**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:

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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.