DEPARTMENT OF HEALTH SERVICES

Division of Medicaid Services F-10076 (03/2017)

SENIORCAR	$\mathbf{E}^{^{\mathbb{R}}}$
Prescription Drugs for Wisconsin Seniors	X

Shade Circles Like This> ●	\neg
Not Like This> 💥	\checkmark

STATE OF WISCONSIN Wis. Stat. § 49.688

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¿Prefiere las notificaciones en español? No	APPLICATION	Select One: New Applica	ation Add Spouse Reapplication		
SECTION I – APPLICANT INFORMATION					
Are you requesting SeniorCare? Yes No Wisco	onsin Resident? Yes No	U.S. Citizen? Yes No	Gender? O Male O Female		
Race/Ethnicity (Optional) American Indian/Alaskan Native Choose all that apply White	○ Hawaiian/Other Pacific Islander○ Asian	○ Black/African American ○ Hispanic Ethnicity	Current Marital Status: Married Divorced		
	<u> </u>	O Hispanie Zamiero,	○ Widowed ○ Separated		
Last Name:			○ Single If married or separated, are you		
First Name:	Middle Initial:		Living with spouse		
Birth Date: / /	Soc. Sec. No		Not living with spouse		
SECTION II – SPOUSE INFORMATION (IF LIVING WITH APPLICANT)					
Are you requesting SeniorCare? Yes No Wisco	onsin Resident? Yes No	U.S. Citizen? Yes No	Gender? \(\rightarrow \text{Male} \(\rightarrow \text{Female} \)		
Race/Ethnicity (Optional) American Indian/Alaskan Native Choose all that apply White	Hawaiian/Other Pacific Islander Asian	○ Black/African American○ Hispanic Ethnicity			
Last Name:					
First Name:	Middle Initial:				
Birth Date: / /	Soc. Sec. No				
SECTION III – MAILING ADDRESS					
Street:		Apartment:			
City:	State:	Zip Code:			
Phone:					
Address is: Same as residence Different than residen	nce Your Authorized Representa	ative's / Legal Guardian's / Power of A	Attorney's address		





SECTION IV - EXPECTED ANNUAL INCOME (Required)

For each item below, enter the total gross (before deductions) expected ANNUAL income for you and your spouse for the next 12 months.

ROUND INCOME TO THE NEAREST DOLLAR – DO NOT INCLUDE CENTS

	APPLICANT		SPOUSE (If Living with Applicant)		
Gross Social Security	\$, ,	Gross Social Security	\$		
Gross Wages	\$,	Gross Wages	\$, ,		
Interest, Dividends, and Capital Gains	\$	Interest, Dividends, and Capital Gains	\$		
Net Self-Employment Income	\$	Net Self-Employment Income	\$		
Retirement Income	\$	Retirement Income	\$		
Other Income	\$	Other Income	\$		
Grand Total	\$	Grand Total	\$		
SECTION V – SIGNATURE (Required)					
I understand the questions and statements on this application form. I understand the penalties for giving false information or breaking the rules as outlined in the rights and responsibilities section of the SeniorCare application instructions. I certify, under penalty of perjury and false swearing, that all my answers are correct and complete to the best of my knowledge, including information provided about the citizenship or immigration status of my spouse and myself. I understand and agree to provide documents to prove what I have said. I understand that the agency may contact other persons or organizations to obtain the necessary proof of my eligibility and benefits.					
SIGNATURE – Applicant or Representative PRINTED NAME – Applicant or Representative					
Signature of: Applicant Authoriz	zed Representative O Legal Guardian	Power of Attorney / Durable Power of Attorney			
Two witness signatures are required only	•				
Witness 1	n you sign with the 12	Witness 2			
SECTION VI – ENROLLMENT FEE (Required)		OFFICE USE ONLY			
Enrollment Fee Enclosed \$30 - One	e Applicant	Return completed application form and fee to:	None		

○ \$60 – Two Applicants

Make check or money order payable to: State of Wisconsin

(Include names of all applicants on payment.)

If you have questions, contact SeniorCare Customer Service Hotline at 1-800-657-2038.

SeniorCare

PO Box 6710

Madison, WI 53716-0710



O None

Other