WISCONSIN MEDICAID FOR THE ELDERLY, BLIND AND DISABLED APPLICATION / REVIEW INSTRUCTIONS

This is a Medicaid application for persons who are age 65 years or older, blind or have a disability. This is not an application for FoodShare Wisconsin. If you are interested in applying for FoodShare benefits, you must contact your local county/tribal social or human services agency (local agency).

If you have a disability and need to access this information in an alternate format, or if you need it translated to another language, call 1-608-266-3356 (voice) or 1-608-266-2555 (TTY). These services are free of charge.

If you need help filling out this application or wish to answer the questions in person or over the telephone, contact your local county/tribal social or human services agency. For other questions regarding Medicaid for persons who are elderly, or blind or have a disability, please call the Recipient Hotline at 1-800-362-3002. Information is also available on the Department of Health and Family Services internet site at: http://dhfs.wisconsin.gov/medicaid.

HOW TO USE THIS FORM

1. Read instructions completely before completing application.
2. Print clearly. Use blue or black ink.
3. Do not write in the shaded sections**.**
4. You may authorize a representative to apply for you. If you do want to authorize a representative, complete and send the Authorized Representative form (HCF 10126) with your application. This form authorizes a representative to complete and sign the application for you. A legal guardian, conservator or power of attorney may apply for an individual without authorization by the individual. If you are applying on someone's behalf, complete the application as if you were that person.
5. Enter information about you and your spouse.
6. Completely fill out application. There may be a delay in Medicaid benefits if the application is not complete. (Use the checklist on page 9 to ensure your application is complete.) If your application is not complete, your county/tribal social or human services agency will contact you for more information.

IMPORTANT INFORMATION

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

- Your application date is the date the signed application is received by your local county/tribal social or human services agency. A decision on your Medicaid eligibility 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 your benefits are based on your application date, if you are eligible. 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 eligibility requirements for those months. If you want help paying for health care for any of the past three months (backdated coverage), make sure you checked the "Yes" box on the first page of the application where you are asked, "Do you need help paying for your medical bills for the past three months" and complete the "Medicaid Backdated Coverage Request" form (HCF 10101B) found in this application packet.

- Learn more about your rights and responsibilities in the *Wisconsin Medicaid Program – Eligibility and Benefits* brochure (PHC 10025). If you do not have a brochure, you may get one at your local agency, by calling Medicaid Recipient Services at 1-800-362-3002, or by downloading one from the Medicaid Internet Site at http://dhfs.wisconsin.gov/medicaid1/publications.htm.

  If you have any questions about your rights and responsibilities contact your local agency or call Medicaid Recipient Services at 1-800-362-3002.

- If you are found eligible for Medicaid, you will need to complete a review at least once every 12 months to determine if you are still eligible for benefits. All changes, such as a change in income or assets or changes to your household, need to be reported to your local agency within 10 days. Changes can be reported using the "Medicaid Change Report" (HCF 10137) form, which can be found in this application packet.

SECTION I – Applicant Information
Personally identifiable information is used only for the direct administration of the Medicaid program.

Do you need help paying for health care received during the past three months?
Check "Yes" if you need help paying for health care during the past three months. (New applications only.) Check "No" if you do not. If you checked "Yes", additional information will be necessary to process your application. Complete the "Medicaid Backdated Coverage Request" (HCF 10101B) form found in this application packet.

Check the language in which you want eligibility notices printed.
Check "English" if you would like your notices printed in English. Check "Spanish" if you would like your eligibility notices printed in Spanish. If you need assistance with translating any eligibility notice you receive into a language other than English or Spanish, contact your local agency.

Language spoken in the home.
Print the name of the language spoken most often in your home.

Are there minor children living in the home?
Check "Yes" if there are minor children living in the home. Check "No" if there are not any minor children living in the home.

Date Received
Do not fill in shaded area.

RFA Number
Do not fill in shaded area.

Name of Person Applying for Aid
Print last name, first name and middle initial of the person applying for Medicaid.

Telephone Number
Print your 10-digit telephone number (include area code).

Address
Print your address, street, city, state and zip code.

Mailing Address
Print the mailing address of where you would like information sent regarding your Medicaid eligibility and benefits. This may be your current address, the current address of your authorized representative or an alternative address to which your mail is sent.

SECTION II – General Information
Eligibility for Medicaid is based on information provided for you and if married, your spouse.

Name
Print the last name, first name and middle initial of the applicant and, if married, the applicant's spouse. List the applicant as "1" and, if married, the applicant's spouse as "2". (When completing the rest of the application continue to use the same format with information for the applicant as "1" and, if married, the applicant's spouse information as "2".)

List previous names used for you and/or your spouse.
Print any previously used married, maiden or other names.

Applying for Medicaid?
Check "Yes" if you are requesting Medicaid. Check "No" if you are not requesting Medicaid. Check "Yes" if your spouse is requesting Medicaid. Check "No" if your spouse is not requesting Medicaid.

Race or Ethnic Code
Print the code or codes that best describe the race or ethnic background for you and your spouse. This information is voluntary and will not be used to determine eligibility.

I = **American Indian/Alaskan Native**
W = **White** - White, not of Hispanic origin
P = **Hawaiian/Other Pacific Islander**
A = **Asian** - Japanese, Chinese, Korean, Indian, Pakistani, Sri Lankan, Bangladeshi, Tibetan, Nepali, Bhutan, Afganistan, Turkestan, Hmong, Lao, Vietnamese, Khmer, Thai, Burmese, Indonesian, Malaysian, Filipino
B = **Black/African American**
H = **Hispanic or Latino**

Social Security Number
Print a Social Security Number (SSN) for you and/or your spouse if applying for Medicaid. You only need to provide SSN information for those applying for Medicaid.

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 s. 49.82(2). SSN information will be used for the administration of the Medicaid program. Your SSN permits a computer check of your information with government agencies such as the federal Internal Revenue Service (IRS), the federal Social Security Administration (SSA) and Wisconsin's Department of Workforce Development. In addition, the Medicaid program will match your name and SSN with information provided by health insurance carriers to determine if you have other health insurance.

If you are applying only for emergency services because of your immigration status; you do not need to provide information about your SSN. Your name or SSN will not be shared with the United States Citizenship and Immigration Services (USCIS).

Gender
Check "Male" if you are a male. Check "Female" if you are a female.

Date of Birth
Print the birth date for you and your spouse. When entering the birth date, use the number of the month, day and year. (Example: If the birth date is February 23, 1970, enter 02/23/70.)

Marital Status
Print the code in the space provided that best describes your marital status.

A	=	Annulled	S	=	Single
D	=	Divorced	N	=	Never Married
LS	=	Legally Separated	W	=	Widowed
M	=	Married			

Are you a United States Citizen?
Check "Yes" if you are a U.S. citizen. Check "No" if you are not a U.S. citizen. Check "Yes" if your spouse is a U.S. citizen. Check "No" if your spouse is not a U.S. citizen. If you checked "No" for yourself or your spouse and are applying for Medicaid, submit a copy of both sides of the immigration documentation with this application. Information may be submitted to the USCIS for verification for those applying for Medicaid.

If not applying for Medicaid, proof of immigration status is not necessary.

Veteran
Check "Yes" if you are a veteran of the U.S. Armed Forces. Check "No" if you are not a veteran. Check "Yes" if your spouse is a veteran of the U.S. Armed Forces. Check "No" if your spouse is not a veteran.

Have you been determined blind or disabled by the Social Security Administration (SSA)?
Check "Yes" if you have been determined blind or disabled by the SSA. Check "No" if you are not blind or disabled. Check "Yes" if your spouse has been determined blind or disabled by the SSA. Check "No" if your spouse is not blind or disabled.

If you are disabled and not currently working, are you interested in working?
Check "Yes" if you are interested in working. Check "No" if you are not interested in working. Check "Yes" if your spouse is interested in working. Check "No" if your spouse is not interested in working.

Have you received Supplemental Security Income (SSI) in the past?
Check "Yes" if you have received SSI in the past. Check "No" if you have not received SSI in the past. Check "Yes" if your spouse has received SSI in the past. Check "No" if your spouse has not received SSI in the past.

SECTION III – Employment Income (Use a separate sheet of paper if additional space is needed.)
To have your eligibility determined, you and your spouse must provide information regarding your income.

Are you or your spouse working?
Check "Yes" if you or your spouse are working and complete the rest of Section III. Check "No" if you and your spouse are not working, and skip to Section IV.

Name of Person Employed
Print the last and the first name of the employed persons.

Employer
Print the employer's name and address for the employed persons.

Date Employment Began
Print the beginning date of employment for the person that is employed. When entering the date use the number of the month, day and year. (Example: If the date that employment began is May 2, 2000, enter 05/02/00.)

Gross Monthly Earnings Expected This Month
Print the expected monthly gross earnings (before taxes and deductions) for this month for each employed person. Round to the nearest dollar.

Gross Monthly Earnings Expected Next Month
Print the expected monthly gross earnings (before taxes and deductions) for next month for each employed person. Round to the nearest dollar.

SECTION IV – Self-Employment (Attach an additional sheet if more space is needed.)
Are you or your spouse self-employed?
Check "Yes" if you are self-employed. Check "No" if you are not self-employed. Check "Yes" if your spouse is self-employed. Check "No" if your spouse is not self-employed. If you answered "Yes" for you and/or your spouse to the above question complete the rest of Section IV.

Self-Employed Person
Enter the last and first name of the person who is self-employed.

Business Name and Address
Enter the name and address of the business for the person who is self-employed.

Type of Business
Enter the type of business for each person who is self-employed.

Net Annual Income
Enter the net annual income for each person that is self-employed. Net annual income equals gross annual income minus (employment expenses and depreciation). List the amounts reported to the Internal Revenue Service (IRS) on your tax forms. If you and/or your spouse did not file taxes last year, leave this box blank. Your local agency will contact you for more information.

Depreciation Amount Claimed
List any depreciation amounts reported to the IRS on your tax forms. If you and/or your spouse did not file taxes last year, leave this box blank. Your local agency will contact you for more information.

Net Income you Expect to Earn this Year
Enter the amount of net annual income (after taxes and deductions) the person who is self-employed expects to earn this year.

SECTION V – Unearned Income
Unearned income may include, but is not limited to alimony/maintenance, charity, child support, disability/sick pay, interest/dividends, pension/retirement, worker's compensation, money from another person, rental income, Supplemental Security Income (SSI), Social Security, veterans benefits and unemployment insurance.

Do you or your spouse have unearned income?
Check "Yes" if either you or your spouse have unearned income. Check "No" if neither you nor your spouse have unearned income. If you checked "Yes" to this question continue on to complete the rest of Section V.

Name of the Person Receiving the Income
Enter the last and first name of the person receiving the income.

Type/Source
List the type or source of the income. Examples include, but are not limited to Social Security, Unemployment Insurance, Railroad Retirement, Worker's Compensation, private retirement/pension, child support, interest income and Veterans Benefits.

Gross Monthly Amount
Enter the gross (before taxes and deductions) monthly amount received for the type or source of income listed.

SECTION VI – Household Expenses
List all household expenses. Expenses include, but are not limited to:

- Mortgage/Rent
- Property Taxes
- Family Support/Alimony
- Court Ordered Attorney and Guardian Fees
- Homeowner/Renter Insurance
- Child Support
- Phone Bills
- Water Bills
- Gas/Electric Bills
- Heating Costs

SECTION VII – Out-of-Pocket Medical Expenses

Describe the Medical Expense

List the types of expenses you have (for example, co-payments or cost of over the counter drugs). Do not include medical insurance premiums or items for which you are reimbursed.

Indicate if the Medical Service/Item is Necessary for You to Work

Check the "Work Expense" box, if the expense listed is for work. A work expense cannot be one that a similar worker without a disability would have, such as uniforms. Check the "Non-Work Expense" box, if the expense listed is non-work related.

Amount

Enter the dollar amount of the expense listed.

How Often Paid?

List if the expense is paid one-time, weekly, bi-weekly, monthly, bi-monthly, quarterly, yearly.

SECTION VIII – Assets

In this Section, list all assets owned by the applicant and his or her spouse. Include assets owned jointly with any other person. Do not include the value of personal household belongings, unless of unusual value. (Motor vehicle information should be listed in Section IX.) List all assets owned by the applicant and his or her spouse. Include assets owned jointly. Your assets may include, but are not limited to:

- Real Estate / Property
- Certificates of Deposit
- Trust Funds
- Life Estates
- Stocks
- Bonds
- IRAs
- Keogh Plans or Other Tax Shelters
- Personal Property of Exceptionally High Value
- Land Contracts
- Mortgage

For each item listed, enter the Name of the Owner(s), Current Dollar Value, Description of the Bank/Financial Institution Name and Account Number.

NOTE: You will be asked to provide documentation to verify assets. For example, you will need to provide a copy of your bank statement showing the value of your bank account on the date the application is completed, or something that shows the death benefit and cash value of your life insurance policy. 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 local agency and be asked to provide verification of missing, conflicting, or vague information, if the information would affect the decision about your Medicaid eligibility.

SECTION IX - Motor Vehicle Information

List all motor vehicles owned by applicant and his or her spouse. Include vehicles owned jointly with another person.

Type of Motor Vehicle

Enter the type of vehicle.

Year, Make and Model of Vehicle
Enter the year, make and model of vehicle.

Name of Owner(s)
Enter the last and first name of owner(s).

Amount owed on Vehicle?
Enter the dollar amount owed on the loan used to purchase this vehicle. If nothing is owed, enter $0.

Vehicle used to get to medical appointments?
Check "Yes" if the vehicle listed is used to get to medical appointments. Check "No" if the vehicle is not used to get to medical appointments.

Vehicle used for employment, training, school or farming?
Check "Yes" if the vehicle is used for employment, training, school or farming. Check "No" if the vehicle is not used for employment, training, school or farming.

SECTION X – Medical Insurance Information
As a condition of Medicaid eligibility you must report any third party that may be liable to pay for medical care for you and your spouse including private health 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 employee's group health plan or long-term care policy.

Do you or your spouse have medical insurance coverage?
Check "Yes" if you and/or your spouse have medical insurance coverage other than Medicaid. "Check "No" if both you and/or your spouse do not have medical insurance.

Date Coverage Began?
Enter the date (mm/dd/yy) the coverage began.

Premium Amount
Enter the dollar amount of the premium (round to nearest dollar).

Premium Paid
Enter how often the premium is paid (quarterly, monthly, bi-monthly, semi-annual or annually).

Who pays the premium?
Enter the first and last name of the person who pays the premium.

Policyholder
Enter the first and last name of the policyholder.

Who is covered?
Enter the first and last names of the persons covered under the policy.

Insurance Company Name and Address
Enter the insurance company name and address, including city, state and zip code.

Insurance Number
Enter the insurance number (this may be group, subscriber, member, division, etc).

Is anyone covered by the Wisconsin Health Insurance Risk Sharing Plan (HIRSP)?
Check "Yes" if anyone listed is covered by HIRSP. Check "No" if no one is covered by HIRSP.

Has anyone incurred medical bills as a result of an accident or does anyone have an accident claim or settlement pending?
Check "Yes, if there are medical bills as the result of an accident for you and/or your spouse. "Check "No" if there are no medical bills as the result of an accident.

If "Yes", check if you have incurred bills or have a claim or settlement pending for you or against you.
Check appropriate box.

Are you receiving Medicare Part A or B?
Check "Yes" if you are receiving Medicare Part A or B. Check "No" if not receiving Medicare Part A or B. Check "Yes" if your spouse is receiving Medicare Part A or B. Check "No" if your spouse is not receiving Medicare Part A or B.

Medicare Card Number
Enter Medicare Card numbers for those receiving Medicare.

If eligible, would you and/or your spouse like the State of Wisconsin to pay your Medicare Part B premium?
Check "Yes" if you and/or your spouse would like the State of Wisconsin to pay Part B premium (if eligible).
Check "No" if you and/or your spouse would not like the State to pay the Part B premium.

SECTION XI – Resource Transfer
Have resources or assets been sold or given away within the last three years?
Check "Yes" if resources or assets have been sold or given away within the last three years.
Check "No" if resources or assets have not been sold or given away within the last three years.

If you checked the "Yes" box, list type of resource or asset, the value and date it was sold or given away in Section XI. (Examples of some types of resources or assets are cash, checking and/or saving accounts, real estate, stocks or bonds.)

Has a trust been set up or funded in the last five years?
Check "Yes" if you and/or your spouse have a trust that has been set up or funded in the last five years. Check "No" if a trust has not been set up or funded in the last five years. If "Yes" was checked, enter the type of fund and the date (mm/dd/yy) the trust was established.

Do you want your spouse to keep the maximum allowed portion of your income, if you are institutionalized?
An institutionalized person (one who is in a skilled nursing facility, intermediate care facility, institution for mental disease, a hospital or participating in a community waivers program), who qualifies for Medicaid may be allowed to protect some of his/her income by transferring it to the community or non-institutionalized spouse, depending on the amount of income the community spouse has.

Check "Yes" if the institutionalized person will allow the maximum portion of income that is available to be transferred to the community spouse. Check "No" if the institutionalized person will not allow the maximum portion of income that is available to be transferred to the community spouse.

If "No" is checked, you can contact your local agency to inquire how much can be made available?

The next set of questions should ONLY be answered if you and/or your spouse are in a nursing home, hospital or institution for mental disease (IMD).

Name of Person in Nursing Home, Hospital or IMD
Enter the last and first name of the person in a nursing home, hospital or IMD.

Name of Nursing Home, Hospital or IMD
Enter the name of the nursing home, hospital or IMD.

Date of Admission
Enter the date of admission to the nursing home, hospital or IMD.

SECTION XII – Rights and Responsibilities

Your signature on the application means that you understand and acknowledge that the county/tribal social or human services agency, W-2 agency and the state Department of Health and Family Services is authorized to request any information that is appropriate and necessary for the proper administration of the Medicaid, programs authorized under Wisconsin law. Any persons, including financial institutions, credit reporting agencies, or educational institutions are authorized to release this information unless it is prohibited or restricted by law.

If you are found eligible for Medicaid, Wisconsin State law, with limited exceptions, requires the recovery of certain Medicaid benefits from your estate. The "Estate Recovery Program" brochure (PHC 13032) provides you with information on estate recovery. You may obtain a copy of the brochure from your local county/tribal social or human services agency or by contacting Medicaid Recipient Services at 1-800-362-3002. Certain benefits you receive in the community after age 55 and all Medicaid benefits you receive 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.

You have the right to an appeal by requesting a Fair Hearing if you do not agree with any action taken concerning your application or ongoing benefits. You may request a Fair Hearing, by writing to:

Wisconsin Department of Administration
Division of Hearings and Appeals
P.O. Box 7875
Madison, WI 53707-7875

Or by calling 1-608-266-7709

You may also contact the county/tribal social or human services agency and ask for a fair hearing verbally or in writing. The form can also be found on the Division of Hearings and Appeals internet site at http://dha.state.wi.us/home/.

DHFS is an equal service provider. To file a complaint of discrimination, contact:

Wisconsin Department of Health and Family Services
Affirmative Action and Civil Rights Compliance Office
1 West Wilson Street, Room 555
Madison, WI 53707-7850
Telephone: 1-608-266-9372 (voice) or 1-608-266-2555 (TTY)
Fax: 1-608-267-2147

Or

U.S. Department of Health and Human Services
Office of Civil Rights – Region V
233 N. Michigan Avenue Suite 240
Chicago, IL 60601
Telephone: 1-312-886-2359 (voice) or 1-312-353-5693 (TTY)

CHECKLIST

- ☐ Read the Rights and Responsibilities Section.
- ☐ Sign and date the application form.
- ☐ Enclose with your application any additional documentation or sheets of paper used to complete application.
- ☐ If you are not a U.S. citizen include a copy of your immigration status documents.
- ☐ If you are acting on behalf of an applicant, include the Authorized Representative form.
- ☐ Complete all applicable sections of the application.
- ☐ If you are requesting backdated coverage, enclose the Medicaid Backdated Coverage Request form (HCF 10101B).
- ☐ Keep pages 1 through 10 and the Medicaid Change Report form (HCF 10137), for future use.

Send the completed application to your local agency or Medicaid outstation site. Addresses for local agencies can be found at: http://dhfs.wisconsin.gov/medicaid1/contacts/index.htm or by calling Recipient Services at 1-800-362-3002.

OTHER PROGRAM INFORMATION

If you are interested in services for veterans, call 1-800-947-8347 (WIS-VETS) or contact your county Veteran Service Officer.

ACCESS TO ELIGIBILITY SUPPORT SERVICES FOR HEALTH AND NUTRITION (ACCESS)

To find out if you may be eligible for health and nutrition programs, visit the state of Wisconsin's web site at http://access.wisconsin.gov/access/.

This online screening tool will take you about 15 minutes to use. We'll ask you to tell us general information about yourself and the people in your home, the money you get from a job or other places, your housing costs and a few other bills. What you tell us will stay private and secure.

When you are finished, ACCESS will let you know about health and nutrition programs you and the people in your home might be eligible for. It will also explain now to apply for these programs. On the last page, you will be able to print out a summary of all the information ACCESS provides. ACCESS does not keep any identifying information after you leave the web site.

This screening tool is optional. You do not have to use the screening tool prior to applying for Wisconsin Medicaid.

STATE OF WISCONSIN
DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 10126 (Rev. 01/05)

REP

MEDICAID / FOODSHARE WISCONSIN
AUTHORIZATION OF REPRESENTATIVE

The person who completed the Medicaid and/or FoodShare Wisconsin application on behalf of an applicant must complete this form.

Personally Identifiable information will only be used for the direct administration of Medicaid and FoodShare Wisconsin.

Did you complete a Medicaid application on behalf of another person and are you that person's court appointed guardian, conservator or have durable power of attorney for finances for that person? ☐ Yes ☐ No

If you answered "Yes", stop here. You must submit, to the local county/tribal social or human services agency, the legal documentation authorizing you to be that person's appointed guardian or durable power of attorney for finances.

Are you an authorized representative completing the Medicaid or FoodShare Wisconsin application for another person? ☐ Yes ☐ No

If you are an Authorized Representative completing the Medicaid or FoodShare Wisconsin application for another person, then you and the applicant must complete the information below and you must sign the Rights and Responsibilities Section of the Medicaid and/or FoodShare Wisconsin application. Also, both you and the applicant must sign this form in order for you to be an authorized representative.

Name – Authorized Representative (Last, First, MI)	Telephone Number ( )
Address (Street, City, State, Zip Code)	Email Address

Medicaid

I authorize _____ (name of representative) to represent me in my application for Medicaid to be filed with the county/tribal human or social services agency administering the program and in the reviews of my eligibility. I also authorize my representative to provide information and documents which may be necessary to establish my eligibility for Medicaid. I will provide information to my representative that will be true and correct to the best of my knowledge. My representative and I understand that penalties for providing fraudulent information could be a fine of up to $10,000 and not more than one year in the county jail.

FoodShare Wisconsin

I authorize _____ (name of representative) to represent me in my application/review for FoodShare Wisconsin. I also authorize my representative to provide information and documents which may be necessary to establish my eligibility for FoodShare Wisconsin. I will provide information to my representative that will be true and correct to the best of my knowledge. My representative and I understand that penalties for providing fraudulent information can be barred from FoodShare Wisconsin for 12 months after the first violation, 24 months after the second violation and permanently for the third violation. Depending upon the value of misused benefits, the individual can also be fined up to $250,000, imprisoned up to 20 years, or both. A court can also bar an individual from the program for an additional 18 months. An individual will be ineligible to participate for 10 years if s/he is found to have made a fraudulent statement or representation with respect to identity and residence in order to receive multiple benefits at the same time

NOTE: Someone other than your representative must witness your signature. Two witness signatures are required if you sign with an "X".

SIGNATURE - Applicant	Date Signed
SIGNATURE – Witness (Required)	Date Signed
SIGNATURE – Witness (Required if signed with an "X".)	Date Signed

As an authorized representative I understand that I am representing the above named applicant for Medicaid and/or FoodShare Wisconsin eligibility and that information provided is true and correct to the best of my knowledge.

SIGNATURE – Authorized Representative	Date Signed

DISTRIBUTION: Case File – Original Recipient – Copy

APP

STATE OF WISCONSIN
DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 10101 (Rev. 01/05)

WISCONSIN MEDICAID ELDERLY / BLIND / DISABLED APPLICATION AND REVIEW

Instructions: Before completing this form, read the attached instructions. Use black or blue ink only.

SECTION I – CLIENT INFORMATION

ARE YOU A HURRICANE KATRINA EVACUEE? ☐ **YES** ☐ **NO**

If you are completing this application/review for someone else the completed Medicaid Authorization of Representative Form (HCF 10126) must be attached. Information provided on this application should be about the applicant not the representative.

If this is a new application, do you need help paying for health care received during the past three months? ☐ Yes ☐ No If yes, complete HCF 10101B Medicaid Backdated Coverage Request form attached.	Check the language in which you want eligibility notices printed. ☐ English ☐ Spanish	Language spoken at home.	Are there minor children living in the home? ☐ Yes ☐ No	Date Received (Office Use Only)	RFA Number (Office Use Only)
Name of Person Applying for Medicaid (Last, First, MI)			Telephone Number		
Address (Street, City, State, Zip Code)					
Mailing Address (only if different from where you live) (Street, City, State, Zip Code)					

SECTION II - GENERAL INFORMATION

	Names (Last, First, MI) (You and, if married, your spouse.)	List names previously used. (Married, maiden or others used.)	Applying for Medicaid?	Race or Ethnic Code (Optional- see instructions)	Social Security Number (Applicants Only)	Gender
1-Applicant (1 – Is applicant in each section)			☐Yes ☐ No			☐ Male ☐ Female
2– Spouse (2 – Is Spouse in each section)			☐Yes ☐ No			☐ Male ☐ Female

WI Stats. s. 49.47(3)

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SECTION II - GENERAL INFORMATION (cont.)

	Date of Birth (MM/DD/YY)	Marital Status Code (see instructions for codes)	Are you a U.S. Citizen? (Applicants Only)	Are you a Veteran?	Have you been determined blind or disabled by the Social Security Administration?	If you are disabled and not currently working, are you interested in working?	Have you received SSI in the past?
1			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

SECTION III - EMPLOYMENT INCOME

(Continue list on another sheet of paper if more space is needed)

Are you and/or your spouse working? (list self-employment in Section IV, Self-employment Income) ☐ Yes ☐ No If yes, list details below. If no, go to section IV.

Name of Person Employed	Employer Name and Address	Date Employment Began	Gross Monthly Earnings Expected This Month (Before Taxes and Deductions)	Gross Monthly Earnings Expected Next Month (Before Taxes and Deductions)
			$	$
			$	$

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SECTION IV - SELF-EMPLOYMENT INCOME

(Continue list on another sheet of paper if more space is needed)

Are you and / or your spouse self-employed? ☐ Yes ☐ No List net amounts reported to Internal Revenue Service (IRS) on tax forms.

Self-Employed Person	Business Name and Address	Type of Business	Net Annual Income	Depreciation Amount Claimed	Net Income you Expect to Earn this Year

SECTION V - UNEARNED INCOME

(Continue list on another sheet of paper if more space is needed)

Do you and / or your spouse have unearned income? ☐ Yes ☐ No If yes, list any unearned income below.

Name of Person Receiving Income	Type / Source (See instructions)	Gross Monthly Amount (Before Taxes and Deductions)	Name of Person Receiving Income	Type / Source (See instructions)	Gross Monthly Amount (Before Taxes and Deductions)
		$			$
		$			$
		$			$

SECTION VI – HOUSEHOLD EXPENSES

List household expenses (see instructions for examples of expenses). (Continue list on another sheet of paper if more space is needed)

Name of Person with Expense	Type of Expense	Amount	How Often Paid

SECTION VII – OUT-OF-POCKET MEDICAL EXPENSES

Describe the Medical Expense	Indicate if the Medical Service / Item is a Work or Non-Work Expense	Amount	How often paid? (Monthly, Bimonthly, Weekly)
	☐ Work Expense ☐ Non-Work Expense	**$**	
	☐ Work Expense ☐ Non-Work Expense	**$**	
	☐ Work Expense ☐ Non-Work Expense	**$**	
	☐ Work Expense ☐ Non-Work Expense	**$**	

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SECTION VIII – ASSETS

List all assets owned by the applicant(s) and spouse. Include assets owned jointly. Do not include the value of personal household belongings, unless of unusually high value or motor vehicles. Continue list on another sheet of paper if more space is needed.

	Name of Owner(s)	Current Dollar Value	Description (Bank / Financial Institution Name and Account Number)	Name of Owner(s)	Current Dollar Value	Description (Bank / Financial Institution Name and Account Number)
Cash		$			$	
Checking Account		$			$	
Savings Account		$			$	
Real Estate / Property		$			$	
Burial Assets / Burial Insurance		$			$	
Life Insurance		$			$	
Other (list type)		$			$	
Other (list type)		$			$	
Other (list type)		$			$	

SECTION IX - VEHICLE INFORMATION

List all vehicles owned by applicant(s) and spouse. Include vehicles owned jointly with another person. Continue list on another sheet of paper if more space is needed.

Type of Vehicle	Year, Make and Model of the Vehicle	Name of the Owner(s)	Amount owed? (If nothing is owed, list "0")	Vehicle used to get to medical appointments?	Is vehicle used for employment, training, school, or farming?
			$	☐ Yes ☐ No	☐ Yes ☐ No
			$	☐ Yes ☐ No	☐ Yes ☐ No

SECTION X – MEDICAL INSURANCE INFORMATION

	Do you and/or your spouse have medical insurance coverage (other than Medicaid)?	Date Coverage Began (mm/dd/yy)	Premium Amount	Premium paid? (Quarterly, Monthly, Bimonthly, etc.)	Who pays the premium?	Policyholder Name	Who is covered?	Insurance Company Name and Address	Insurance Number (may include member, subscriber, division, group number)
1	☐ Yes ☐ No		$						
2	☐ Yes ☐ No		$						

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MEDICAL INSURANCE INFORMATION CONT.

	Are you and / or your spouse covered by the Wisconsin Health Insurance Risk Sharing Program (HIRSP)?	Have you and / or your spouse incurred medical bills as a result of an accident or do either of you have an accident claim or settlement pending? ☐ Yes ☐ No If yes, check if you and/or your spouse have incurred bills or have a claim or settlement pending.	Are you and / or your spouse receiving Medicare Part A or B?	Medicare Card Number (If you and/or your spouse receive Medicare, list your Medicare card number.)	If eligible, would you and / or your spouse like the State of Wisconsin to pay your Part B premium?
1	☐ Yes ☐ No	☐ Incurred bills ☐ Claim or Settlement Pending	☐ Yes ☐ No		☐ Yes ☐ No
2	☐ Yes ☐ No	☐ Incurred bills ☐ Claim or Settlement Pending	☐ Yes ☐ No		☐ Yes ☐ No

SECTION XI - RESOURCE TRANSFER

The local agency may contact you for more information, if needed. (Continue list on another sheet of paper if more space is needed)

	Have resources or assets been given away within the last three years? ☐ Yes ☐ No If yes, list type of resource or asset, the value, and the date it was sold or given away.				Have you and / or your spouse set up or funded a trust in the last five years?	Do you want your spouse to keep the maximum allowed portion of your income if you are institutionalized? ☐ Yes ☐ No If No, you can contact your local agency to inquire how much can be made available.
1	Type of Resource/Asset		Type of Resource/Asset:		☐ Yes ☐ No Type	$
	(MM/DD/YY)	$	(MM/DD/YY)	$	(MM/DD/YY)	
2	Type of Resource/Asset		Type of Resource/Asset		☐ Yes ☐ No Type	$
	(MM/DD/YY)	$	(MM/DD/YY)	$	(MM/DD/YY)	

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List the following information if you and / or your spouse are in a nursing home, institution for mental disease (IMD) or hospital.

	Name of Person in Nursing Home, IMD or Hospital	Name of Nursing Home, IMD or Hospital	Date of Admission to each Nursing Home, IMD or Hospital
1			
2			

SECTION XII - Rights and Responsibilities

Please read the Rights and Responsibilities, Section XII on the instructions before signing.

I understand the questions and statements on this application form. I understand the penalties for giving false information or breaking the rules. I certify, under penalty of perjury and false swearing, that all my answers are correct and complete to the best of my knowledge, including information provided about the citizenship or immigration status of each household member, applying for benefits. I understand and agree to provide documents to prove what I have said. I understand that the local agency may contact other persons or organizations to obtain the necessary proof of my eligibility and level of benefits. (The applicant's signature must be witnessed by two people if signed with an "x".)

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

Did you use the ACCESS online screening tool, prior to applying? ☐ Yes ☐ No

NOTE: The ACCESS online screening tool is optional. You **do not** have to use the tool prior to applying for Wisconsin Medicaid. See page 10 of the instructions for more information about ACCESS.

STATE OF WISCONSIN
DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Eligibility
HCF 10101B (Rev. 01/05)

APP

MEDICAID BACKDATED COVERAGE REQUEST

If you are found eligible for Medicaid, you may be able to get Medicaid benefits for up to three months before your application date if all the needed information is collected for the prior months and you are determined to have been eligible in 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 on 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, income, assets (only if someone in your household is 65 years of age or older, blind or disabled), vehicles, insurance.

Month 1 will be the earliest month that you could be found eligible. Example, if you applied in June, your application month is June. If you have medical bills in March and want backdated coverage to March, then March is month 1, April is month 2, and May is month 3. Complete the following questions for each month that you have medical bills and want backdated coverage.

Month 1

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.

Month 2

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.

Month 3

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	Date Signed

STATE OF WISCONSIN
DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 10137 (Rev. 12/04)

CHG

MEDICAID CHANGE REPORT

If you are receiving Medicaid, you must report any changes in your household composition (if anyone moves in or out of your household, if anyone gets married, becomes pregnant, or gives birth to a child), address, income, assets (only people age 65 or older, blind or disabled) or employment status **within ten days**. If such a change has occurred, fill out this report and mail it or take it to the office shown in the box below, or contact your worker by telephone or in person about any changes. If this report does not provide enough room to document a change, attach a sheet of paper to this report with the additional information written on it.

(County agency address)

Your Name	Case Number	Worker Name

If you intentionally fail to report any changes or provide false information, you may be fined, have to pay back any Medicaid benefits you wrongfully received, be prosecuted, or all three. You may be required to provide proof of any changes you report.

SECTION I - CHANGE IN ADDRESS

If you move, you must report your new address.

Date of change	New telephone number

New address (street, city, state, zip code)

SECTION II - 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 III - 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, Veterans benefits, Unemployment Insurance, Worker's Compensation, or any other change in the amount of money your household receives.

Name (Last, First, MI)	Date income changed

Source of income	Monthly amount	How often Paid

SECTION IV - CHANGE IN ASSETS

Those who are elderly, blind or disabled must report changes in their cash, bank accounts, bonds, stocks, vehicles or other assets.

Name of owner (Last, First, MI)		Date of change
Type of asset	Describe the change	New value or amount $

Name of owner (Last, First, MI)		Date of change
Type of asset	Describe the change	New value or amount $

SECTION V – CHANGE IN VEHICLES

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

Name of owner (last, first, MI)					Date of change
Type of vehicle	Make	Model	Year	Amount received $	Describe change (bought, sold, etc.)

SECTION VI - OTHER CHANGES

Report any other changes that you believe may affect your Medicaid eligibility. Examples of other changes include someone getting or dropping health insurance or someone becoming disabled or recovering from a disability. Include the date of any other change.

Describe change

Do you expect that the changes reported on this form will remain the same next month? ☐ Yes ☐ No

If No, explain.

SECTION VII – SIGNATURE

I understand that there are penalties for hiding information or giving false information. I also understand that I may have to pay back any benefits I receive because I do not fully report changes in my circumstances. I agree to provide proof of any changes, if asked to do so. My answers on this form are correct and complete to the best of my knowledge.

SIGNATURE – Participant	Date signed	Telephone number

RETAIN COMPLETED FORM IN CASE FILE (FOR AGENCY USE ONLY)