

**DECLARATION OF INCOME AND ASSETS AND STATE RESIDENCY  
 COMMUNITY OPTIONS PROGRAM (COP)**

(Care Managers: Refer to line by line Instructions when completing Declaration)

Name – Applicant/Participant _____	County of Residence _____
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**PART I—RESIDENCY** (Complete Part I at application only)

Have you resided in the State of Wisconsin for the past six months? (See instructions to determine if this applies)

Yes—Continue     No—**STOP**, individual is not eligible for COP 100% State funding but may be eligible for Medicaid Waivers

**PART II—DIVESTMENT**

Ask **both** questions [see instructions to determine if a referral to the Income Maintenance (IM) Agency is appropriate]

1. Within the last 36 months have you or your spouse disposed of, given away, or transferred property (such as land, stocks, bonds, cash, etc.) including transfers of property to children, relatives or other persons?

Yes                       No

2. In the last 60 months have you or your spouse set up a trust or have you added funds to a trust? (Exception: Exempt funeral trusts described on page 5 of the instructions to this Declaration).

Yes                       No

**PART III—INCOME AND ASSET INFORMATION**

FOR SSI RECIPIENTS ONLY: Fill in amount on Income line 4 below. For SSI recipients who live at home, go directly to Part V of this Declaration for signature and date. Enter zero on line 9 of COP Worksheet 1. Applicant is eligible without cost-sharing. It is not necessary to complete Asset information or information in Part IV. For SSI recipients who live in substitute care, complete this form and then complete applicable COP cost-share worksheet to determine cost-share.

**A. Monthly Earned Income**

	<u>Client</u>	<u>Spouse</u>
1. Before-tax wages or salary		
2. Before-tax income from self-employment		

**Monthly Unearned Income**

3. Social Security, SSDI or Railroad Ret.		
4. SSI		
5. SSI-E		
6. Veteran's Pension		
7. Pension / Annuities		
8. Interest / Dividend Income if ↑ \$20xmo. *		
9. Other (i.e., estates / trusts, net rental income, farm income, business income, worker's compensation, unemployment compensation, alimony, child support, etc.)		
* Consult with IMW for exceptions.		

**A10 Total Monthly Earned & Unearned Income** (Add Lines 1 – 9) \_\_\_\_\_

**B. Combined Assets of Client and Spouse**

**Do not count** the home, furnishings, one car, or burial trusts under \$3000. If the spouse is not applying or is not eligible for COP, do not count his/her IRA.

1. Cash on hand	
2. Savings	
3. Checking	
4. IRA (Do not count ineligible spouse's IRA)	
5. Certificates of Deposit	
6. Money Market	
7. Life Insurance cash value if face value exceeds \$1500	
8. Other, specify (i.e., count the value of burial trusts that is over \$3000, other types of trusts, stocks, bonds, money owed to you, etc.)	
9. Value of divested amount, if applicable	

**B10 Total Assets** (Add Lines 1 – 9) \_\_\_\_\_

**PART IV—MONTHLY EXPENSES**

**1. Impairment Related Work Expenses (IRWEs)** (Do not include IRWEs again under # 3 or # 4 below)

Client's impairment related expenses:

**TOTAL**..... Client's \_\_\_\_\_ Spouse's \_\_\_\_\_

**2. Monthly Court-Ordered Expenses Paid by the Applicant(s)**

Child support or family support:	Client's _____	Spouse's _____
Maintenance or alimony:	Client's _____	Spouse's _____
Court ordered guardian and guardian ad litem fees:	Client's _____	Spouse's _____
Court ordered attorney fees:	Client's _____	Spouse's _____
Other court ordered expenses (specify type) _____	Client's _____	Spouse's _____

**TOTAL**

**3. Monthly Out-of-Pocket Medical/Remedial Expenses**

Applicant's medical/remedial expenses	Cost	If applicable, list spouse's med/remedial	Cost

**TOTAL**

**TOTAL**

**4. Monthly Expenses—County Determined (In COP Plan)**

Are there other, non-medically related household expenses that impact your household and which are approved under the county's COP Plan?

**YES**

**NO**

Applicant's other expenses	Cost	If applicable, list spouse's other expenses	Cost

**TOTAL**

**TOTAL**

**PART V—SIGNATURE AND DATE**

I have provided true and accurate information. I understand that the agency may request more detailed and documented information later. I have received information regarding the Estate Recovery Program.

<b>SIGNATURE</b> – Applicant/Participant	<b>PRINT</b> Name – Applicant/Participant	Date Signed
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If signed by a legal representative, specify legal authority (Guardian, Conservator, DPOA for finances, etc.)