

WISCONSIN HEMOPHILIA HOME CARE PROGRAM APPLICATION INSTRUCTIONS

The Wisconsin Chronic Disease Program (WCDP) is a state-funded program whose purpose is to provide payment for chronic renal disease, adult cystic fibrosis and hemophilia home care supplies. The WCDP provides payment after all other payment sources have been used.

Completion of this application is voluntary. However, if it is not completed, your eligibility for benefits cannot be determined. The Department of Health Services has the authority to collect personally identifiable information necessary to determine continued eligibility and benefits for the Wisconsin Chronic Disease Program. The personally identifiable information collected on this application will only be used to determine eligibility and benefits. Provision of your social security number is voluntary, however, your social security number is one of the unique identifiers used to identify you as a unique person in our claim system. Applicants who need assistance completing their application should contact their treatment facility social worker.

Upon determination that an applicant is eligible for WCDP benefits, the applicant receives a letter of notification, and a WCDP identification card. WCDP members are required to inform WCDP of any qualifying changes such as change in address, eligibility, mode of treatment, health insurance coverage, Medicare coverage, an up or down income change of more than 10%, or change in family size. Within 30 days of any qualifying change in circumstance, the WCDP member is responsible for submitting any qualifying change(s) in writing to the WCDP. WCDP members may be responsible for income deductibles, inpatient/outpatient deductibles, drug copayments, and coinsurance.

Instructions

Print clearly and follow these instructions carefully. Incomplete or illegible applications will be returned and delay determination of your eligibility. If you are an applicant's representative, provide the applicant's information. Make a copy of your completed application for your records.

SECTION 1. APPLICANT INFORMATION

- Item 1. Print your last name, first name and middle initial.
- Item 2. Indicate your Social Security Number.
- Item 3. Indicate your street address. You must indicate the physical residential address. A post office box alone is not acceptable.
- Item 4. Indicate your home telephone number including the area code. If you do not have a telephone, indicate "None."
- Item 5. Indicate your city, state and zip code.
- Item 6. Indicate the county where you live.
- Item 7. Check "Male" or "Female".
- Item 8. Indicate the month, date and year of birth.
- Item 9. Answer "Yes" if you have dependent family members who are members of the Wisconsin Chronic Disease Program. If you answered "Yes", indicate the name(s) and Social Security Number(s) of all dependent family members currently eligible for benefits from the Chronic Disease Program.
- Item 10. Indicate your race/ethnicity by checking the appropriate box. This information will be used for statistical purposes only.

SECTION 2. RESIDENCY INFORMATION

- Item 11. Check "Yes" or "No." If you answered "No", indicate the month, date, and year you moved to Wisconsin.
- Item 12a. 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 drivers 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.
- Item 12b. 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 drivers license with current address **OR** state identification with current address **OR** school identification.
 - Alien registration card issued by the INS if you are not a U.S. citizen.
- Item 13. If you do not have these documents, explain why. Attach additional pages if necessary.

SECTION 3. MEDICARE, MEDICAID, BADGERCARE PLUS, & SENIORCARE INFORMATION

- Item 14. Check "Yes" or "No."
If you answered "Yes", indicate your Medicare Part A (hospital insurance), Part B (medical insurance) and Part D (drugs) begin date(s). If your coverage has ended, indicate the end date(s). *If you currently have Medicare coverage, do not indicate a Medicare end date.* If you answered "No", proceed to item 15.
- Item 15. Check "Yes" or "No."
If "Yes", indicate your Wisconsin Medicaid, BadgerCare Plus, or SeniorCare identification number. Wisconsin Medicaid and BadgerCare Plus may also be called Medical Assistance, MA, Title 19, or T-19.
- Item 16. Check "Yes" or "No" to indicate whether you have applied for Wisconsin Medicaid, BadgerCare Plus, or SeniorCare in the past year, if you answered no in item 15.
If "Yes", explain why you were denied eligibility for Medicaid, BadgerCare Plus, or SeniorCare.
Wisconsin law requires applicants must first complete applications for other health care programs, if they may be reasonably eligible given their financial and non-financial circumstances, before applying to WCDP. The department may waive the requirement for an applicant who requests a waiver for religious reasons under 49.687 (1m) (b) of the Wisconsin State Statutes.

SECTION 4. SOCIAL WORKER SIGN OFF

- Item 17. This section should be completed by a health professional who is involved with the care of the applicant if the applicant has not applied for Wisconsin Medicaid, BadgerCare Plus, or SeniorCare.

SECTION 5. INSURANCE INFORMATION

- Item 18. Check "Yes" or "No" to indicate whether you have private, group, HIRSP (Health Insurance Risk Sharing Plan) or other health insurance coverage for medical expenses. Do not include Medicare, Wisconsin Medicaid, BadgerCare Plus, or the Wisconsin Chronic Disease Program here.
If "Yes", complete items 18a through 18o.
- a. Indicate the name of the company through which you have health insurance coverage.
 - b. Indicate the telephone number, including the area code of the insurance company.
 - c. Indicate the name of the policyholder.
 - d. Indicate your relationship of the policyholder to you (e.g. wife, husband, self).
 - e. Indicate the policy number.
 - f. Indicate the group policy number.
 - g. Indicate the date the coverage began.
 - h. Indicate the date the coverage ended if you no longer have the coverage. If the coverage is still in effect, leave the coverage termination date blank.
- i-o. Check "Yes" or "No" for each question. Refer to your insurance policy or contact your insurance company or representative for more information on your coverage.

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

SECTION 6. FINANCIAL INFORMATION.

- Item 19. Indicate the number of dependent family members; include yourself if you are a dependent family member. Include all family members who may be claimed as dependents by the applicant for the purpose of filing a federal income tax return. This information is needed to determine your deductible for the Hemophilia Home Care program.
- Item 20. Indicate your average total income by completing items a. - 1. Choose to complete either the average monthly totals OR annual totals.

If you are completing the “Average Monthly Totals” column, indicate the income received during a month in the most recent 12-month period. Do not use the highest or lowest monthly totals for income, use a monthly total that reflects an average amount of income. Indicate the month and year of this income (e.g. March 2010). If you are completing the “Annual Totals” column, indicate the income for the most recently completed calendar year. Indicate the calendar year of this income (e.g. 2010).

- **If you are claimed as a dependent on someone else’s income tax return**, enter the current total monthly or annual income from that person’s paycheck stub and enter all federal social security payments, dividends, interest income, estate or trust income, net rental income, royalties, cash public benefits (e.g. W-2 payments), pensions, annuities, veteran’s benefits, unemployment compensation, worker’s compensation, maintenance payments, alimony, child support, nontaxable interest, and nontaxable deferred compensation received by that person. **Also, include any of these same types of payments or income received by you and everyone included in Item 19.**
- **If you are not claimed as a dependent by anyone else on their income tax return, but file your own income tax return and claim yourself as an exemption**, enter the current total monthly or annual income from your paycheck stub and enter all federal social security payments, dividends, interest income, estate or trust income, net rental income, royalties, cash public benefits (e.g. W-2 payments), pensions, annuities, veteran’s benefits, unemployment compensation, worker’s compensation, maintenance payments, alimony, child support, nontaxable interest, and nontaxable deferred compensation **received by you and everyone included in Item 19.**
- **If you are not claimed as a dependent by anyone else on their income tax return, and you do not file an income tax return of your own**, enter the current total monthly or annual income from your paycheck stub, all federal Social Security payments, dividends, interest income, estate or trust income, net rental income, royalties, cash public benefits (e.g. W-2 payments), pensions, annuities, veteran’s benefits, unemployment compensation, worker’s compensation, maintenance payments, alimony, child support, nontaxable interest, and nontaxable deferred compensation **received by you and everyone included in Item 19.**

Item 20m. Add up the amounts in items 20a. through 20l. and indicate the current total monthly or annual income.

Item 21. Indicate whether you anticipate your monthly income to increase or decrease more than 10%. If your monthly or annual income increases or decreases more than 10%, you must notify in writing the Wisconsin Chronic Disease Program of the change within 30 days.

Item 22. If you answered “Yes” in item 21 explain why.

Item 23. Indicate your total gross family income based on last year’s Wisconsin Income Tax return. If you did not file a state tax return leave this area blank.

SECTION 7. AGREEMENT AND SIGNATURES

Item 24. Indicate the medical facility from which you are receiving treatment.

Item 25. Enter signatures and date signed for applicant or applicant’s representative if applicant is a minor.

SECTION 8. HEMOPHILIA HOME CARE PATIENT MEDICAL INFORMATION

Section 8 is to be completed by the appropriate medical professional.

Send the completed form to:

Wisconsin Chronic Disease Program
Attention: Eligibility Unit
P.O. Box 6410
Madison, WI 53716-0410

If you have questions regarding the completion of this application, please contact your treatment center social worker or call the Chronic Disease Program at (800) 362-3002.

Did you remember to:

- Sign and date the application.
- Include a copy of last year's Wisconsin Income Tax return with all attachments.
- Include a copy of the most recent rental agreement OR property tax bill.
- Include a copy of your Wisconsin drivers license with current address OR state identification with current address OR Student ID (only for applicants under age 19).
- Include a copy of your Alien registration card issued by the INS if you are not a U.S. citizen.

CAUTION: Failure to fully complete your application and provide the requested documentation may result in delayed processing and eligibility determination.