

FINANCIAL INFORMATION

Providing the information requested on this form meets the provisions of HFS 1.02(6) and 1.03(8), Wisconsin Administrative Code. Failure or refusal to provide the information may result in the full cost of care being charged. Provision of social security numbers is voluntary; however, it is a unique identifier used to ensure proper identification of the individuals listed on this form. Personally identifiable information on this form will be used only for billing and collection purposes as specified in s. 51.30, Wis. Stats.

Name – Client (Last, First, Middle)	Client No.	Facility (Abbreviate)	Service From – Date
Family Address – Street	City	State	Zip
			Home Telephone No.

PART 1 – THIRD PARTY PAYERS – INSURANCE

Medical Assistance Number	M.A. Eligibility Dates From: To:	Medicare Number	V.A. / Champus Number
Name – Insurance Carrier	Name of Policy Holder		Subscriber Number
Insurance Carrier's Address – Street	City	State	Zip
			Group Number
Name – Insurance Carrier	Name of Policy Holder		Subscriber Number
Insurance Carrier's Address – Street	City	State	Zip
			Group Number

PART 2 – FAMILY INCOME INFORMATION

EARNED INCOME	Earnings come from employment or self-employment (farm or non-farm). Enter earnings for all persons except children in school.				GROSS AVERAGE MONTHLY INCOME
UNEARNED INCOME	See income definition list in HSS 1.01(2). Enter unearned income for all persons				
Client	(If client lives in substitute care facility, do not enter client income.)				
Birth Date	Social Security No.	Name – Employer	Work Telephone No.	Earned	1a
Work Address – Street	City	State	Zip	Unearned	1b
Spouse of Client					
Name	Social Security No.	Birth Date	Date Married	Earned	2a
Home Address (if different from Client) – Street	City	State	Zip	Unearned	2b
Home Telephone No.	Employer – Name and City				
Father of Minor Client (Enter Stepfather information in lines 5a and 5b.)					
Name	Social Security No.	Birth Date		Earned	3a
Home Address (if different from Client) – Street	City	State	Zip	Unearned	3b
Home Telephone No.	Employer – Name and City				
Mother of Minor Client (Enter Stepmother information in lines 5a and 5b.)					
Name	Social Security No.	Birth Date		Earned	4a
Home Address (if different from Client) – Street	City	State	Zip	Unearned	4b
Home Telephone No.	Employer – Name and City				
Others in Family	Is there income in lines 1a through 4b? <input type="checkbox"/> Yes, CONTINUE. <input type="checkbox"/> No, Skip to line 18 & enter 0. Relatives in the home who are federal tax exemptions (siblings, stepparents, etc.) ● Enter earnings for all persons except children in school. ● Enter unearned income for all persons.				
Name	Relationship to Client	Birth Date	Social Security No.	Earned	5a
				Unearned	5b
TOTAL MONTHLY INCOME: Find the total of lines 1a through 5b and enter the result.					6

Total Monthly Income carried forward from line 6.		7
Court Ordered Obligations paid monthly.		8
Total Income after court ordered obligations. Subtract Line 8 from line 7.		9
PART 3 - MAXIMUM MONTHLY PAYMENT AND ADJUSTMENTS		
Total Number of Persons Dependent on Family income for support. Exclude persons for whom court ordered support is paid and persons living in care facilities.		10
MAXIMUM MONTHLY PAYMENT FROM TABLE. Use the values in line 9 and line 10.		11
ADJUSTMENT TO MAXIMUM MONTHLY PAYMENT for income from non-liable parties.		
Is there income reported on either line 5a or 5b? (That is, from a person other than client, spouse, father, or mother?) <input type="checkbox"/> No – Copy the amount from line 11 to line 18. Skip lines 12 through 17. <input type="checkbox"/> Yes – Complete lines 12 through 17.		
Total Average UNEARNED INCOME of the Client, Spouse, Father and Mother. (This is, the total of lines 1b, 2b, 3b and 4b.) Exclude client's income in out of home placements.		12
Total Average EARNED INCOME of Client, Spouse, Father and Mother. (This is, the total of lines 1a, 2a, 3a and 4a.) Exclude client's income in out of home placements.	13	
Find one-half of the amount in line 13. Enter the result.		14
Add line 12 and line 14. Enter the result.		15
ALLOWANCES FOR WORK-RELATED EXPENSES. For each line in this workspace, enter the lesser of the amount in each earning line or \$90. (For example if line 1a is \$50, enter \$50; if line 1a is \$100, enter \$90.)	1a 2a 3a 4a	
Find the total of the allowances.		16
Subtract line 16 from line 15. Enter the result. THE MAXIMUM MONTHLY PAYMENT MUST NOT EXCEED THIS AMOUNT.		17
ADJUSTED MAXIMUM MONTHLY PAYMENT: Enter the lesser of line 17 or line 11 if income is contributed by someone other than the client, spouse, father, or mother. In all other cases, enter the amount from line 11.		18
PART 4 - OTHER INFORMATION		
OTHER SERVICE: Is the family currently being billed for STATE OR COUNTY FUNDED service relating to the mental hygiene, alcohol and other drug abuse, developmental disabilities, social services, youth corrections services? <input type="checkbox"/> Yes - Indicate payment amounts and agencies in comments section below. It may be necessary to coordinate billings and payment application. See HSS 1.05(11) & (12). <input type="checkbox"/> No - Continue		
SPECIAL PAYMENT ARRANGEMENT: If the family requests an extended or delayed payment privilege, indicate reasons for the request in the comments section below. Include information on current payments and expenses.		
Comments		

Name – Applicant (Print or Type)		I understand that the statements made in this application must be, and are to the best of knowledge true and correct. I also understand these statements may be verified.
Interviewed by Name	Date Interviewed	
		SIGNATURE – Applicant
Annual or Periodic Review Name – Reviewer	Date Reviewed	Action
		<input type="checkbox"/> No Change <input type="checkbox"/> Change Notes <input type="checkbox"/> Updated DMT-130 Prepared <input type="checkbox"/> No Change <input type="checkbox"/> Change Notes <input type="checkbox"/> Updated DMT-130 Prepared <input type="checkbox"/> No Change <input type="checkbox"/> Change Notes <input type="checkbox"/> Updated DMT-130 Prepared