WISCONSIN DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-10130 (07/2024)

ADDMD

MEDICAID PRESUMPTIVE DISABILITY

INSTRUCTIONS: This form is for Medicaid applicants who need a disability determination and who can be determined presumptively disabled while waiting for a final decision from the Disability Determination Bureau (DDB). In addition to this form (F-10130), the applicant must complete and submit the Medicaid – Disability Application (F-10112) and Authorization to Disclose Information to Disability Determination Bureau (F-14014) forms to be determined presumptively disabled.

This form must be completed by a health care professional. For purposes of this form, a health care professional is defined as a licensed physician, physician's assistant, nurse practitioner, licensed or registered nurse, psychologist, osteopath, podiatrist, optometrist, hospice coordinator, medical records custodian, or social worker.

If the applicant lives in Milwaukee County, return completed form to:
MDPU
6055 N. 64th St.
Milwaukee WI 53218
Fax: 888-409-1979

If the applicant does **not** live in Milwaukee County, return completed form to:
CDPU
PO Box 5234
Janesville, WI 53547-5234
Fax: 855-293-1822

If the applicant has both an urgent need for services and one of the listed impairments, and the applicant meets all other Medicaid program rules, the income maintenance or tribal agency will certify the presumptive disability.

Applicants with an urgent need but whose impairments are not listed can still be determined presumptively disabled, but the decision must be made by DDB, with one exception: If Box A in Section I is checked and the form is signed by an attending physician, the income maintenance or tribal agency will certify the presumptive disability if the applicant meets all other Medicaid program rules, even if they do not have any of the specific impairments listed in Section II.

First Name, Middle Initial, and Last Name – Applicant	
Date of Birth – Applicant	Case Number or ForwardHealth ID (if known)

SECTION I – URGENT NEED FOR MEDICAL SERVICES

I have determined the above-named applicant (check the appropriate box or boxes):

A ☐ Has one or more medically determinable physical or mental impairments that cause severe functional limitations and/or inability to work, and have lasted or can be expected to last for at least 12 months or are expected to result in death.

Note: If Box A is checked, this form **must be signed by the attending physician** (MD or DO). If Box A is checked and the form is signed by an attending physician, the agency will certify the presumptive disability if the applicant meets all other Medicaid program rules, even if they do not have any of the specific impairments listed in Section II.

B ☐ Is a patient in a hospital or other long-term care medical institution.

C ☐ Will be admitted to a hospital or other long-term care medical institution if immediate health care treatment is not provided.

D ☐ Needs long-term care, and the nursing home or other long-term care medical institution will not admit the applicant until Medicaid benefits are in effect.

E ☐ Is unable to return home from a nursing home or other long-term care medical institution unless Medicaid-covered in-home services or equipment is available.

F ☐ Meets none of the above.

SECTION II – IMPAIRMENTS

I have determined the above-named applicant has (check the appropriate box or boxes):

A ☐ An amputated leg at the hip.

B ☐ Total deafness.

C ☐ Total blindness.

D ☐ Bed confinement or immobility without a wheelchair, walker, or crutches due to a condition expected to last 12 months or longer.

E ☐ Had a stroke (cerebral vascular accident) more than three months in the past and continued marked difficulty in walking or using a hand or arm.

F ☐ Cerebral palsy, muscular dystrophy or muscle atrophy, and marked difficulty in walking (for example, use of braces), speaking, or coordination of the hands or arms.

G ☐ Down syndrome.

H ☐ Intellectual disability or another neurodevelopmental impairment (for example, autism spectrum disorder) with complete inability to independently perform basic self-care activities (such as toileting, eating, dressing, or bathing). This category only pertains to persons who are at least four years old.

I ☐ Not yet reached their first birthday and had a birth weight under 1200 grams (2 pounds, 10 ounces).

J ☐ Not yet reached their first birthday and had a gestational age (GA) at birth and corresponding birth weight within one of the ranges below:

- GA of 37-40 weeks and birth weight under 2000 grams (4 pounds, 6 ounces)
- GA of 36 weeks and birth weight of 1875 grams (4 pounds, 2 ounces) or less
- GA of 35 weeks and birth weight of 1700 grams (3 pounds, 12 ounces) or less
- GA of 34 weeks and birth weight of 1500 grams (3 pounds, 5 ounces) or less
- GA of 33 weeks and birth weight of 1325 grams (2 pounds, 15 ounces) or less
- GA of 32 weeks and birth weight of 1250 grams (2 pounds, 12 ounces) or less

K ☐ Hospice services because of a terminal condition, as confirmed by a licensed physician or knowledgeable hospice official (hospice coordinator, staff nurse, social worker, or medical records custodian).

L ☐ A spinal cord injury producing inability to ambulate without the use of a walker or bilateral handheld devices for more than two weeks.

M ☐ End-stage renal disease requiring chronic dialysis.

N ☐ Symptomatic human immunodeficiency virus (HIV) infection or acquired immunodeficiency syndrome (AIDS).

O ☐ Amyotrophic lateral sclerosis (ALS), also known as Lou Gehrig’s disease.

P ☐ None of the above.

SECTION III – HEALTH CARE PROFESSIONAL INFORMATION

First Name, Middle Initial, and Last Name – Health Care Professional	Professional Title	
Street Address		
City	State	ZIP Code
SIGNATURE – Health Care Professional	Date Signed	