DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-22564 (07/08)

STATE OF WISCONSIN

AUTHORIZATION FOR RETROACTIVE CARETAKER SUPPLEMENT (CTS)

Instructions: Complete and fax to 608-221-0991 (EDS).

Completion of this form is required under the provisions of Section 49.775 of the Wisconsin Statutes. Failure to comply may result in a denial of your retroactive payment. Personally identifiable information on this form will only be used to obtain relevant data required.

*The provision of your Social Security Number is mandatory under Wisconsin Statutes. Your Social Security Number will be used to verify whether you receive SSI and to make certain that your SSI Caretaker Supplement benefits are paid to the correct person. If you do not provide your Social Security Number, your SSI Caretaker Supplement benefits will be denied.

ES Worker Name	FAX Number ( )	Telephone Number ( )
Caretaker Name	Caretaker Social Security Number*	
Caretaker CARES Case Number		

Itemized Retroactive Payments

Month / Year	Name of Child	Social Security Number*	Dollar Amount
			$
			$
			$
			$
			$
			$
			$

Total Dollar Amount to be Paid Retroactively

$

Date - Case Comments on CARES Screen ACCC (Authorizations without completion of CARES Screen ACMP will be returned.)

(mm/dd/yyyy)

SIGNATURE - ES Worker	Date Signed (mm/dd/yyyy)
SIGNATURE - Supervisor	Date Signed (mm/dd/yyyy)

For EDS Use

Date Keyed _____

Date Returned _____