WISCONSIN DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-10101 (02/2020)

WISCONSIN MEDICAID FOR THE ELDERLY, BLIND OR DISABLED APPLICATION PACKET

HOW TO APPLY

This is an application for health care benefits for people who are 65 years of age or older, blind or have a disability.

To apply for health care benefits, complete this application and return it to the following address or complete an application online at access.wi.gov. See below for more information about applying online.

Mail or Fax Applications and/or Proof/Verification to:

If you live in Milwaukee County:	If you **do not** live in Milwaukee County
MDPU PO Box 05676 Milwaukee, WI 53205	CDPU PO Box 5234 Janesville, WI 53547-5234
Fax: 888-409-1979	Fax: 855-293-1822

You can also scan and/or upload any proof online at access.wi.gov.

You will need to provide proof of some of your answers. For more information on what you will need to provide, see the Proof/Verification Section starting on page 4.

If you have questions about Medicaid, need help filling out this application or want to answer the questions in person or over the phone, contact your agency to set up an appointment. If you need the address and/or phone number of your agency, see page 6. Information is also available online at www.dhs.wisconsin.gov/forwardhealth/resources.htm.

If you have a disability and need this information in an alternate format, or if you need it translated to another language, contact your agency. These services are free of charge.

APPLY ONLINE

ACCESS is an online tool that lets you apply for benefits, check the status of your benefits, report changes or complete your annual renewal. To visit ACCESS go to access.wi.gov. An online application is the same as a paper application.

LETTERS AVAILABLE THROUGH THE ACCESS WEBSITE

Members can get letters and information about their benefits online instead of by regular mail. To make this choice, the member needs to contact their agency, or log into their ACCESS account at access.wi.gov. If a member does not have an ACCESS account, they must create one to view their letters online.

HOW TO USE THIS FORM

1. Read the Important Information section and all the instructions before completing the application.
2. Print clearly. Use blue or black ink.
3. Write dates in the mm/dd/yyyy format. (Example: April 2, 1958, would be 04/02/1958.)
4. Enter information about you and/or your spouse.
5. Completely fill out the application. There may be a delay in Medicaid benefits if the application is not complete. (Use the checklist on page 15 to make sure your application is complete.) If your application is not complete, the agency will contact you for more information.

IMPORTANT INFORMATION

The following is important information regarding Medicaid for persons who are elderly, blind or have a disability.

Legal Guardian, Conservator, or Power of Attorney

If you have a legal guardian, conservator, or power of attorney for finances, that person can fill out and submit this form on your behalf. That person would also need to submit documents about his or her appointment along with this form.

Authorized Representative

You may have an authorized representative apply for you. To appoint an authorized representative, fill out either the Appoint, Change, or Remove an Authorized Representative: Person form, F-10126A, or the Appoint, Change, or Remove an Authorized Representative: Organization form, F-10126B, found in this application packet. This will allow your authorized representative to complete and sign the application for you.

Application Date

Your application date is the date the Medicaid office gets your signed application. A decision on your Medicaid will be mailed to you within 30 days of your application date. Unsigned forms will be returned. It is important to apply as soon as possible since the date your benefits will begin, if you meet all program rules, is based on your application date.

Backdated Coverage

You may be able to get Medicaid benefits for up to three months before your application date if you provide the necessary information to show you met the Medicaid rules for those months. If you want help paying for health care for any of the past three months (backdated coverage), complete the "Medicaid Backdated Coverage Request" page found in this application packet.

Personally Identifiable Information / Social Security Number

Personally identifiable information and Social Security Numbers are used only for the direct administration of the Medicaid program.

If someone in your household is not applying for Medicaid, you do not need to provide Social Security Number (SSN) information for that person. Any person who wants Wisconsin Medicaid, but does not provide their SSN or apply for one will not be eligible for benefits, pursuant to Wis. Stat. § 49.82(2).

If you are applying only for Emergency Services because of your immigration status, or you are a pregnant woman applying for BadgerCare Plus Prenatal Services, you do not need to provide SSN information.

Your SSN permits a computer check of your information with government agencies such as the Internal Revenue Service (IRS), Social Security Administration, Department of Revenue and the Department of Workforce Development. In addition, the Department of Health Services will match your name and SSN with information provided by health insurance carriers to determine if you have other health insurance.

Your SSN will not be shared with the United States Citizenship and Immigration Services (USCIS).

Renewals

If you are able to get Medicaid, you will need to complete a renewal at least once every 12 months to see if you still meet all the program rules for enrollment in Medicaid.

Estate Recovery

If you are enrolled in Medicaid, Wisconsin State law, with limited exceptions, requires the recovery of certain Medicaid benefits from your estate. The Estate Recovery Program Handbook (P-13032) provides you with information on estate recovery. You may get a copy of the brochure from your local agency or by contacting Member Services at 800-362-3002. Certain benefits you get in the community after age 55 and all Medicaid benefits you get while residing in a nursing home or while you are an inpatient in a hospital for 30 days or more, are recoverable. Also, if you reside in a nursing home or are institutionalized in a hospital, and are not expected to return home to live, a lien may be placed on your home. A lien may not be placed on your home if you, your spouse or certain other family members reside in the home.

Rights and Responsibilities

Rights

State and Federal laws guarantee rights for members, which include:

- The right to be treated with respect by state and county employees.
- The right to confidentiality of all information given to agencies to determine eligibility. (This does not prohibit the use of such records for program administration.)
- The right of access to agency's records and files relating to your case, except information obtained by the agency under a promise of confidentiality.
- The right to remain eligible for Medicaid benefits even if temporarily absent from the state, if you remain a Wisconsin resident.
- The right to a speedy determination of eligibility status and prior notice of proposed changes in such status.
- The right to emergency medical care.
- The right to request reasonable accommodation to participate in the program for a disability-related reason, or the right to request interpreters or translators to participate in the program.
- The right to appeal any action taken concerning your Medicaid application or ongoing benefits that you do not agree with by requesting a fair hearing.

Fair Hearing

You may appeal to the Division of Hearings and Appeals or your agency if:

- Your application for Medicaid was denied in error.
- Your application was not processed within 30 days from the date the agency received it.
- You disagree with the agency's decision to discontinue, terminate, suspend, or reduce your benefit.
- Your request for prior authorization for a medical service was denied.

You may request a fair hearing by writing to:

Wisconsin Department of Administration
Division of Hearings and Appeals
PO Box 7875
Madison, WI 53707-7875

The Request for Fair Hearing form can be found at www.dhs.wisconsin.gov/forwardhealth/resources.htm.

If you choose to write a letter instead of using the form, you must include:

- Your name.
- Your mailing address.
- A brief description of the problem.
- The name of the agency.
- Your CARES case number.
- Your signature.

An appeal must be made no later than 45 days after the date of the action.

You may also contact the agency where you applied and ask for help filing a Fair Hearing request. Refer to the ForwardHealth Enrollment and Benefits Handbook (P-00079) to learn more about the fair hearing process. You will get a handbook when the agency gets your application or you can find the handbook at www.dhs.wisconsin.gov/forwardhealth/resources.htm.

If you have questions about the fair hearing process, you can call the Division of Hearings and Appeals at 608-266-7709.

Responsibilities

Reporting Changes

Report to the agency **within 10 days:**

- Any changes in income of any member of your household.
- Any other change in the information you have given on your application that is required to be reported on the Medicaid Change Report form, F-10137, located in this application packet.

Note: If you are in a Medicaid HMO and you move out of state but do not report this move, you will be responsible to repay Wisconsin Medicaid any payment they made to your HMO. For example, if Wisconsin Medicaid paid your HMO $175 per month for you and your spouse, the amount of overpayment you would have to repay Wisconsin Medicaid is $350, for each month the HMO was paid after you moved out of state, even if you did not use your Forward card.

Changes can be reported online at access.wi.gov, by calling your agency or you can use the Medicaid Change Report form, F-10137, in this application packet. **Do not send this form with your application; keep it for future use**.

Verification/Proof

You will need to provide verification/proof of certain information. Some of these include:

Citizenship / Identity

Federal law requires that all U.S. citizens applying for, or getting Medicaid benefits must show proof of their U.S. citizenship and identity unless they are exempt. Exempt people include recipients of Social Security Disability Insurance (SSDI), Supplemental Security Income (SSI), Medicare, Foster Care, and Adoption Assistance. If you are applying for benefits, you will have at least 95 days, from the date of your application, to provide proof to the agency. If you have provided this information in the past,, it may already be on file; your agency will let you know if more proof is needed.

We also verify with the U.S. Department of Homeland Security the immigration status of all immigrants who apply for benefits for themselves. Immigration status will not be verified with United States Citizenship and Immigration Services (USCIS) for people in your household who are not applying for assistance. If someone in your household is not applying for Medicaid, you do not need to answer this question for that person.

Note: Undocumented immigrants are only eligible for coverage of emergency health care services if they would otherwise be eligible for Medicaid. Pregnant immigrants may be able to enroll in BadgerCare Plus Prenatal Services.

Examples of what you can use to prove both citizenship and identity are:

- U.S. passport
- Certificate of U.S. Citizenship
- Certification of U.S. Naturalization
- A state-issued enhanced driver's license
- Tribal identification documents

Examples of what you can use to prove citizenship are:

- U.S. birth certificate
- U.S. State Department Report of Birth Abroad
- U.S. citizen ID card
- Adoption papers showing U.S. birth
- Hospital record of U.S. birth
- U.S. military record of service or draft record showing U.S. birth
- Life or health insurance record showing U.S. birth
- Nursing home admission papers showing U.S. birth

Examples of what you can use to prove identity are:

- State driver's license
- ID card issued by federal, state, or local government
- School ID card with photo
- U.S. military dependent ID card
- U.S. military ID card
- For children under age 18, a signed Statement of Identity form, F-10154

Assets

You will be required to provide proof of all your assets. Examples of proof include a copy of your bank statement showing the value of your bank account on the date the application is completed, property tax bill, vehicle title/registration, or something that shows the face value and cash value of your life insurance policy. If married and applying for Institutional Medicaid, an Asset Assessment will be required for both the applicant and spouse.

Other

Your worker may also ask for proof of the following:

- Medical expenses to meet a deductible,
- Physician's certification (verbally or in writing) that the person is likely to return to the home or apartment within 6 months for institutionalized persons maintaining a home or property and who may be entitled to a home maintenance allowance. If allowed, expenses will need to be verified,
- Documentation for Power of Attorney and Guardianship, and/or
- Disability.

If you have these items available on the day you submit this application, provide a copy of them with your application. You will be contacted by the agency and be asked to provide proof of missing, conflicting or vague information, if the information would affect the decision about your Medicaid enrollment.

Do not send original documents in the mail. You may bring in original documents or send photocopies of these items with your application. If you are having trouble getting what you need to provide proof, contact your agency and ask for help.

Nondiscrimination Notice: Discrimination is Against the Law – Health Care-Related Programs
The Wisconsin Department of Health Services complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Department of Health Services does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Department of Health Services:
- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters.
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters.
  - Information written in other languages.

If you need these services, contact the Department of Health Services civil rights coordinator at 844-201-6870.

If you believe that the Department of Health Services has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Department of Health Services, Attn: Civil Rights Coordinator, 1 West Wilson Street, Room 651, PO Box 7850, Madison, WI 53707-7850, 844-201-6870, TTY: 711, fax: 608-267-1434, or email to dhscrc@dhs.wisconsin.gov. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Department of Health Services civil rights coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

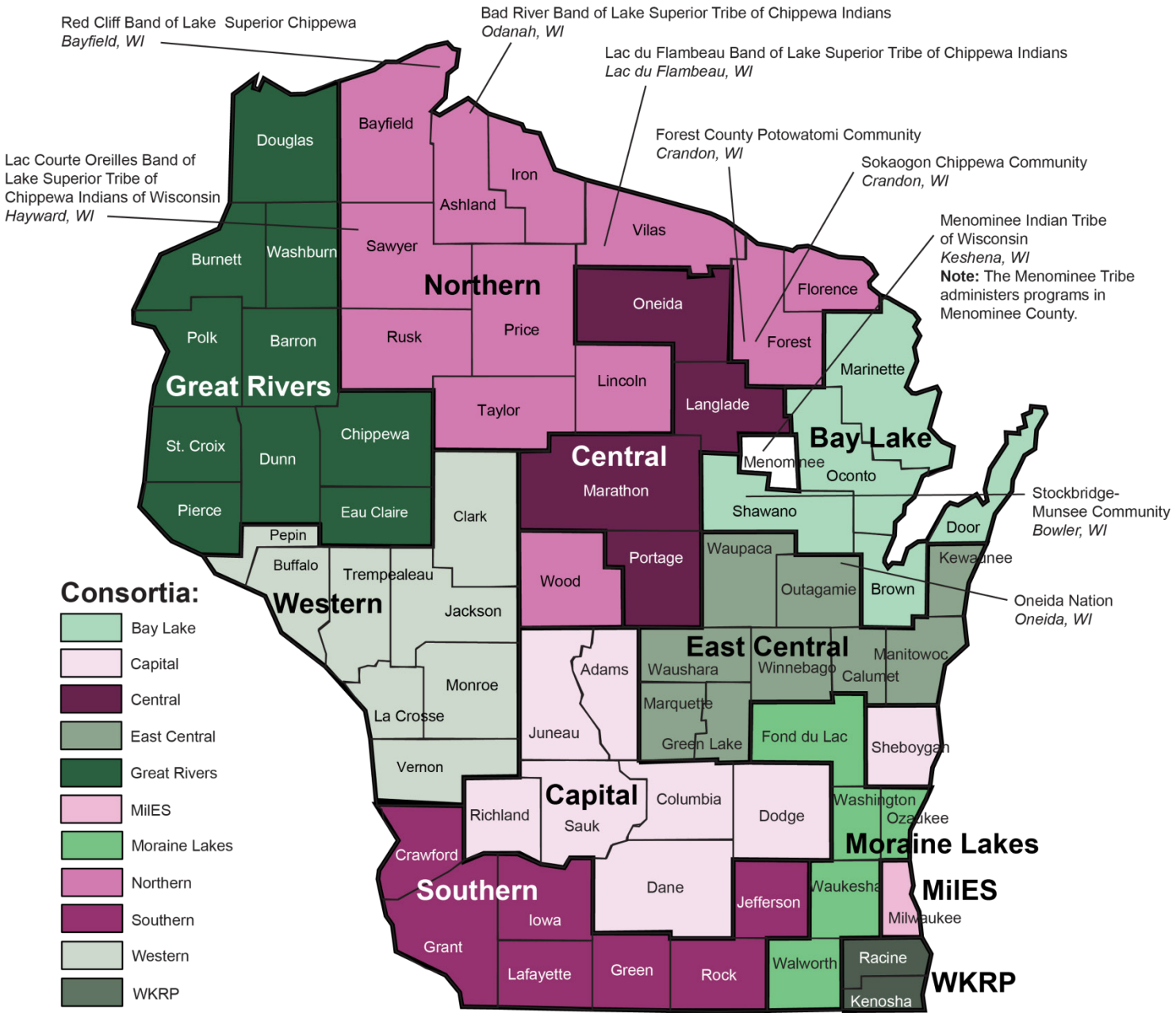
Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 844-201-6870 (TTY: 711).	**Deitsch (Pennsylvania Dutch)** Wann du Deitsch (Pennsylvania Dutch) schwetzscht, kannscht du ebber griege as dich helfe kann mit Englisch, unni as es dich ennich eppes koschte zellt. Ruf 844-201-6870 uff (TTY: 711).
Hmoob (Hmong) LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 844-201-6870 (TTY: 711).	**ພາສາລາວ (Laotian)** ເຊີນຊາບ: ຖ້າທ່ານເວົ້າພາສາລາວ ແມ່ນມີບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ໃຫ້ໂທຫາເບີ 844-201-6870 (TTY: 711).
繁體中文 (Traditional Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 844-201-6870 (TTY: 711).	**Français (French)** ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 844-201-6870 (ATS : 711).
Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 844-201-6870 (TTY: 711).	**Polski (Polish)** UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 844-201-6870 (TTY: 711).
العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان اتصل برقم 844-201-6870 (رقم هاتف الصم والبكم: 711).	**हिंदी (Hindi)** ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 844-201-6870 (TTY: 711) पर कॉल करें।
Русский (Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 844-201-6870 (телетайп: 711).	**Shqip (Albanian)** KUJDES: Nëse flisni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 844-201-6870 (TTY: 711).
한국어 (Korean) 알림: 한국어 지원 서비스를 무료로 이용하실 수 있습니다. 844-201-6870 (TTY: 711) 번으로 전화해 주십시오.	**Tagalog (Tagalog – Filipino)** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 844-201-6870 (TTY: 711).
Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 844-201-6870 (TTY: 711).	**Soomaali (Somali)** FIIRO GAAR AH: Haddii aad ku hadashid af Soomaali, adeegyada caawinta luuqada, oo bilaash ah, ayaa laguu heli karaa. Soo wac 844-201-6870 (TTY: 711).

Income Maintenance Consortiums and Tribal Agencies Contact Information

Income maintenance consortiums (often called agencies) and tribal agencies can help you with eligibility services for programs like Medicaid, BadgerCare Plus, and FoodShare. The table below lists income maintenance consortiums and tribal agencies alphabetically and includes telephone numbers as well as the counties that make up each consortium. If you have questions about your eligibility or case, call the consortium that represents your county or your tribal agency.

Bad River Band of Lake Superior Tribe of Chippewa Indians			**715-682-7127**
Bay Lake			**888-794-5747**
• Brown	• Marinette	• Shawano	
• Door	• Oconto		
Capital			**888-794-5556**
• Adams	• Dodge	• Sauk	
• Columbia	• Juneau	• Sheboygan	
• Dane	• Richland		
Central			**888-445-1621**
• Langlade	• Oneida		
• Marathon	• Portage		
East Central Income Maintenance Partnership			**888-256-4563**
• Calumet	• Manitowoc	• Waupaca	
• Green Lake	• Marquette	• Waushara	
• Kewaunee	• Outagamie	• Winnebago	
Forest County Potawatomi Community			**715-478-4433**
Great Rivers			**888-283-0012**
• Barron	• Dunn	• Polk	
• Burnett	• Eau Claire	• St. Croix	
• Chippewa	• Pierce	• Washburn	
• Douglas			
Lac Courte Oreilles Band of Lake Superior Tribe of Chippewa Indians of Wisconsin			**715-634-8934**
Lac du Flambeau Band of Lake Superior Tribe of Chippewa Indians			**715-588-4235**
Menominee Indian Tribe of Wisconsin			**715-799-5137**
Milwaukee Enrollment Services (MilES)			**888-947-6583**
Milwaukee			
Moraine Lakes			**888-446-1239**
• Fond du Lac	• Walworth	• Waukesha	
• Ozaukee	• Washington		
Northern			**888-794-5722**
• Ashland	• Iron	• Sawyer	
• Bayfield	• Lincoln	• Taylor	
• Florence	• Price	• Vilas	
• Forest	• Rusk	• Wood	
Oneida Nation			**800-216-3216**
Red Cliff Band of Lake Superior Chippewa			**715-779-3706**
Sokaogon Chippewa Community			**715-478-3265**
Southern			**888-794-5780**
• Crawford	• Iowa	• Lafayette	
• Grant	• Jefferson	• Rock	
• Green			
Stockbridge-Munsee Community			**715-793-4032**
Western Region for Economic Assistance			**888-627-0430**
• Buffalo	• La Crosse	• Trempealeau	
• Clark	• Monroe	• Vernon	
• Jackson	• Pepin		
Wisconsin's Kenosha Racine Partnership (WKRP)			**888-794-5820**
• Kenosha	• Racine		

Map of Income Maintenance Consortiums and Tribal Agencies



WISCONSIN DEPARTMENT of HEALTH SERVICES

Division of Medicaid Services
P-02342 (02/2019)

APP

WISCONSIN MEDICAID FOR THE ELDERLY, BLIND OR DISABLED APPLICATION

Instructions: Before completing this form, read all instructions. Use black or blue ink only. Write all dates in the mm/dd/yyyy format (for example, April 2, 1958, would be 04/02/1958). If you need more space to write your answers, use an additional sheet of paper.

Keep pages 1 through 6 and the Medicaid Change Report, F-10137, of this application packet for future use.

If you are completing this application for someone else, complete either the Appoint, Change, or Remove an Authorized Representative: Person form, F-10126A, or the Appoint, Change, or Remove an Authorized Representative: Organization form, F-10126B, found in this application packet, or attach legal documentation authorizing you as the appointed guardian or durable power of attorney for finances for the applicant. Information provided on this application should be about the applicant, not the representative.

SECTION I – APPLICANT INFORMATION – In this section, we need you to tell us about yourself.

Name – Applicant (last, first, MI)		
Do you have any names you have previously used such as a married or maiden name? ☐ Yes ☐ No If yes, what are those names?		
Date of birth	Social Security Number	Sex ☐ Male ☐ Female
Where were you born? (city, state)	Ethnicity* (optional) ☐ Hispanic or Latino ☐ Not Hispanic or Latino	
Race* (optional, choose one or more) ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Hawaiian/Other Pacific Islander ☐ White ** You don't have to answer the ethnicity and race questions if you don't want to. We're asking these questions to help improve our programs and make sure they do not discriminate based on ethnicity or race. Your answers will not be used to make a decision about your programs and benefits.*		
Are you a member, or a child of a member, of a tribe? ☐ Yes ☐ No	In what language do you want your letters printed? ☐ English ☐ Spanish	
Primary language spoken in your home	Are there any minor children in the home? ☐ Yes ☐ No	

SECTION 2 – CONTACT INFORMATION – Please tell us how we can contact you. For phone numbers, please include the area code.

Name of contact, if not the applicant		
Phone Number – Applicant ☐ Home ☐ Cell ☐ Work	Phone Number – Authorized Representative / Power of Attorney ☐ Home ☐ Cell ☐ Work	
Other Number Where We Can Leave a Message	Who does this message number belong to? ☐ Self ☐ Friend ☐ Neighbor ☐ Relative	
Email Address	Who does this email address belong to? ☐ Self ☐ Friend ☐ Neighbor ☐ Relative	
What is the best way to contact you during weekdays?		

SECTION 3 – ADDITIONAL APPLICANT INFORMATION – In this section we need additional information about you, the applicant.

Address where you reside? If you reside in a medical institution, use the name and address of the institution.

Street City State Zip Code

Is this also your mailing address? ☐ Yes ☐ No If you answered no, what is your mailing address?

Are you currently residing in a nursing home, institution for mental disease (IMD), or hospital? ☐ Yes ☐ No
If yes, what is the date you were admitted? _____
Did you reside in a nursing home, institution for IMD, or hospital in the past? If so when? _____

Do you intend to continue residing in Wisconsin? ☐ Yes ☐ No

Do you need help paying for health care you received in the last three months? ☐ Yes ☐ No
If you answered yes, complete the Medicaid Backdated Coverage Request form in this packet.

Marital Status
☐ Married ☐ Legally separated ☐ Annulled ☐ Divorced ☐ Widowed ☐ Never married

Are you a U.S. citizen? (See page 4)
☐ Yes ☐ No
If no, complete the following questions:

What is your Alien Registration or USCIS number?

When did you come to the U.S. to live?

Do you have a sponsor?
☐ Yes ☐ No

Are you on active duty in the U.S. military or an honorably discharged veteran, married to someone on active duty or an honorably discharged veteran, the surviving spouse of a veteran, or the child of someone on active duty or an honorably discharged veteran?
☐ Yes ☐ No

SECTION 4 – SPOUSE INFORMATION – In this section we will ask you general information about your spouse, if you are married. Answer all questions in this section with your spouse's information. If you are not married, go to Section 5.

Name (last, first, MI)

Social Security Number | Date of Birth

Other Names Previously Used, Such as a Maiden or Married Name

Spouse's Address (if different from applicant's address)

Street City State Zip Code

If you are applying for long-term care services, do you want your spouse to get the maximum allowed portion of your income? ☐ Yes ☐ No If "No," how much would you like your spouse to get? $_____

Are you residing in a nursing home, IMD, or hospital? ☐ Yes ☐ No
If you answered "Yes," stop here and go to Section 5.

Applying for Medicaid? ☐ Yes ☐ No	Ethnicity* (optional) ☐ Hispanic or Latino ☐ Not Hispanic or Latino
Race* (optional, choose one or more) ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Hawaiian/Other Pacific Islander ☐ White ** You don't have to answer the ethnicity and race questions if you don't want to. We're asking these questions to help improve our programs and make sure they do not discriminate based on ethnicity or race. Your answers will not be used to make a decision about your programs and benefits.*	
Are you a member, or a child of a member, of a tribe? ☐ Yes ☐ No	
Are you a U.S. citizen? (See page 4) ☐ Yes ☐ No *If no, complete the following questions:*	
What is your Alien Registration or USCIS number?	
When did you come to the U.S. to live?	
Do you have a sponsor? ☐ Yes ☐ No	
Are you on active duty in the U.S. military or an honorably discharged veteran, married to someone on active duty or an honorably discharged veteran, the surviving spouse of a veteran, or the child of someone on active duty or an honorably discharged veteran? ☐ Yes ☐ No	

SECTION 5 – DISABILITY INFORMATION

Applicant

Have you been determined blind or disabled by the Social Security Administration?	☐ Yes	☐ No
If not, would you like us to send you a Disability Application Form?	☐ Yes	☐ No
Have you received Supplemental Security Income (SSI) in the past?	☐ Yes	☐ No
If you are disabled and not currently working, are you interested in working?	☐ Yes	☐ No

Spouse

Has your spouse been determined blind or disabled by the Social Security Administration?	☐ Yes	☐ No
Has your spouse received SSI in the past?	☐ Yes	☐ No
If your spouse is disabled and not currently working, is he or she interested in working?	☐ Yes	☐ No

SECTION 6 – ASSETS

List all assets owned by you and/or your spouse. Include assets owned jointly with any other person. Do not include the value of personal household belongings (televisions, furniture, appliances). Do not list motor vehicle information in this section as we will ask for that in Section 9. Assets include items such as cash, checking or savings accounts, certificates of deposit, trust funds, stocks, bonds, retirement accounts, interest in annuities, U.S. savings bonds, property agreements, contracts for deeds, timeshares, rental property, life estates, tools, livestock, farm machinery, Keogh plans or other tax shelters, personal property being held for investment purposes, health savings accounts, etc.

NOTE: You will be asked to provide proof of your assets. See page 5, for more information. Use an additional sheet of paper if more room is needed.

Type of Asset (See above.)	Name of Owner(s)	Current Dollar Amount	Bank / Financial Institution Name and Account Number
		$	
		$	
		$	
		$	
		$	
		$	

SECTION 7 – BURIAL ASSETS

List all burial assets owned by you and/or your spouse. You will be asked to provide proof of your assets. Use an additional sheet of paper if more room is needed.

Type of Burial Asset			Name of Owner(s)	Value
Burial insurance	☐ Yes	☐ No		$
Irrevocable burial trust	☐ Yes	☐ No		$
Other	☐ Yes	☐ No		$

SECTION 8 – ANNUITY OWNERSHIP

Do you or your spouse own an annuity? ☐ Yes ☐ No

Did you or your spouse purchase an annuity on or after 01/01/2009? ☐ Yes ☐ No

Did you or your spouse make any substantive changes on or after 01/01/2009 to any annuity that either you or your spouse own, regardless of when it was purchased? ☐ Yes ☐ No

A substantive change would be an addition to principal, an elective withdrawal, a distribution change request, a change in ownership or other similar action.

Note: If you answered "Yes," to any of the questions above, you will be required to provide and verify additional information about this annuity in order to qualify for Medicaid Institutional/Long-Term Care Services.

I, the applicant and my spouse acknowledge that we are naming the State of Wisconsin as a remainder beneficiary on my/our annuity, by virtue of the provision of Medicaid Institutional/Long Term Care services. This assignment provision will apply to any annuity purchased by me or my spouse, on or after 01/01/2009, or any annuity owned by me or my spouse, regardless of the purchase date, for which a substantive change and/or transaction has occurred on or after 01/01/2009. The State of Wisconsin will be named as the remainder beneficiary in my/our annuity in the first position or if I am married or have a minor and/or disabled child, the State of Wisconsin will be named as a remainder beneficiary in the next position after my spouse and/or minor or disabled child.

SECTION 9 – VEHICLE INFORMATION

List all motor vehicles owned by you and/or your spouse, if married. Include vehicles owned jointly with another person.

Vehicle 1

Type of Vehicle	Year	Make	Model
Amount Owed on Vehicle $		Fair Market Value* $	

Vehicle 2

Type of Vehicle	Year	Make	Model
Amount Owed on Vehicle $		Fair Market Value* $	

Section 10 – Real Property Information

List all real property owned by you and/or your spouse, if married. Include all real property, whether the property is located in the State of Wisconsin or not, owned solely or jointly with another person. Include any rental property owned.

Property 1

Owner(s) of property			
Address – Street	City	State	Zip Code
Amount owed on property $	Fair Market Value* $		

*By fair market value, we mean the amount that you would get if you sold it on the open market.

Property 2

Owner(s) of Property			
Address – Street	City	State	Zip Code
Amount Owed on Property $	Fair Market Value* $		

SECTION 11 — LIFE INSURANCE

Please tell us about any life insurance you and/or your spouse has.

Do you and/or your spouse have any life insurance policies? ☐ Yes ☐ No If yes, complete the section below. If no, stop and go to Section 12.			
Name of Owner(s)	Type: (whole life, term, etc.)	Cash Value $	Face Value $
		$	$

SECTION 12 – RESOURCE/INCOME TRANSFER

Please tell us about any income or resources you and/or your spouse have given away or sold for less than fair market value in the last five years. Examples of resources include cash and cash gifts, real estate, stocks or bonds, etc. Use an additional sheet of paper if more room is needed.

Check all that apply. In the last five years, did you and/or your spouse:

- ☐ Yes ☐ No Sell any assets for less than fair market value*?
- ☐ Yes ☐ No Trade assets or income?
- ☐ Yes ☐ No Transfer or give away assets or income?
- ☐ Yes ☐ No Establish or fund a trust?
- ☐ Yes ☐ No Decline or refuse to accept an inheritance,?
- ☐ Yes ☐ No Purchase an annuity, life estate in another person's home, promissory note, loan or mortgage?

If you answered "Yes," to any of the above fill out the following information. If "No," go to Section 13.

Asset or Income 1

Type of Asset or Income	Date Given Away or Sold	Value of Asset or Income $
What did you get in return? _____ Who was asset given/sold to? _____		

Asset or Income 2

Type of Asset or Income	Date Given Away or Sold	Value of Asset or Income $
What did you get in return? _____ Who was asset given/sold to? _____		

*By fair market value, we mean the amount that you would get if you sold it on the open market.

SECTION 13 – JOB INCOME AND WAGES

In this section, we need to know about any job income or wages you and/or your spouse receive from employment. List the gross income for each job. By gross, we mean the amount earned before taxes and deductions. Do not list self-employment in this section, we will ask you about self-employment in Section 14.

Job 1

Are you and/or your spouse employed? ☐ Yes ☐ No If yes, answer the following questions. If no, stop here and go to Section 14.	
Who has a job? ☐ You ☐ Your spouse	Date Employment Began
Employer Name and Address	Gross Monthly Earnings Expected This Month $
	Gross Monthly Earnings Expected Next Month $
Hours worked each week?	How much are you paid each hour? $
How often are you paid? ☐ Each week ☐ Every other week ☐ Twice each month ☐ once a month	
Are you paid a salary? ☐ Yes ☐ No If "yes," how much are you paid each pay period? $	
Do you get tips or compensation other than your hourly wages or salary? ☐ Yes ☐ No If "yes," how much do you get each pay period? $	

Job 2

Who has a job? ☐ You ☐ Your spouse	Date Employment Began
Employer Name and Address	Gross Monthly Earnings Expected This Month $
	Gross Monthly Earnings Expected Next Month $
Hours worked each week?	How much are you paid each hour? $
How often are you paid? ☐ Each week ☐ Every other week ☐ Twice each month ☐ Once each month	
Are you paid a salary? ☐ Yes ☐ No If "yes," how much are you paid each pay period? $	
Do you get tips or compensation other than your hourly wages or salary? ☐ Yes ☐ No If "yes," how much do you get each pay period? $	

Note: If you have any other jobs or wages from a job, you can use an additional sheet of paper and attach it to this application.

SECTION 14 – SELF-EMPLOYMENT

Please tell us about any self-employment income you and/or your spouse receive. If more room is needed or you have more than two self-employment businesses, use a separate sheet of paper.

Self-Employment 1

Are you and/or your spouse self-employed? ☐ Yes ☐ No If yes, answer the questions below. If no, go to Section 15.	
Who is self-employed? ☐ You ☐ Your spouse	Business Name
Business Address	Business Ownership Type ☐ Partnership ☐ S corporation ☐ Sole proprietorship ☐ I don't know
Business Type (for example, a farm, home day care)	Date Business Started
Has this business filed taxes? ☐ Yes ☐ No If yes, for what tax year did the business last file taxes?	
Has the business had a significant change in income or expenses? ☐ Yes ☐ No ☐ I don't know	
On average, how much does this business make each month? Please give us the income received before expenses are taken out. $ _____	
On average, what are the total expenses this business has each month? $ _____	
On average, how many hours per month does this person work for this business?	

Self-Employment 2

Are you and/or your spouse self-employed? ☐ Yes ☐ No If yes, answer the questions below. If no, go to Section 15.	
Who is self-employed? ☐ You ☐ Your spouse	Business Name
Business Address	Business Ownership Type ☐ Partnership ☐ S corporation ☐ Sole proprietorship ☐ I don't know
Business Type (for example, a farm, home day care)	Date Business Started
Has this business filed taxes? ☐ Yes ☐ No If yes, for what tax year did the business last file taxes?	
Has the business had a significant change in income or expenses? ☐ Yes ☐ No ☐ I don't know	
On average, how much does this business make each month? Please give us the income received before expenses are taken out. $ _____	
On average, what are the total expenses this business has each month? $ _____	
On average, how many hours per month does this person work for this business?	

SECTION 15 – OTHER TYPES OF INCOME

In this section, tell us if you and/or your spouse receive any other types of income (other than a current job or self-employment). Examples of other income may include, but are not limited to payments from an annuity or trust, alimony/maintenance, charity, child support, disability/sick pay, interest/dividends, pension/retirement, worker's compensation, money from another person, interest on loan/promissory note repayments, rental income, severance pay, Supplemental Security Income (SSI), Social Security, Veterans Benefits, unemployment insurance, etc. List the gross amount, before taxes and deductions.

Type of Income	Who Gets Income	Gross Monthly Amount	Company Name / Address
	☐ You ☐ Spouse	$	
	☐ You ☐ Spouse	$	
	☐ You ☐ Spouse	$	
	☐ You ☐ Spouse	$	
	☐ You ☐ Spouse	$	
	☐ You ☐ Spouse	$	

SECTION 16 – OUT-OF POCKET MEDICAL EXPENSES

List the types of out-of-pocket medical expenses you and/or your spouse have such as co-payments or the cost of over-the-counter drugs. You must indicate if the item is an impairment related work expense. By impairment related work expense, we mean any item you or your spouse needs due to your impairment in order to do your job. The expense cannot be one that a similar worker without a disability would have, such as uniforms. Do not list medical insurance premiums or items for which you are reimbursed.

Expense 1

Do you and/or your spouse have any medical expenses? ☐ Yes ☐ No If yes, complete the information below. If no, stop and go to Section 17.			
Type of Medical Expense	Amount of Expense $	Who has the expense? ☐ You ☐ Your spouse	How often paid?
Is this an impairment related work expense? ☐ Yes ☐ No			

Expense 2

Type of Medical Expense	Amount of Expense $	Who has the expense? ☐ You ☐ Your spouse	How often paid?
Is this an impairment-related work expense? ☐ Yes ☐ No			

SECTION 17 – SHELTER / UTILITY COST

In this section, tell us about your household expenses. Some of these may include, but are not limited to mortgage/rent, property taxes, condominium fees, homeowner/renter insurance, water or sewer bills, gas/electric bills, and heating cost. If shared expense, be sure to list actual amount paid per person.

Type of Expense	Who has Expense	Amount of Expense	How Often Paid
		$	
		$	
		$	
		$	
		$	
		$	

SECTION 18 – OTHER ALLOWABLE EXPENSES

In this section, tell us about any other allowable expenses you and/or your spouse have. Allowable expenses may include court ordered family support/alimony, court ordered attorney and guardian fees, court ordered child support, and other support obligations.

Who has an Expense	What is the Expense	Amount of Expense	How Often Paid
		$	
		$	
		$	

SECTION 19 – MEDICAL INSURANCE INFORMATION

You must report any third party that may be liable to pay for medical care for you and/or your spouse, including private health insurance, nursing home/long term care insurance, Medicare or Medi-GAP insurance. You must cooperate by giving information as requested. This also includes any insurance that may be available through an employer group health plan or long-term care policy.

Do you and/or your spouse have Medicare Part A or Part B coverage? ☐ Yes ☐ No				
Who has the coverage?	Medicare ID Number	Premium Amount	Part A Start Date	Part B Start Date
		$		
		$		

Do you and/or your spouse have Medicare Part D coverage? ☐ Yes ☐ No			
Who has the coverage?	Name of Plan	Start Date	Monthly Premium Amount
			$
			$

Do you have private health or long term care insurance? ☐ Yes ☐ No			
Name – Policy Holder	Date Coverage Began	Premium Amount $	How Often Paid
Policy/Insurance Number	Group Number		
Name and Address of Insurance Company			

Does your spouse have private health or long term care insurance? ☐ Yes ☐ No			
Name of Policy Holder	Date Coverage Began	Premium Amount $	How Often Paid
Policy/Insurance Number	Group Number		
Name and Address of Insurance Company			

If eligible, would you and/or your spouse like the State of Wisconsin to pay your Medicare premiums?
☐ Yes ☐ No

Have you or your spouse incurred medical bills as a result of an accident or do you have an accident claim pending?
☐ Yes ☐ No If yes, check all that apply. ☐ Incurred bills ☐ Claim or settlement pending

SECTION 20 – CHECKLIST

Please read and check each off before you mail your application. This could save time in processing your application.

- ☐ Read the Rights and Responsibilities Section.
- ☐ Complete all applicable sections of the application.
- ☐ Enclose with your application any current proof, additional documentation or sheets of paper used to complete the application. If requesting backdating, be sure to include verification for those months.
- ☐ Include a copy of your immigration status documents, if you are not a U.S. citizen.
- ☐ Complete either the Appoint, Change, or Remove an Authorized Representative: Person form, F-10126A, or the Appoint, Change, or Remove an Authorized Representative: Organization form, F-10126B, found in this application packet, or enclose legal documentation that allows you to be the appointed guardian or durable power of attorney for finances, if you are acting on behalf of an applicant. Health Care Power of Attorney is not valid for the Medicaid Application purposes.
- ☐ Complete the enclosed Medicaid Backdated Coverage Request page if you are requesting backdated coverage.
- ☐ Keep pages 1 through 7 and the Medicaid Change Report, F-10137, of this application packet for future use.
- ☐ Sign and date the application form.

SECTION 21 – SIGNATURE

By signing the application, you are authorizing the local agency and the Wisconsin Department of Health Services to request any information that is appropriate and necessary for the proper administration of the Medicaid program under Wisconsin law. Any person, including financial institutions, credit reporting agencies or educational institutions may release this information, unless it is prohibited or restricted by law. Your authorization remains in effect until:

1. Your Medicaid application is denied,
2. Your Medicaid eligibility ends, or
3. You inform the Department of Health Services in writing that you wish to end your authorization.

Also, your signature on the application means that you understand the questions and statements on this application form and the penalties for giving false information or breaking the rules. By signing the application, you are certifying, under penalty of perjury and false swearing, that all of your answers are correct and complete to the best of your knowledge, including information provided about the immigration and citizenship status of each household member applying for benefits. Also, you understand and agree to provide documents to prove what you have said.

SIGNATURE – Applicant/Representative/Guardian/Power of Attorney/Conservator	Date Signed
SIGNATURE – Applicant/Representative/Guardian/Power of Attorney/Conservator	Date Signed
SIGNATURE – Witness (Needed if signed with an "X" above)	Date Signed
SIGNATURE – Witness (Needed if signed with an "X" above)	Date Signed

Note: The applicant's signature must be witnessed by two people, if signed with an "X."

A Community Spouse must sign the application to be considered a valid application for Long Term Care Medicaid or Institutional Medicaid.

Mail or Fax Applications and/or Proof/Verifications

If you live in Milwaukee County:	If you **do not** live in Milwaukee County
MDPU PO Box 05676 Milwaukee WI 53205	CDPU PO Box 5234 Janesville, WI 53547-5234
Fax: 888-409-1979	Fax: 855-293-1822

You can also scan and/or upload any proof online at access.wi.gov.

MEDICAID BACKDATED COVERAGE REQUEST

If you meet all program rules and you are enrolled in Medicaid, you may be able to get Medicaid benefits for up to three months before your application date. The application date is the business day the application is received by the agency. You must provide all the needed information for the prior months and you must meet all program rules for those months. If you want help paying for health care for any of the three months before your application date (backdated coverage), make sure you checked the "Yes" box in Section 3 of the application where this question is asked and complete this form.

If there are any differences in circumstances in any of the three months before your application month list the differences below for each month that you are requesting backdated coverage. Differences may include: address, household composition, vehicles, insurance, income, assets, etc.

What is the date you want your enrollment to begin? _____

Month Prior to Application

Are you requesting backdated coverage for this month? ☐ Yes ☐ No
Is any information included in your application different in this month from the application month?
☐ Yes ☐ No If "Yes," describe the changes.

Two Months Prior to Application

Are you requesting backdated coverage for this month? ☐ Yes ☐ No
Is any information included in your application different in this month from the application month?
☐ Yes ☐ No If "Yes," describe the changes.

Three Months Prior to Application

Are you requesting backdated coverage for this month? ☐ Yes ☐ No
Is any information included in your application different in this month from the application month?
☐ Yes ☐ No If "Yes," describe the changes.

SIGNATURE – Applicant/Representative/Guardian/Power of Attorney/Conservator	Date Signed

WISCONSIN DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-10126A (06/2018)

REP

APPOINT, CHANGE, OR REMOVE AN AUTHORIZED REPRESENTATIVE: PERSON

Fill out and submit the Appoint, Change, or Remove an Authorized Representative: Person form, F-10126A, to appoint, change, or remove a person as your authorized representative.

To appoint an **organization** as your authorized representative, fill out and submit the Appoint, Change, or Remove and Authorized Representative: Organization form, F-10126B, instead.

If you have a legal guardian, conservator, or power of attorney, that person must appoint an authorized representative for you if you want someone besides them to be your authorized representative.

The personally identifiable information provided on this form will only be used for the direct administration of Wisconsin Medicaid, BadgerCare Plus, FoodShare, Family Planning Only Services, and Caretaker Supplement.

Authorized Representative Information
An authorized representative is a person who is familiar with your household's circumstances and that you trust to act on your behalf. Anyone can serve as your authorized representative **except** for the following:

- People who are disqualified for an intentional FoodShare program violation cannot serve as an authorized representative during their disqualification period unless no one else is able to serve as an authorized representative.
- Homeless meal providers cannot serve as an authorized representative for a homeless food unit. (A food unit is one or more people who live together and buy and make food together.)
- Agency employees who help determine eligibility or benefits may not serve as an authorized representative. Special written approval may be given for them to serve as an authorized representative in certain circumstances though.
- Retailers who are authorized to accept FoodShare benefits may not serve as an authorized representative.

Once appointed, your authorized representative may do any or all of the following on your behalf:

- Apply for or renew benefits
- Report changes to your information
- Work with your agency on any matters related to your benefits
- File grievances and appeals about your eligibility for programs you are applying for or are enrolled in

You can also choose to have your authorized representative get copies of letters about your eligibility and benefits, get your ForwardHealth card, work with ForwardHealth Member Services and your HMO (health maintenance organization) on your behalf, and file grievances and appeals about your health care services (for example, treatment and bills).

You do **not** need to have an authorized representative to apply for or get benefits.

The authorized representative you appoint on this form can act on your behalf for **any** of the following programs: Wisconsin Medicaid, BadgerCare Plus, FoodShare, Family Planning Only Services, and/or Caretaker Supplement. If you are enrolled in any of these programs **and** Wisconsin Works (W-2), your authorized representative may also act on your behalf for W-2.

The authorized representative you appoint on this form **cannot** act on your behalf for the Wisconsin Shares Child Care Subsidy Program. However, if you want your authorized representative to get copies of letters about your eligibility and benefits and you are enrolled Wisconsin Shares in addition to one of the other programs, your authorized representative will be able to look at or get copies of letters from Wisconsin Shares.

Form Instructions
If required information is missing on this form, including any of the signatures, the form will be considered incomplete, and your authorized representative **cannot** act on your behalf.

Section 1 – You need to complete Section 1. You will need to choose if you are appointing, changing, or removing an authorized representative. You will also need to provide your name and date of birth so we can identify you. If you are appointing or changing an authorized representative, choose if you want your authorized representative to get copies of your letters. If you are also applying for or are enrolled in a health care program, choose if you want to let your authorized representative take more actions on your behalf. Make sure you read and agree to the protected health information authorization before you check Yes. Next, read the statements of understanding. If you agree, sign and date the form.

REP

Section 2 – Your authorized representative needs to complete Section 2. Your authorized representative will need to provide his or her name and contact information. He or she will also need to read the statements of understanding and sign and date the form if he or she agrees to the statements.

Section 3 – If you are appointing or changing an authorized representative, you will need to have someone besides your authorized representative watch you sign this form. This person is called a witness. If you sign this form with an "X," then two witnesses must watch you sign the form. The witness or witnesses will need to provide their name, signature, and the date they signed the form.

Form Submission
You can submit your completed form in one of the following ways:

Online

Scan all pages of the form to ACCESS. You can do this through your ACCESS account, which you can log into at access.wi.gov. (**Note:** If you do not have an ACCESS account, you can go to access.wi.gov and create one.)

Note: You can only scan forms to ACCESS at certain times. If you are unable to scan the form to ACCESS, submit the form using one of the other ways.

Mail

- If you live in **Milwaukee County**, mail the form to:
  MDPU
  P.O. Box 05676
  Milwaukee, WI 53205

- If you do **not** live in Milwaukee County, mail the form to:
  CDPU
  P.O. Box 5234
  Janesville, WI 53547

Fax

- If you live in **Milwaukee County**, fax the form to 888-409-1979.
- If you do **not** live in Milwaukee County, fax the form to 855-293-1822.

In Person

Take the form to your agency. Your agency contact information is on the Wisconsin Department of Health Services (DHS) website at www.dhs.wisconsin.gov/forwardhealth/imagency/index.htm.

For more information about authorized representatives, go to the DHS website at www.dhs.wisconsin.gov/forwardhealth/representative-types.htm.

SECTION 1 To Be Filled Out by Applicant/Member

I am:

☐ Appointing an authorized representative. You must fill out **all** of Section 1.

☐ Changing my authorized representative. You must fill out **all** of Section 1. Make sure you write in the name of your new authorized representative in Part B.

☐ Removing my authorized representative. You must fill out **Part A and E** of Section 1. Leave Part B and C blank.

Part A: Personal Information

Name – Applicant/Member (Last, First, Middle Initial)

Date of Birth	Case Number (if you have one)

REP

Part B: Authorization Information

I appoint the following person to be my authorized representative:

I want my authorized representative to get copies of letters about my eligibility and benefits.

☐ Yes ☐ No

If yes, I want the copies to be sent in the following language:

☐ English ☐ Spanish

Part C: Additional Authorization Information – Health Care Programs Only (Optional)

I am applying for or am enrolled in a **health care program** (for example, Wisconsin Medicaid, BadgerCare Plus, or Family Planning Only Services) and want my authorized representative to do all of the following:

- Get my ForwardHealth card instead of me.
- Enroll me in an HMO.
- Talk to ForwardHealth Member Services or my HMO about a bill, service, or other medical information, including protected health information. Make sure you read and agree to the protected health information authorization below before you check Yes.
- File grievances and appeals about my health care services (for example, treatment and bills).

☐ Yes ☐ No

Authorization for Use and Disclosure of Protected Health Information

By checking **Yes** above, I am authorizing the Wisconsin Department of Health Services and its contractors, including HMOs, to disclose (share) my protected health information with my authorized representative.

The information that I am authorizing to be shared may include the following types of information: claims, medical records, substance abuse care, reproductive care, mental health, communicable diseases, pharmacy services, HIV/AIDS, dental records, and developmental disabilities.

The information is being shared so my authorized representative can help me manage my health care benefits.

I understand that any information used or shared based on this authorization could be redisclosed (reshared) by the person or entity receiving the information and will no longer be protected by federal privacy regulations.

I understand that this authorization is voluntary and that I may refuse to authorize the release of my protected health information by checking No above. Checking No will not affect the provision of treatment, payment, enrollment in a health plan, or eligibility for benefits unless the authorization is necessary for determining eligibility for the program or enrollment in the program.

This authorization will continue until I remove the authorized representative on this form from being my authorized representative or let my agency know that I do not want my authorized representative to have access to my protected health information any longer. I can let my agency know in writing about this at any time; however, removing the authorization will not affect protected health information that has already been shared.

REP

Part D: Statements of Understanding

I understand and agree that:

- I have the right to choose any person I want to be my authorized representative.
- I can change or remove my authorized representative at any time. I must let my agency know in writing that I want to change or remove my authorized representative.
- I do not have to tell a person that I am removing him or her as my authorized representative.
- The authorized representative listed on this form will stay my authorized representative until I change or remove him or her.
- My authorized representative will have access to my personal information, such as my Social Security number, financial statements, and medical information, to help me manage my eligibility. If I agreed to the protected health information authorization above, I understand that my authorized representative will also have access to this information to help me manage my health care services (for example, treatment and medical bills).
- I must provide my authorized representative with true and accurate information.
- I am responsible for errors and incorrect information that my authorized representative reports. I understand that if either my authorized representative or I give false information or withhold information, I may:
  - Have to pay back benefits I should not have gotten.
  - Be fined.
  - Be banned from a program.
  - Be prosecuted for fraud.
- By signing this form, I am saying that I understand and agree to the statements above.

Part E: Signature and Date

SIGNATURE – Applicant/Member	Date Signed

SECTION 2 To Be Filled Out by Authorized Representative

Part A: Contact Information

Name – Authorized Representative (Last, First, Middle Initial)

Street Address

City	State	Zip Code

Phone Number (include area code)	Email Address (optional)

REP

Part B: Statements of Understanding

I understand and agree that:

- As an authorized representative, I am limited to doing any or all of the following on the applicant's or member's behalf:
  - Applying for or renewing benefits
  - Reporting changes
  - Working with the applicant's or member's agency on any benefit-related matters
  - Filing eligibility-related grievances and appeals
- I am expected to be familiar with the applicant's or member's circumstances.
- The applicant or member can remove me from being his or her authorized representative at any time.
- The applicant or member does not need to notify me that I have been removed from serving as his or her authorized representative.
- I am the applicant's or member's authorized representative until he or she requests a different authorized representative or chooses not to have an authorized representative.
- I must provide truthful and accurate information.
- If I provide inaccurate or false information, the applicant or member may need to repay any health care benefits received in error.
- If I intentionally violate program rules, I must repay any FoodShare benefits that were misused or received in error.
- I must comply with applicable state and federal laws concerning conflicts of interest and confidentiality of information.
- By signing this form, I am saying that I understand and agree to the statements above.
- By signing this form, I am saying that I will serve as the authorized representative for the applicant or member listed in Section 1.

Part C: Signature and Date

SIGNATURE – Authorized Representative	Date Signed

SECTION 3 To Be Filled Out by Witness(es)

Name – Witness (Last, First, Middle Initial)

SIGNATURE – Witness	Date Signed

Name – Witness (Last, First, Middle Initial) (if applicant/member signed with an X)

SIGNATURE – Witness	Date Signed

RESET FORM

USDA Joint Nondiscrimination Statement

This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and in some cases religion or political beliefs.

The U.S. Department of Agriculture also prohibits discrimination based on race, color, national origin, sex, religious creed, disability, age, political beliefs or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027), found online at: How to File a Complaint, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the State Information/Hotline Numbers (click the link for a listing of hotline numbers by State); found online at: SNAP Hotline.

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (800) 537-7697 (TTY).

This institution is an equal opportunity provider.

WISCONSIN DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-10126B (06/2018)

REP

APPOINT, CHANGE, OR REMOVE AN AUTHORIZED REPRESENTATIVE: ORGANIZATION

Fill out and submit the Appoint, Change, or Remove an Authorized Representative: Organization form, F-10126B, to appoint, change, or remove an organization as your authorized representative. To change the organization's contact person, either you or the organization must contact your agency. Your agency contact information is on the Wisconsin Department of Health Services (DHS) website at www.dhs.wisconsin.gov/forwardhealth/imagency/index.htm.

To appoint a **person** as your authorized representative, fill out and submit the Appoint, Change, or Remove an Authorized Representative: Person form, F-10126A, instead.

If you have a legal guardian, conservator, or power of attorney, that person must appoint an authorized representative for you if you want someone besides them to be your authorized representative.

The personally identifiable information provided on this form will only be used for the direct administration of Wisconsin Medicaid, BadgerCare Plus, FoodShare, Family Planning Only Services, and Caretaker Supplement.

Authorized Representative Information
An authorized representative is an organization that is familiar with your household's circumstances and that you trust to act on your behalf. Anyone can serve as your authorized representative **except** for the following:

- People who are disqualified for an intentional FoodShare program violation cannot serve as an authorized representative during their disqualification period unless no one else is able to serve as an authorized representative.
- Homeless meal providers cannot serve as an authorized representative for a homeless food unit. (A food unit is one or more people who live together and buy and make food together.)
- Agency employees who help determine eligibility or benefits may not serve as an authorized representative. Special written approval may be given for them to serve as an authorized representative in certain circumstances though.
- Retailers who are authorized to accept FoodShare benefits may not serve as an authorized representative.

Once appointed, your authorized representative may do any or all of the following on your behalf:

- Apply for or renew benefits
- Report changes to your information
- Work with your agency on any matters related to your benefits
- File grievances and appeals about your eligibility for programs you are applying for or are enrolled in

You can also choose to have your authorized representative get copies of letters about your eligibility and benefits.

You do **not** need to have an authorized representative to apply for or get benefits.

The authorized representative you appoint on this form can act on your behalf for **any** of the following programs: Wisconsin Medicaid, BadgerCare Plus, FoodShare, Family Planning Only Services, and/or Caretaker Supplement. If you are enrolled in any of these programs **and** Wisconsin Works (W-2), your authorized representative may also act on your behalf for W-2.

The authorized representative you appoint on this form **cannot** act on your behalf for the Wisconsin Shares Child Care Subsidy Program. However, if you want your authorized representative to get copies of letters about your eligibility and benefits and you are enrolled Wisconsin Shares in addition to one of the other programs, your authorized representative will be able to look at or get copies of letters from Wisconsin Shares.

Form Instructions
If required information is missing on this form, including any of the signatures, the form will be considered incomplete, and your authorized representative **cannot** act on your behalf

Section 1 – You need to complete Section 1. You will need to choose if you are appointing, changing, or removing an authorized representative. You will also need to provide your name and date of birth so we can identify you. If you are appointing or changing an authorized representative, choose if you want your authorized representative to get copies of your letters. Next, read the statements of understanding. If you agree, sign and date the form.

Section 2 – A person who can act on behalf of the organization needs to complete Section 2. The person will need to provide the organization's name and contact information as well as his or her own. The person will also need to read the statements of understanding and sign and date the form if the organization and contact person agree to the statements.

REP

Section 3 – If you are appointing or changing an authorized representative, you will need to have someone besides your authorized representative watch you sign this form. This person is called a witness. If you sign this form with an "X," then two witnesses must watch you sign the form. The witness or witnesses will need to provide their name, signature, and the date they signed the form.

Form Submission
You can submit your completed form in one of the following ways:

Online

Scan all pages of the form to ACCESS. You can do this through your ACCESS account, which you can log into at access.wi.gov. (**Note:** If you do not have an ACCESS account, you can go to access.wi.gov and create one.)

Note: You can only scan forms to ACCESS at certain times. If you are unable to scan the form to ACCESS, submit the form using one of the other ways.

Mail

- If you live in **Milwaukee County**, mail the form to:
  MDPU
  P.O. Box 05676
  Milwaukee, WI 53205

- If you do **not** live in Milwaukee County, mail the form to:
  CDPU
  P.O. Box 5234
  Janesville, WI 53547

Fax

- If you live in **Milwaukee County**, fax the form to 888-409-1979.
- If you do **not** live in Milwaukee County, fax the form to 855-293-1822.

In Person

Take the form to your agency. Your agency contact information is on the DHS website at www.dhs.wisconsin.gov/forwardhealth/imagency/index.htm.

For more information about authorized representatives, go to the DHS website at www.dhs.wisconsin.gov/forwardhealth/representative-types.htm.

SECTION 1 To Be Filled Out by Applicant/Member

I am:

☐ Appointing an authorized representative. You must fill out **all** of Section 1.

☐ Changing my authorized representative. You must fill out **all** of Section 1. Make sure you write in the name of your new authorized representative in Part B.

☐ Removing my authorized representative. You must fill out **Part A and D** of Section 1. Leave Part B blank.

Part A: Personal Information

Name – Applicant/Member (Last, First, Middle Initial)

Date of Birth	Case Number (if you have one)

REP

Part B: Authorization Information

I appoint the following organization to be my authorized representative:

I want my authorized representative to get copies of letters about my eligibility and benefits. Please note that the letters will be sent to the organization's contact person.

☐ Yes ☐ No

If yes, I want the copies to be sent in the following language:

☐ English ☐ Spanish

Part C: Statements of Understanding

I understand and agree that:

- I have the right to choose any organization I want to be my authorized representative.
- I can change or remove my authorized representative at any time. I must let my agency know in writing that I want to change or remove my authorized representative.
- I do not have to tell an organization that I am removing it as my authorized representative.
- The authorized representative listed on this form will stay my authorized representative until I change or remove them.
- My authorized representative will have access to my personal information, such as my Social Security number, financial statements, and medical information to help me manage my eligibility.
- I must provide my authorized representative with true and accurate information.
- I am responsible for errors and incorrect information that my authorized representative reports. I understand that if either my authorized representative or I give false information or withhold information, I may:
  - Have to pay back benefits I should not have gotten.
  - Be fined.
  - Be banned from a program.
  - Be prosecuted for fraud.
- By signing this form, I am saying that I understand and agree to the statements above.

Part D: Signature and Date

SIGNATURE – Applicant/Member	Date Signed

REP

SECTION 2 To Be Filled Out by Authorized Representative

Part A: Contact Information

Name – Organization

Street Address

City	State	Zip Code	Phone Number (include area code)

Name – Organization Contact (Last, First, Middle Initial)

Job Title – Organization Contact	Email Address – Organization Contact (optional)

Part B: Statements of Understanding

I understand and agree that:

- I am authorized to act on behalf of the organization listed in Section 2, Part A.
- As an authorized representative, the organization is limited to doing any or all of the following on the applicant's or member's behalf:
  - Applying for or renewing benefits
  - Reporting changes
  - Working with the applicant's or member's agency on any benefit-related matters
  - Filing eligibility-related grievances and appeals
- The organization is expected to be familiar with the applicant's or member's circumstances.
- The organization must report to the applicant's or member's agency any changes to the contact listed in Section 2, Part A.
- The applicant or member can remove the organization from being his or her authorized representative at any time.
- The applicant or member does not need to notify the organization that it has been removed from serving as his or her authorized representative.
- The organization is the applicant's or member's authorized representative until he or she requests a different authorized representative or chooses not to have an authorized representative.
- The organization and anyone acting on its behalf must provide truthful and accurate information.
- If the organization provides inaccurate or false information, the applicant or member may need to repay any health care benefits received in error.
- If the organization intentionally violates program rules, it must repay any FoodShare benefits that were misused or received in error.

REP

- The organization and anyone acting on its behalf must comply with applicable state and federal laws and regulations, including 42 C.F.R. Part 431, Subpart F; 42 C.F.R. § 447.10; and 45 C.F.R. § 155.260(f), concerning conflicts of interest and confidentiality of information.
- By signing this form, I am saying that I understand and agree to the statements above on behalf of the organization listed in Section 2, Part A.
- By signing this form, I am saying that the organization listed in Section 2, Part A will serve as the authorized representative for the applicant or member listed in Section 1.

Part C: Signature and Date

SIGNATURE – Organization Contact	Date Signed

SECTION 3 To Be Filled Out by Witness(es)

Name – Witness (Last, First, Middle Initial)

SIGNATURE – Witness	Date Signed

Name – Witness (Last, First, Middle Initial) (if applicant/member signed with an X)

SIGNATURE – Witness	Date Signed

RESET FORM

USDA Joint Nondiscrimination Statement

This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and in some cases religion or political beliefs.

The U.S. Department of Agriculture also prohibits discrimination based on race, color, national origin, sex, religious creed, disability, age, political beliefs or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027), found online at: How to File a Complaint, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the State Information/Hotline Numbers (click the link for a listing of hotline numbers by State); found online at: SNAP Hotline.

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (800) 537-7697 (TTY).

This institution is an equal opportunity provider.

WISCONSIN DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-10137 (07/2018)

CHG

WISCONSIN MEDICAID CHANGE REPORT

If you are receiving Medicaid, you must report any changes in the make up of your household (if anyone moves in or out of your household, if anyone gets married, becomes pregnant, or gives birth to a child), a change in address, income, assets or employment status **within 10 days.** If this report does not provide enough room to document a change, attach a sheet of paper with the additional information written on it to this report. You may also report changes online at access.wi.gov, by telephone or in person.

If you fail to report any changes or provide false information, you may be fined, have to pay back any Medicaid benefits you received that you should not have (even if you did not use your card), be prosecuted or all three. You may be required to provide proof of any changes you report.

Personally identifiable information will be used only for the direct administration of the Medicaid program.

Your Name	Case Number	Worker Name

SECTION 1 - CHANGE IN ADDRESS

If you have moved, you must report your new address.

Date of Change		New Telephone Number	
New Address - Street	City	State	Zip Code

SECTION 2 - CHANGE IN HOUSEHOLD COMPOSITION

You must report if anyone moves in or out of your household, if anyone gets married, becomes pregnant or gives birth to a baby (include information about the person who gave birth and the newborn.)

Name(s) (Last, First, MI)		Date of Change
Social Security Number (SSN)*	Date of Birth	Relationship to Case Head
Describe the Change		

*Providing or applying for an SSN is voluntary; however, any person who wants Wisconsin Medicaid but does not want to provide their SSN or apply for one will not be eligible for benefits, pursuant to Wisconsin Statutes section 49.82(2).

SECTION 3 - CHANGE IN ASSETS

You must report changes in your household's cash, bank accounts, bonds, stocks or other assets.

Name of Owner (Last, First, MI)		Date of Change
Type of Asset	Describe the Change	New Value or Amount $

Administrative Rule DHS 102.01 (6)

CHG

SECTION 4 – CHANGE IN RESOURCES/INCOME

You must report any income or resources you and/or your spouse have given away or sold for less than fair market value. Examples of resources include cash and cash gifts, real estate, stocks or bonds, an inheritance, etc.

Type of asset or income	Date sold or given away	Value of asset or income $
What did you get in return?		

SECTION 5 – CHANGE IN VEHICLES

You must report if you obtain, sell or give away a car, truck, motorcycle, boat, snowmobile, camper or another type of vehicle.

Name of Owner(s) (last, first, MI)			Date of Change
Type of Vehicle	Make	Model	Year
Describe Change (bought, sold, etc.)	Amount Received $	Fair Market Value* $	Amount Owed $

* By fair market value, we mean the amount that you would get if you sold it on the open market.

SECTION 6 - CHANGE IN INCOME

You must report a change in your gross income amount, a new source of income, changes in your employment status (part-time to full-time or full-time to part-time, loss of employment), changes in salary or rate of pay, changes in the amount of Social Security, Unemployment Insurance, Worker's Compensation, Veterans benefits, or any other change in the amount of money your household gets.

Name (Last, First, MI)	Date Income Changed
Source of Income	Monthly Amount $
How Often Paid ☐ Each Week ☐ Every Other Week ☐ Twice Each Month ☐ Once Each Month	

SECTION 7 - OTHER CHANGES

You must report any other changes that may affect your Medicaid eligibility. Examples of other changes include someone getting or dropping health insurance, someone becoming disabled or recovering from a disability. A change could also be a change in expenses such as an increase or decrease in health insurance premiums, medical costs or shelter costs.

Describe change	
Do you expect that the changes reported on this form will remain the same next month? ☐ Yes ☐ No If no, explain.	Date of Change

CHG

SECTION 8 – SIGNATURE

☐ Yes ☐ No I understand that there are penalties for hiding information or giving false information.	
☐ Yes ☐ No I understand that I may have to pay back any benefits I receive because I do not fully report changes in my circumstances (even if I do not use my Medicaid card).	
☐ Yes ☐ No I agree to provide proof of any changes, if asked to do so.	
☐ Yes ☐ No My answers on this report are correct and complete to the best of my knowledge.	
SIGNATURE – Applicant/Representative/Guardian/Power of Attorney/Conservator	Date Signed
Telephone Number (including area code)	

If this report does not provide enough room to document a change, attach a sheet of paper with the additional information written on it to this report.

Mail or Fax Applications, Forms and/or Proof/Verifications

If you live in Milwaukee County:

MDPU
PO Box 05676
Milwaukee WI 53205

Fax: 1-888-409-1979

If you **do not** live in Milwaukee County

CDPU
PO Box 5234
Janesville, WI 53547-5234

Fax: 1-855-293-1822

You can also scan and/or upload any proof online at access.wi.gov.

RESET FORM

WISCONSIN DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-16019A (10/2019)

APP

FOODSHARE WISCONSIN REGISTRATION

If you have a disability and need to access this application in an alternate format or need it translated to another language, please contact your agency. To get the phone number of your agency, go to www.dhs.wisconsin.gov/forwardhealth/resources.htm or call Member Services at 800-362-3002. Translation services are free of charge.

You may have another adult complete the application for you. If your FoodShare benefits stopped within the last 30 days, you may complete this application or contact your agency to find out if you can reopen your FoodShare benefits without completing this application.

If you are found eligible for FoodShare, your FoodShare benefits will start on the date your application is received by your agency. Your application will be processed as soon as possible but no later than 30 days from the date your application is received by your agency.

Name – Applicant (Last, First MI)		
Social Security Number (optional)	Date of Birth (mm/dd/yy – optional)	Phone Number (optional)
Street Address		
City	State	Zip Code
SIGNATURE – Applicant or Authorized Representative	Date Signed (mm/dd/yy)	

Priority FoodShare Services

If you need help right away, you may be able to get FoodShare benefits within seven days of providing your application and/or registration form if any of the following are true:

- Your household has $100 or less available in cash or in the bank and expects to receive less than $150 of income this month.
- Your household has rent, mortgage, or utility costs that are more than your total gross monthly income (available cash or in bank accounts) for this month.
- Your household includes a migrant or seasonal farm worker whose income has stopped.

Answer the following questions to be considered for faster service.

What is the total gross income expected by your household this month (before taxes or other deductions)?	$_____
What are your household's total available assets (for example, cash or money in checking or savings accounts or a lump sum of money)?	$_____
What is the amount your household pays in total for rent or mortgage this month?	$_____
Did your household receive Wisconsin FoodShare benefits this month?	☐ Yes ☐ No
Are you currently residing in a shelter for victims of domestic violence?	☐ Yes ☐ No
Did your household receive Supplemental Nutrition Assistance Program (SNAP, food stamps, electronic benefits transfer) benefits in another state this month?	☐ Yes ☐ No
Is anyone in your household a migrant or seasonal farm worker whose income has recently stopped and who does not expect to receive more than $25 in income in the next 10 days?	☐ Yes ☐ No

If your household has to pay utilities, answer the following questions.

If you pay rent, is heat included in your rent?	☐ Yes ☐ No

Check the box(es) for the utilities your household is required to pay and check "Yes" or "No" to tell us whether the utility is used to heat your home.

	Used for heat?			Used for heat?	
☐ Gas (natural)	☐ Yes	☐ No	☐ Fuel oil/kerosene	☐ Yes	☐ No
☐ Electric	☐ Yes	☐ No	☐ Coal	☐ Yes	☐ No
☐ Liquid propane gas	☐ Yes	☐ No	☐ Wood	☐ Yes	☐ No

Check the box(es) for the utilities your household is required to pay.

☐ Phone ☐ Water ☐ Sewer ☐ Trash removal ☐ Installation ☐ Other:_____

RESET FORM

You have the right to submit your application at any time. To set your filing date (which is the date your benefits can start) you must provide at least your name, address, and signature. You can then complete a full application online at access.wi.gov, by mail, by fax, by phone, or in person.

You will need to have an interview with your agency in person or over the phone in order to finish the rest of your application.

You may have to provide proof of some of your answers. See "Proof Needed" for a list of proof you may need to give us.

Mail or fax applications and/or proof/verifications to:

If you live in Milwaukee County:
MDPU
PO Box 05676
Milwaukee, WI 53205

Or fax: 888-409-1979

If you **do not** live in Milwaukee County:
CDPU
PO Box 5234
Janesville, WI 53547-5234

Or fax: 855-293-1822

You can also scan and upload any proof online at access.wi.gov.

If you want to apply for BadgerCare Plus or Medicaid, you can apply for these health care programs online at access.wi.gov at the same time you are applying for FoodShare benefits. Or you can complete a paper application for health care. Applications can be found online at www.dhs.wisconsin.gov/forwardhealth/resources.htm. Or you can get them by contacting your agency.

FOODSHARE WISCONSIN IMPORTANT INFORMATION

This application is for FoodShare benefits only. It is not an application for BadgerCare Plus, Family Planning Only Services, Medicaid, Wisconsin Shares Child Care Subsidy, or Wisconsin Works (W-2). You can apply for BadgerCare Plus, Family Planning Only Services, Medicaid, and Wisconsin Shares online at access.wi.gov at the same time you are applying for FoodShare. You must contact your agency to apply for W-2.

FoodShare is an entitlement. You do not have to apply for W-2 or other programs to be able to get FoodShare benefits. FoodShare benefits are available to help meet nutritional needs of low-income households. A household is usually made up of people who live together and share food. The amount of FoodShare benefits a household gets is based on the household's size and income. FoodShare benefits are issued on a Wisconsin QUEST card, which is used like a debit card at grocery stores that accept FoodShare.

You have the right to be notified of your enrollment status within 30 days of applying. You have the right to receive benefits within seven days if you qualify for immediate help.

You have the right to be treated with respect and not be discriminated against because of age, sex, race, color, disability, religious creed, national origin, or political beliefs.

You are responsible for:

- Answering all questions on the application completely and honestly and signing your name to certify, under penalty of perjury, that all your answers are true and correct.
- Providing proof of all information needed to determine eligibility.
- Reporting required changes within the time frame provided to you in your notices.
- Not putting your money or possessions in someone else's name to be able to receive benefits.
- Not selling, trading, or giving away benefits.
- Using FoodShare benefits only to buy allowed items.

People who break FoodShare rules may be disqualified from the program, fined, imprisoned or all three.

USDA NONDISCRIMINATION STATEMENT
In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: https://www.ascr.usda.gov/how-file-program-discrimination-complaint, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

WRITTEN NOTICE
You have the right to receive a written notice from your agency before any action is taken to stop or reduce your FoodShare benefits. For most actions, you will receive a letter at least 10 days before the action is taken.

FAIR HEARING
You have the right to a fair hearing if you disagree with any agency action. You may request a fair hearing verbally by calling 608-266-7709 or sending a letter requesting a hearing to:

Department of Administration
Division of Hearing and Appeals
PO Box 7875
Madison, WI 53707-7875
Fax: 608-264-9885

Your request must be received within 90 days of the agency's effective date for your FoodShare benefits **or**, if you do not agree with the amount of your FoodShare benefits, at any time while you are getting benefits.

The Request for Fair Hearing form may be downloaded at www.dhs.wisconsin.gov/forwardhealth/resources.htm.

In most cases, if your fair hearing request is received by the Division of Hearings and Appeals prior to the action's effective date, your FoodShare benefits will not stop or be reduced. You can ask that your benefits continue, at least until a decision is made about your appeal. During this time, if another unrelated change occurs, your FoodShare benefits may change. If another change occurs, you will get a new letter. If you are not satisfied with the fair hearing decision, you may appeal and request a second fair hearing. If the fair hearing decision ends or reduces your benefits, you may have to repay any benefits you got while your appeal was pending. You may ask not to receive continued benefits.

You may represent yourself or be represented at the hearing or conference by an attorney, friend, or anyone else you choose. We cannot pay for your attorney. However, free legal service may be available to you if you qualify. To learn more about free legal help, call 888-278-0633.

If you fail to appear or your representative fails to appear at the hearing without good cause, your appeal is considered abandoned and will be dismissed.

LEGAL GUARDIAN, CONSERVATOR, OR POWER OF ATTORNEY
If you have a legal guardian, conservator, or power of attorney, that person can fill out and submit this form on your behalf. That person would also need to submit documents about his or her appointment along with this form.

AUTHORIZED REPRESENTATIVE
You may have an authorized representative fill out and submit this form on your behalf. To appoint an authorized representative, fill out either the Appoint, Change, or Remove an Authorized Representative: Person form, F-10126A, **or** the Appoint, Change, or Remove an Authorized Representative: Organization form, F-10126B. Both forms are available at www.dhs.wisconsin.gov/library/F-10126.htm. If an authorized representative provides wrong information that is used to determine your FoodShare benefits, either you or your authorized representative will be responsible for any mistakes.

COLLECTION OF INFORMATION / USE OF SOCIAL SECURITY NUMBERS / PERSONALLY IDENTIFIABLE INFORMATION
The collection of this information, including the Social Security number of each household member, is authorized under the Food and Nutrition Act of 2008, as amended, 7 U.S.C. 2011-2036. The information will be used to determine whether your household is eligible or continues to be eligible to participate in SNAP. We will verify this information through computer matching programs. This information will also be used to monitor compliance with program regulations and for program management.

The information will be used to determine if your household can get or keep getting benefits.

Information you give will be verified through computer matching programs. This information will also be used to monitor compliance with program rules and for program management.

This information may be disclosed to other federal and state agencies for official examination and to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law.

If a SNAP claim arises against your household, the information on this application, including all Social Security numbers, may be referred to federal and state agencies, as well as private claims collection agencies, for claims collection action.

Providing the requested information, including the Social Security numbers of each household member, is voluntary. However, failure to provide a Social Security number will result in the denial of SNAP benefits to each individual failing to provide a Social Security number. Any Social Security numbers provided will be used and disclosed in the same manner as Social Security numbers of eligible household members.

Your Social Security number will not be shared with the United States Citizenship and Immigration Services (USCIS).

IMMIGRATION STATUS
To be able to get FoodShare, you must be a U.S. citizen or have qualifying immigration status with USCIS. Immigration status of all individuals applying for FoodShare will be verified with USCIS and may affect FoodShare enrollment and benefits. Immigration status will **not** be verified with USCIS for any individual who is not applying for FoodShare or who indicates he or she does not have qualifying immigration status with USCIS. However, income from those individuals may affect FoodShare enrollment or benefits.

QUALITY CONTROL REVIEW
Your FoodShare case may be randomly selected by the Wisconsin Department of Health Services for a quality control review. A FoodShare quality control review is a review of your FoodShare case to make sure the agency that enrolled you in FoodShare issued your benefits correctly and is following the rules set by the federal government. Federal law states

that you must cooperate with the quality control review. If you do not give the information requested and do not cooperate with the review, your FoodShare case may be closed. If this happens, you will be told how long your case may be closed.

WORK REGISTRATION REQUIREMENT FOR INDIVIDUALS AGES 16 THROUGH 59

All FoodShare applicants and members ages 16 through 59 must be registered for work unless they are considered exempt. You will be registered for work at the time you are determined eligible for FoodShare unless you meet an exemption.

You meet an exemption from the work registration requirements if **any** of the following is true:

- You are 16 or 17 years old and are not the primary person in the FoodShare group.
- You are 16 or 17 years old and are the primary person in the FoodShare group but are enrolled in school or in an employment and training program at least half time.
- You are found to be unfit for work. This applies if:
  - You get temporary or permanent disability benefits from the government or a private source.
  - You are found to be mentally or physically unable to work by your agency.
  - You are verified as unable to work by a statement from a health care professional or social worker.
- You are enrolled in W-2 and complying with the W-2 work requirements.
- You are the primary caregiver for a dependent child younger than age 6 (whether the child lives in your home or out of your home). However, if you and another person both have parental control of the child, only one of you can be exempt from the work registration requirements as the primary caregiver of that child.
- You are the primary caregiver for another person who cannot care for himself or herself (whether the person lives in your home or out of your home).
- You have applied for or are receiving unemployment compensation.
- You are regularly taking part in an alcohol or other drug abuse treatment or rehabilitation program.
- You are working 30 or more hours per week or earning wages equal to 30 or more hours per week at the federal minimum wage.
- You are enrolled at least half time in a recognized school, training program, or institution of higher education.

You may need to provide proof to your agency if you meet one of these exemptions. Although registration for work is required, taking part in a work program is voluntary.

WORK REGISTRATION REQUIREMENT SANCTION

If you do not comply with the work registration requirements and you do not meet an exemption, you will not be able to get FoodShare benefits for a specified sanction period. This includes if you voluntarily and without good cause do any of the following:

- Turn down a suitable job offer
- Quit a job of 30 or more hours per week (or a job with earnings equal to 30 hours per week at the federal minimum wage)
- Reduce your work hours to less than 30 hours per week (or your earnings to less than 30 times the federal minimum wage)
- Take part in W-2 but do not meet the W-2 program work requirements
- Apply for or get unemployment benefits but do not meet the unemployment compensation program work requirements

If, during the sanction period, you move to another FoodShare household, the remainder of your sanction period will transfer with you to that household. The length of a sanction period is:

- One month for the first sanction.
- Three months for the second sanction.
- Six months for the third or subsequent sanctions.

You can end a sanction period early if you become exempt from the work registration requirements.

You will need to reapply for FoodShare if you want to get benefits after the sanction period ends. If you are part of a FoodShare group, you will need to let your worker know to update your case instead of having to reapply.

WORK REQUIREMENT FOR ABLE-BODIED ADULTS AGES 18 THROUGH 49
Certain adults ages 18 through 49 with no minor children living in the home may only get three months of time-limited FoodShare benefits in a 36-month (three-year) period unless they meet the FoodShare work requirement or are considered exempt. This work requirement is different from the work registration requirement.

There are three ways to meet the work requirement:
1. Work at least 80 hours each month.
2. Take part in an allowable work program at least 80 hours each month, such as:
   - FoodShare Employment and Training (FSET).
   - W-2.
   - Certain programs under the Workforce Innovation and Opportunity Act (WIOA).
3. Both work and take part in an allowable work program for a combined total of at least 80 hours each month.

You will get information about the FSET program if you are enrolled in FoodShare.

You may be considered exempt and may not need to meet the work requirement if any of the following is true:
- You are living with a child under age 18 who is part of the same FoodShare household.
- You are the primary caregiver for a person who cannot care for himself or herself.
- You are the primary caregiver for a dependent child under age 6.
- You are physically or mentally unable to work. This includes being homeless long term. Being homeless long term means you will not have a regular place to stay for the next 30 nights.
- You are pregnant.
- You are receiving or have applied for unemployment insurance.
- You are taking part in an alcohol or other drug abuse (AODA) treatment or rehabilitation program.
- You are enrolled in an institution of higher learning at least half-time.
- You are age 18 or older attending high school at least half-time.
- You are enrolled in W-2 and complying with W-2 requirements.
- You are working 30 or more hours per week or are earning wages equal to 30 or more hours per week at the federal minimum wage.
- You are living in an unemployment exemption county or are a tribal member living on tribal land or a reservation that has an unemployment exemption. These areas have an unemployment rate higher than the national average. For a list of the unemployment exemption counties and tribal lands or reservations, go to www.dhs.wisconsin.gov/fset/exemptions.htm.

  Note: You may need to provide proof that you have an exemption.

JOB CENTER
Job Center is available to you. Job Center is the largest source of job openings in Wisconsin. Visit the Job Center website at jobcenterofwisconsin.com, or you can use touch-screen computers at your local job center. To find a job center near you, call 888-258-9966 (toll free).

COMPUTER CHECK
Information on your application will be subject to verification through the state income and eligibility verification system. If you work, job income and wages you report will be checked by computer against wages your employer reports to the Department of Workforce Development. The IRS, Social Security Administration, and Unemployment Insurance Division are also contacted about income and assets you may have. Information from these agencies may affect your household's enrollment and/or benefit amount.

If any information you give is found to be incorrect, you may be denied FoodShare benefits and/or be subject to criminal prosecution for knowingly providing false information. You must repay any benefits you get if you gave false information. If a FoodShare claim is made against your household, information on the application, including all Social Security numbers, may be referred to federal and state agencies, as well as private collection agencies, for claims collection action.

FOODSHARE PENALTY WARNING

Any member of your household who intentionally breaks any of the following rules can be barred from FoodShare for 12 months after the first violation, 24 months after the second violation or for the first violation involving a controlled substance, and permanently for the third violation.

- **Giving false information or hiding information to get or continue to get FoodShare benefits**
- **Trading or selling FoodShare benefits**
- **Altering cards to get benefits you are not entitled to receive**
- **Using FoodShare benefits to buy nonfood items like alcohol or tobacco**
- **Using another person's FoodShare benefits, identification cards, or other documentation**

Depending on the value of the misused benefits, you can also be fined up to $250,000, imprisoned up to 20 years, or both. A court can also bar you from FoodShare Wisconsin for an additional 18 months. You will be permanently disqualified if you are convicted of trafficking FoodShare benefits of $500 or more. You will not be able to take part in FoodShare Wisconsin for 10 years if you are found to have made a fraudulent statement or representation with respect to identity and residence to receive multiple benefits at the same time. Fleeing felons and probation and parole violators are not able to take part in FoodShare Wisconsin. You may also be subject to further prosecution under other applicable federal laws.

If you trade (buy or sell) FoodShare benefits for a controlled substance or illegal drugs, you will be barred from the FoodShare program for a period of two years for the first finding and permanently for the second finding. If you trade (buy or sell) firearms, ammunition, or explosives, you will be barred from FoodShare Wisconsin permanently.

PROOF NEEDED

Enrollment in FoodShare cannot be determined until you provide proof of certain answers. The list below shows what proof is needed and some of the items you can use.

- If your interview is at the agency, please bring as many items of proof as you can from the list below.
- If your interview is by phone, you will be sent a list of what you will need to provide proof of after your phone interview.

If you are not able to get the items you need, tell your agency what items you are not able to get, and your agency can help you. You may be asked to give proof of items not listed below. If so, your agency will send you a list of other proof that is needed.

Identity

- Driver's license
- Birth certificate
- Passport or U.S. citizen card
- Paycheck
- Employee ID
- Hospital record

Earned Income

- All check stubs received in the last 30 days
- A signed statement from employer that includes gross earnings and pay dates expected in the next 30 days
- Employer Verification of Earnings form

Other Income

(for example, unemployment insurance, disability insurance, Social Security, retirement, veterans benefits, military allotments)

- Award letter
- Copy of last check

The following items may be required to get a credit.

Housing Costs and Utility Bills

- Current rent receipt with landlord's name and phone number on it
- Lease or mortgage papers
- Real estate property tax statement
- Utility bills

Child Support

(received or paid in a state other than Wisconsin)

- Court order papers or other record of payment
- Payment record from other state

If you are age 60 or over, blind, or a person with a disability, you may get a credit for certain medical costs.

Medical Costs / Expenses

Medical costs include, but are not limited to, the following:

- Hospital, medical, dental, and vision services
- Premiums for health insurance, Medicare premiums, and costs for prescriptions drug plans
- Prescription and over-the-counter medicine
- Nursing home and home health services
- Medical equipment and supplies
- Transportation and lodging costs to get medical care
- Related cost for a specially trained service animal
- Lifeline/Medic Alert costs if prescribed by a health care professional
- Billing statement
- Itemized receipts
- Medicine or pill bottle with price on label
- Health insurance policy showing premium, coinsurance, co-payments, or deductible
- Statement from pharmacy
- Repayment agreement with provider
- Statement from doctor verifying over-the-counter drug was prescribed
- Bill for services of a visiting nurse, homemaker, or home health aide
- Lodging and/or transportation receipts for obtaining medical treatment or services
- Bill or receipts for animal food, training, or veterinarian services for a specially trained service animal.