Staff Initials: ________________ Client ID: _______________

Rock County Human Services Department
Demographic and Financial Information Form

DATE: ________________

PART 1: Client Information:

Name: ____ Date of Birth: ________________

Address: ____

Mailing Address (if different): ____

City: _____________________ State: _______ Zip: ___________ Primary Phone: ______________

Social Security Number: _________________________ Gender: _____ Rock County Resident? _____

Emergency Contact: ____________________________________ Phone: ______________________

If client is a minor or has a guardian, complete this section:

Parent/Guardian's Name _____________________________________ Phone ____________________

Parent/Guardian's Street Address ____

City ____________________________ State __________________________ Zip ________________

Is this the client's parent? ☐ Yes ☐ No (see below*)

*A copy of the final court order documenting guardianship is needed if client is age 18 or older or if you are not the parent of the minor.

For Office Use Only - Children, Youth & Families Only

Court Case # ____________ Supervision: Start Date _____________ End Date ____________

PART 2: Payment Information (Medical Assistance, Medicare, Insurance)

Please present your insurance card (including Forward/Medicare) so our staff can make a copy

Please complete all blanks for each payer listed – please check type/coverage:

Medicaid/BadgerCare - ______ Medicare – _______ Commercial Insurance/Private or Employer provided - ________

Insurance/HMO Name: _________________________________ Dates of coverage: ____________________________

Insurance Carrier Address: ____

Policy Holder's Name: _________________________________ Relationship to client (if not self): _______________

Group #: _________________________________ Subscriber/ID #: ______________________________

Please complete all blanks for each payer listed – please check type/coverage:

Medicaid/BadgerCare - ______ Medicare – ________ Commercial Insurance/Private or Employer provided - ________

Insurance/HMO Name: ________________________________ Dates of coverage: ____________________________

Insurance Carrier Address: ____

Policy Holder's Name: ________________________________ Relationship to client (if not self): _______________

Group #: _________________________________ Subscriber/ID #: _______________________________

Please complete all blanks for each payer listed – please check type/coverage:

Medicaid/BadgerCare - ______ Medicare – ________ Commercial Insurance/Private or Employer provided - ________

Insurance/HMO Name: ________________________________ Dates of coverage: ____________________________

Insurance Carrier Address: ____

Policy Holder's Name: ________________________________ Relationship to client (if not self): _______________

Group #: _________________________________ Subscriber/ID #: _______________________________

Authorization for Payment

1. I hereby request and authorize payment directly to the Rock County Human Services Department of the benefits specified for services rendered.

2. I hereby authorize the Rock County Human Services Department to release to the named insurance company or other third party payer any personal or medical information necessary to determine benefits and/or for the processing of claims for payment.

3. I hereby declare that the statements and information given on this application are true and correct to the best of my knowledge. I understand that the agency may contact other persons or organizations to verify the accuracy of this information.

Print Name (of person taking responsibility for payment) ________________________________

SIGNATURE ____ **Date** _________________

Financial Information

Providing the information requested on this form meets the provisions of DHS 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.

Client Name: ____ Client ID#: __________________

PART 3: FAMILY INCOME INFORMATION – see attached instruction page for more information.

EARNED INCOME Earnings come from employment or self-employment (farm or non-farm). Enter earnings for all persons except children in school.

UNEARNED INCOME See income definition list in DHS 1.01(2). Enter unearned income for all persons.

GROSS AVERAGE MONTHLY INCOME

Client	(If client lives in substitute care facility, do not enter client income. If client is a child, complete for all relevant parents/guardians)					
Birth Date	Social Security No.	Employer Name		Work Phone	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 Phone	Employer – Name and City					

Father of Minor Client	(Enter Stepfather information in lines 5a and 5b.)					
Name		Social Security No.	Birth Date		Date Married	Earned
Home Address (if different from Client) – Street	City		State	Zip	Unearned	2b
Home Phone	Employer – Name and City					

Mother of Minor Client	(Enter Stepmother information in lines 5a and 5b.)					
Name		Social Security No.	Birth Date		Date Married	Earned
Home Address (if different from Client) – Street	City		State	Zip	Unearned	4b
Home Phone	Employer – Name and City					

Others in Family Is there income in lines 1a through 4b? ☐ Yes, CONTINUE. ☐ No, Skip to line 8.

Relatives in the home who are federal tax exemptions (siblings, stepparents, etc.)
- Enter earnings for all persons except children enrolled in school full time (see attached instruction page for more information.)
- 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 4: 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?) ☐ Yes – Complete lines 12 through 17. ☐ No – Copy the amount from line 11 to line 18. Skip lines 12 through 17.		
Total Average EARNED INCOME of the Client, Spouse, Father and Mother. (Exclude client's income if placed out of home.) - This is the total of lines 1a, 2a, 3a and 4a from page 1.		12
Total Average UNEARNED INCOME of the Client, Spouse, Father and Mother. (Exclude client's income if placed out of home.) - This is the total of lines 1b, 2b, 3b and 4b from page 1.		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.	1a	
For each line in this workspace, enter the lesser of the amount in each earning line or $90.	2a	
(For example if line 1a is $50, enter $50; if line 1a is $100, enter $90.)	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 5: 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?

☐ Yes - Indicate payment amounts and agencies in comments section below.
It may be necessary to coordinate billings and payment application. See DHS 1.05(11) & (12).

☐ 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: