**DEPARTMENT OF CHILDREN AND FAMILIES**
Division of Family and Economic Security

**WPM**

At Risk Pregnancy (ARP) Medical Information/Verification

Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

The purpose of this form is to gather information for the Wisconsin Works (W-2) program At Risk Pregnancy (ARP) placement. The W-2 ARP placement provides payment and services to eligible pregnant women who are unable to work due to an at risk pregnancy. **This placement requires:**

* **The pregnant woman to** **not have custody of any dependent (minor) children in their home;**
* **The pregnant woman to be unmarried; and**
* **The pregnant woman to provide medical verification of:**
	+ **Third trimester of pregnancy (based on the due date);**
	+ **The pregnancy is a high risk pregnancy; and**
	+ **The high risk pregnancy results in the woman not being able to work.**

The W-2 ARP placement requires this form (or all of the same items on the physician’s letterhead) **to be completed by the patient’s physician** based on the physician’s medical examination of the patient within four months from the due date.

Note: The information you provide on this form will not affect billing or reimbursement from Medicaid.

If you have any questions*,* please contact the W-2 agency at:

|  |
| --- |
| W-2 Agency Name      |
| W-2 Agency Street Address      | City      | State   | Zip Code      |
| Telephone Number      | Fax Number      |
|  |
| Patient’s Full Name      | Patient’s Birthdate (mm/dd/yyyy)      |
| What is the patient’s due date? (mm/dd/yyyy)       |
|  [ ]  Yes [ ]  No Does this patient have a high risk pregnancy and does the high risk pregnancy cause the patient to be unable to work (based on the physician’s best determination)? |
| If “Yes”, what is the cause of the patient’s pregnancy being a high risk pregnancy?      |
| What is the start date (if prior to the signature date on this form) for the patient being unable to work due to the high risk pregnancy?       |
| Any other comments (by the patient’s physician)      |
| Physician’s specialty area: (check all that apply) [ ]  General Medicine [ ]  Family Medicine [ ]  Obstetrics[ ]  Other, please specify:      |
| National Provider Identifier (NPI)      |
| Physician’s Office Address (Street)      | City      | State   | Zip Code      |
| Physician’s Telephone Number      | Physician’s Fax Number      | Physician’s email address      |
| Physician’s Name (legibly printed)       | Physician’s Signature      | Date Signed      |

Please return the completed form to the agency listed above.