DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-10101 (03/10)

STATE OF WISCONSIN
WI Stats. §. 49.47(3)

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 age 65 years or older, blind or have a disability.

To apply for health care benefits, complete this application and return it to your local county or tribal agency or complete an application online at access.wi.gov. See below for more information about applying online.

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

Call 1-800-362-3002, if you have questions about Medicaid or you need the address and/or telephone number of your local county or tribal agency.

If you need help filling out this application or wish to answer the questions in person or over the telephone, contact your local county or tribal agency. Information is also available online at dhs.wisconsin.gov/medicaid.

If you have a disability and need this information in an alternate format, or if you need it translated to another language, call 1-608-266-3356 (voice) or 1-888-701-1251 (TTY). 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 or report changes to your worker. To visit ACCESS go to access.wi.gov. An online application is the same as a paper application.

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 **county or tribal agency** will contact you for more information.

Address – Local County or Tribal Agency

IMPORTANT INFORMATION

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

Authorized Representative

You may authorize a representative to apply for you. If you want to authorize a representative, fill out the Authorized Representative page (Attachment 2 of this application packet). This will allow that person 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 a person's court appointed guardian, conservator or have durable power of attorney for finances, you must submit the legal documentation authorizing you to be that person's appointed guardian or durable power of attorney for finances.

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 are eligible, 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 (Attachment 1) 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 Wisconsin Statutes § 49.82(2).

If you are applying only for emergency services because of your immigration status, or you are a pregnant woman applying for the 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 and Family 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).

Reviews

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

Estate Recovery

If you get Medicaid, Wisconsin State law, with limited exceptions, requires the recovery of certain Medicaid benefits from your estate. The "Estate Recovery Program" brochure (P-13032) provides you with information on estate recovery. You may get a copy of the brochure from your local county or tribal agency or by contacting Member Services at 1-800-362-3002. 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 local county or tribal agencies to determine eligibility. (This does not prohibit the use of such records for program administration.)
- The right of access to local county or tribal agency's records and files relating to your case, except information obtained by the local county or tribal 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, and
- The right to appeal any action taken concerning your Medicaid application or on-going benefits that you do not agree with by requesting a Fair Hearing.

Fair Hearing

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: Telephone (608) 266-3096

The *Request for Fair Hearing* form can also be found on the Division of Hearings and Appeals web site at dha.state.wi.us/home/.

You may also contact the local county or tribal agency where you applied and ask for help filing a Fair Hearing request. Refer to the *Wisconsin Medicaid Program – Enrollment and Benefits* handbook (P-10025), or the Notices of Enrollment you will get, to learn more about the fair hearing process. If you are determined eligible for Medicaid, you will get your handbook with your Medicaid *ForwardHealth* card. You can also find the handbook on the Medicaid web site at dhs.wisconsin.gov/em/customerhelp.

If you have any questions about your rights and responsibilities, contact your local county or tribal agency or call Member Services at 1-800-362-3002.

Discrimination

The Department of Health Services (DHS) is an equal opportunity employer and service provider. For civil rights questions, call (608) 266-9372 (voice) or 1-888-701-1251 (TTY).

To file a complaint of discrimination contact either the:

Wisconsin Department of Health Services
Affirmative Action and Civil Rights Compliance Office
1 W. Wilson, Room 555
Madison, WI 53707-7850
Telephone: (608) 266-9372 (voice);
(888) 701-1251 (TTY)
Fax: (608) 267-2147

OR

U.S. Department of Health and Human Services
Office for Civil Rights – Region V
233 N. Michigan Avenue, Suite 240
Chicago, IL 60601
Telephone: (312) 886-5077 (voice) or
(312) 353-5693 (TTY)

Responsibilities

Reporting Changes

Report to the local county or tribal agency **within 10 days:**

- Any changes in **income** of any member of your household, AND
- Any other change in the information you have given on your application that is required to be reported on the Medicaid Change Report form. See the Medicaid Change Report form 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 worker or you can use the Medicaid Change Report (Attachment 3) in this application packet. **Do not send this form with your application; keep it for future use**.

Verification/Proof

You will need to provide 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. If you are applying for benefits, you will have at least 30 days, from the date of your application, to provide proof to the local county or tribal agency. If you have provided this information in the past, or you receive Medicare, Supplement Security Income or Social Security Disability Income, it may already be on file; your worker will let you know if s/he needs more proof.

We also verify with the U.S. Department of Homeland Security the alien 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 eligible for the 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

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
- 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 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 or draft record showing U.S. birth
- 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, or something that shows the face value and cash value of your life insurance policy.

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,
- Documentation for Power of Attorney and Guardianship,
- Disability, and/or
- Pregnancy.

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 local county or tribal 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 local county or tribal agency for help.

Race / Ethnicity Codes

Print the code(s) in the space provided that best describes your race/ethnicity.

- **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, Afghanistani, Turkestan, Hmong, Lao, Vietnamese, Khmer, Thai, Burmese, Indonesian, Malaysian, Filipino
- **B** = **Black/African American**
- **H** = **Hispanic or Latino**

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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 (example: April 2, 1958 would be 04/02/1958). If you need more space to write your answers, please use an additional sheet of paper.

Keep pages 1 through 6 and the Medicaid Change Report (Attachment 3), for future use.

If you are completing this application for someone else, complete the Authorization of Representative page (Attachment 2), or attach legal documentation authorizing you to be that person's appointed guardian or durable power of attorney for finances. 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	Where were you born? (city, state)	Sex ☐ Male ☐ Female	
Social Security Number	*Race or Ethnicity	Are you a member, or a child of a member, of a tribe? ☐ Yes ☐ No	In what language do you want your notices printed? ☐ English ☐ Spanish
Primary language spoken in your home		Are there any minor children in the home? ☐ Yes ☐ No	

*You do not have to answer this question. If you do wish to answer, the codes are on page 5 of the Important Information.

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

Name of contact, if not the applicant

Telephone Number (Applicant)	☐ Home ☐ Cell ☐ Work	Telephone 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?

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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?

Do you reside in a nursing home, institution for mental disease (IMD), or hospital? ☐ Yes ☐ No If yes, what is the date you were admitted? _____	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 (Attachment 1) in this packet.

Marital status ☐ Single ☐ Married ☐ Legally Separated ☐ Annulled ☐ Divorced ☐ Widowed ☐ Never Married	Are you a U.S. citizen? ☐ Yes ☐ No (See page 4)
If you are not a U.S. citizen, in what country were you born?	Are you the sponsor of an immigrant? ☐ 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 not married, go to Section 5.

Name (last, first, MI)

Other names previously used such as a maiden or married name.

Spouse's address, if different from applicant's address.

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? $_____

Residing in a nursing home, institution for mental disease (IMD) or hospital? ☐ Yes ☐ No

If you answered yes, stop here and go to Section 5.

Applying for Medicaid? ☐ Yes ☐ No	Race or ethnicity (This question is optional.)	Social Security Number

Are you a member, or a child of a member, of a tribe? ☐ Yes ☐ No

Date of birth	U.S. citizen? ☐ Yes ☐ No	Sponsor of an immigrant? ☐ Yes ☐ No

If not a U.S. citizen, place where born?

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SECTION 5 – DISABILITY INFORMATION

Applicant

Have you been determined blind or disabled by the Social Security Administration?	☐ 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 Supplemental Security Income (SSI) in the past?	☐ Yes ☐ No
If your spouse is disabled and not currently working, is s/he 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 8. 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, livestock, tools, farm machinery, Keogh plans or other tax shelters, personal property being held for investment purposes, 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		$

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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* $	

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

SECTION 10 – 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 11.

Name of Owner(s)	Cash Value $	Face Value $
	$	$

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SECTION 11 – 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, (By fair market value, we mean the amount that you would get if you sold it on the open market.)
- ☐ 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, or
- ☐ 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 12.

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?		

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?		

SECTION 12 – 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'll ask you about self-employment in Section 13.

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 13.

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, use a separate sheet of paper and attach it to this application.

SECTION 13 – SELF-EMPLOYMENT

Please tell us about any self-employment income you and/or your spouse receive. You may use an additional sheet of paper if more room is needed.

Self-employment 1

Are you and/or your spouse self-employed? ☐ Yes ☐ No If yes, answer the questions below. List the gross amount reported to the Internal Revenue Service on your tax forms. If no, go to Section 14.

Who is self-employed? ☐ You ☐ Your Spouse	Name and address of this business
Gross annual income $	
Gross annual expenses (include amounts claimed for depreciation) $	Type of business

Self-employment 2

Who is self-employed? ☐ You ☐ Your Spouse	Name and address of this business
Gross annual income $	
Gross annual expenses (include amounts claimed for depreciation) $	Type of business

SECTION 14 – 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, rental income, 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 15 – 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 16.

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 16 – 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, heating cost, etc.

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

SECTION 17 – OTHER ALLOWABLE EXPENSES

In this section, tell us about any other allowable expenses you and/or your spouse have. Allowable expenses may include 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 18 – 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
			$
			$

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SECTION 18 – MEDICAL INSURANCE INFORMATION (Continued)

Do you and/or your spouse have private health or long term care insurance? ☐ Yes ☐ No

Who Is Covered? ☐ You ☐ Your Spouse	Date Coverage Began	Premium Amount $	How Often Paid
Who Pays The Premium? ☐ You ☐ Your Spouse	Name of Policyholder	Policy/Insurance 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 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

Has your spouse incurred medical bills as a result of an accident or does your spouse have an accident claim pending? ☐ Yes ☐ No

If yes, check all that apply. ☐ Incurred Bills ☐ Claim or Settlement Pending

SECTION 19 - 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 proof, additional documentation or sheets of paper used to complete the application.
- ☐ Include a copy of your immigration status documents, if you are not a U.S. citizen.
- ☐ Complete the Authorized Representative page (Attachment 2) 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.
- ☐ Enclose the Medicaid Backdated Coverage Request page (Attachment 1), if you are requesting backdated coverage.
- ☐ Keep pages 1 through 5 and the Medicaid Change Report (Attachment 3), for future use.
- ☐ Sign and date the application form.

Send the completed application to your local county or tribal agency. Addresses for local agencies can be found at: dhs.wisconsin.gov/em/customerhelp or by calling Member Services at 1-800-362-3002.

SECTION 20 - SIGNATURE

Your signature on the application means that you understand and acknowledge that the local county or tribal agency and the Wisconsin Department of Health Services is authorized to request any information that is appropriate and necessary for the proper administration of the Medicaid program 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.

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”.

APP

ATTACHMENT 1 - 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 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 eligibility 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

REP

ATTACHMENT 2 - AUTHORIZATION OF REPRESENTATIVE

If you wish to authorize another person to apply for Medicaid, on your behalf, you must complete this section. If you are an Authorized Representative completing the Medicaid application for another person, then you and the applicant must sign the signature section of the Medicaid application. If you are this person's court appointed guardian, conservator or power of attorney for finances, you must submit to the local county or tribal agency the legal documentation authorizing you to apply on behalf of the applicant. You do not need to complete this section.

I authorize _____ (name of representative) to represent me in my application for Medicaid to be filed with the local county or tribal agency administering the program and in the renewal 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.

Authorized Representative Information

Name – Authorized Representative (last, first, MI)	Telephone Number (Include Area Code)
Address (Street, City, State, Zip Code)	Email Address

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" above.) _____ Date Signed _____

☐ Yes ☐ No As an authorized representative I understand that I am representing the above named applicant for Medicaid eligibility and that information provided is true and correct to the best of my knowledge.

SIGNATURE – Authorized Representative _____ Date Signed _____

CHG

ATTACHMENT 3 - MEDICAID CHANGE REPORT

Do not send with your application. Keep for future use. If you have a change, you can use this form to report changes. You may also report changes online at access.wi.gov or you can contact your worker by telephone or in person. If you report changes using this form, return the completed form to your local county or tribal agency. You can get the address to the local county or tribal agency in the box below, by calling 1-800-362-3002 or at dhs.wisconsin.gov/em/customerhelp.

You must report 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 ten days**. If you do not have enough room on this report to document a change, attach a sheet of paper with the additional information written on it to this report.

If you fail to report any changes or provide false information, you may be fined, have to pay back any Medicaid benefits you wrongfully received (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.

(Local County or Tribal Agency)

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 HSF 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, Veterans benefits, Unemployment Insurance, Worker's Compensation, 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	Date of Change

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

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

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.

Complete this form if you want to request FoodShare benefits. You may have another adult complete the application process for you. If your FoodShare benefits stopped within the last 30 days you may complete this form or contact your worker to find out if you can provide information to reopen your FoodShare without completing this form.

You can start the application process for FoodShare online at access.wi.gov or you can complete this page and return it to your local agency. You can also apply online at access.wi.gov, by mail, in person or by telephone. To complete the application for FoodShare, you must have an interview. The interview will be done by telephone, unless you prefer to go to the agency.

You will be asked to provide proof of certain information such as identity, address and income. If you are enrolled in FoodShare, benefits will begin from the date a completed registration form (online or paper) is received by your local agency.

Name – Applicant (Last, First, MI)			
Social Security Number (Optional)	Date of Birth (Optional)	Telephone Number (Optional)	
Address – Street	City	State	Zip Code
Signature (Applicant or Authorized Representative)		Date Signed	

Is there anyone living in your home who is not listed on the Medicaid application? ☐ Yes ☐ No

Your FoodShare application will be processed as soon as possible, but no later than 30 days from the date your registration form is received by the local agency.

If you need help right away or have an emergency, you may be able to get FoodShare benefits within 7 days of providing your registration form, if your household:

- Has $100 or less available in cash or in the bank and
- Expects to receive less than $150 of income this month; **or**
- Has rent/mortgage or utility costs that are more than your total gross monthly income, available cash or bank accounts for this month; **or**
- Includes a migrant or seasonal farm worker whose income has stopped.

Answer the following questions to be considered for faster service.

Total gross income expected by your household this month (before taxes or other deductions)	$_____
Total available assets (examples-cash, money in checking/savings accounts, CDs, stocks, IRAs, etc)	$_____
Total rent or mortgage this month	$_____
Total utilities this month (examples- gas, electric, water, sewer, trash removal)	$_____
Did your household receive FoodShare benefits this month?	☐ Yes ☐ No
Is anyone in your household a migrant or seasonal farm worker whose income has recently stopped and does not expect to receive more than $25 in income, in the next 10 days?	☐ Yes ☐ No

Tear Off and Submit This Page to Your Local FoodShare Office

Keep the attached pages. If you do not understand any part of this form, ask you local agency to explain it.

Important Information - FoodShare

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 in 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 take part in FoodShare.

NON-DISCRIMINATION

In accordance with Federal law and the U.S. Department of Agriculture policy, this institution (local county or tribal agency) is prohibited from discriminating on the basis of race, color, national origin, sex, age, religion, political beliefs or disability.

To file a complaint of discrimination write to the USDA or the Department of Heath Services:

USDA
Director, Office of Civil Rights
Room 326-W, Whitten Building
1400 Independence Avenue, S.W.,
Washington D.C. 20250-9410

Telephone: (800) 795-3272 (voice) or
(202) 720-6382 (TTY)

Department of Health Services (DHS)
Affirmative Action/Civil Rights Compliance Office
1 W. Wilson, Room 555
Madison, WI 53707-7850

Telephone: (608) 266-9372 (Voice) or
1-888-701-1251 (TTY)
Fax: (608) 267-2147

USDA is an equal opportunity provider and employer.

FAIR HEARING

You have the right to a fair hearing if you do not agree with any action taken regarding your application or your ongoing benefits. You may request a fair hearing by writing or calling:

Department of Administration
Division of Hearing and Appeals
P.O. Box 7875
Madison, WI 53707-7875
(608) 266-3096

The Request for a Fair Hearing form may be downloaded at dhs.wisconsin.gov/em/customerhelp. You may also contact your local county or tribal office to ask for a Fair Hearing verbally or in writing.

USE OF SOCIAL SECURITY NUMBERS/PERSONALLY IDENTIFIABLE INFORMATION

Personally identifiable information, including Social Security Numbers (SSN) will be used only for the direct administration of FoodShare Wisconsin. Providing or applying for an SSN is voluntary; however anyone who does not provide their SSN or apply for one, will not be able to get FoodShare benefits. Anyone in the household who is not applying for FoodShare does not need to provide an SSN. Your SSN permits a computer check of your information from government agencies, such as the Internal Revenue Service (IRS), Social Security Administration, Department of Workforce Development or School Lunch Program. SSNs are also used to check identity and to verify income from sources such as employers.

AUTHORIZED REPRESENTATIVE

You have the right to have another person apply for FoodShare benefits for you. This person will act as an "authorized representative". If you want to have an authorized representative, complete the Authorization of Representative form (F-10126). To get this form go to dhs.wisconsin.gov/em/customerhelp or ask the local agency. If an authorized representative provides wrong information which is used to determine your FoodShare benefits, you will be responsible for any mistakes.

IMMIGRATION STATUS

To be able to get FoodShare, you must be a United States citizen or have a qualifying immigration status with the United States Citizenship and Immigration Services (USCIS). Immigration status of all people applying for FoodShare will be verified with USCIS and may affect FoodShare enrollment and benefit amount. Immigration status will NOT be verified with USCIS for any person who is not applying for FoodShare or who indicate they do not have qualifying immigration status with the USCIS. However, income from those individuals may affect FoodShare enrollment or benefit amount.

COLLECTION OF INFORMATION

The collection of information on the application, including the Social Security Number of each household member applying, is authorized under the Food Stamp Act of 1977, as amended, 7 U.S.C. 2011-2036 to determine if your household is able to take part in FoodShare Wisconsin. Information will be verified through computer matching programs and will also be used to monitor compliance with FoodShare program rules and program management.

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,
- 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/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/illegal drugs, you will be barred from the FoodShare program for a period of 2 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.