participation.

Total Funeral Expenses $	Total Cemetery/Crematory Expenses $
Minus Amount Available from Estate $	Minus Amount Available from Estate $
Minus Amount Available from Other Sources $	Minus Amount Available from Other Sources $
Payment Request from WFCAP $	Payment Request from WFCAP $

SECTION 9 – Signatures of Service Provider and Executor or Family Representative

The **service provider** certifies by signing below that: (1) the expenses indicated represent total actual expenses for goods and services provided by the service provider, and (2) funds to which the service provider is entitled are included in the "Amount Available from Estate" and "Amount Available from Other Sources."

The **executor or family representative** certifies by signing below that the "Amount Available from Estate" and "Amount Available from Other Sources" indicated represent the total funds available from the estate and other funding sources to cover funeral, burial, cemetery, and crematory expenses of the decedent. **The executor or family representative must sign for each category of goods and services requested.**

FUNERAL HOME

SIGNATURE – Service Provider	Date Signed

Print Name of Service Provider

SIGNATURE – Executor or Family Representative	Date Signed

Print Name of Executor or Family Representative

Street Address – Executor or Family Representative

City	State	Zip Code	Phone Number

Email Address – Executor or Family Representative

CEMETERY

☐ Cash Advanced – if checked, Service Provider initial: _____

SIGNATURE – Service Provider (if not cash advanced)	Date Signed

Print Name of Service Provider

SIGNATURE – Executor or Family Representative	Date Signed

Print Name of Executor or Family Representative

Street Address – Executor or Family Representative

City	State	Zip Code	Phone Number

Email Address – Executor or Family Representative

SECTION 9 (CONTINUED) – Signatures of Service Provider and Executor or Family Representative

CREMATORY

☐ Cash Advanced – if checked, Service Provider initial: _____

SIGNATURE – Service Provider (if not cash advanced)	Date Signed
Print Name of Service Provider	
SIGNATURE – Executor or Family Representative	Date Signed
Print Name of Executor or Family Representative	
Street Address – Executor or Family Representative	

City	State	Zip Code	Phone Number
Email Address – Executor or Family Representative			

SECTION 10 – Signatures of Service Provider and Executor/Family Representative – Life Insurance Declaration

The **funeral home, cemetery, or crematory service provider** declares by signing below that inquiry was made of the executor or family representative of the existence of any life insurance policies, created on or after October 3, 2016, insuring the life of the decedent.

SIGNATURE – Service Provider	Date Signed
Print Name of Service Provider	

The **executor or family representative** declares by signing below that the service provider inquired as to the existence of any life insurance policies, created on or after October 3, 2016, insuring the life of the decedent and has disclosed all known policies on this application.

SIGNATURE – Executor or Family Representative	Date Signed
Print Name of Executor or Family Representative	

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Wisconsin Funeral and Cemetery Aids Program
QUALIFIED PAYMENT FORM FOR THE CEMETERY REQUIRED BUT NOT PROVIDED

This form is to be completed by the funeral home when cash advancing a cemetery *and* requesting a Qualified Payment.

Decedent Name	Date of Death
Funeral Home Name	Cemetery Name
CEMETERY CHARGES	
Monument or Marker $	Nameplate $
Cemetery Plot $	Crypt or Niche Space $
Mausoleum Space $	Perpetual Care $
Vault, Grave Box, or Outer Burial Container $	
Opening and closing – Grave $	
Opening and closing – Mausoleum $	Admin Fees $
Opening and closing – Crypt or Niche $	
Other (detailed description required) $	Detailed Description
Is the good or service something that your cemetery requires, but does not provide?	Yes ☐ No ☐
Is the good or service something that your cemetery requires and provides?	Yes ☐ No ☐
SIGNATURE – Cemetery Provider	Date Signed
SIGNATURE – Executor or Family Representative	Date Signed
SIGNATURE – Funeral Home Provider	Date Signed

Disclaimer: The Funeral Home, Cemetery, and Executor or Family Representative must sign and date this form verifying the information is accurate and true.

Wisconsin Funeral and Cemetery Aids Program
VERIFICATION FOR THIRD PARTY CASH ADVANCES

This form is to be completed, signed, and dated by the third party vendor when the vendor does not provide a receipt for third party cash advances listed on the Final Itemized Funeral Home Billing Statement with Payment Sources.

Third Party Vendor Name	Third Party Vendor Phone Number
Good and/or Service Purchase Date	Amount of Cash Advance $
SIGNATURE – Third Party Vendor	Date Signed

Third Party Vendor Name	Third Party Vendor Phone Number
Good and/or Service Purchase Date	Amount of Cash Advance $
SIGNATURE – Third Party Vendor	Date Signed

Third Party Vendor Name	Third Party Vendor Phone Number
Good and/or Service Purchase Date	Amount of Cash Advance $
SIGNATURE – Third Party Vendor	Date Signed

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