BadgerCare Plus Application Packet

F-10182 — July 2020

BADGERCARE PLUS APPLICATION PACKET

This is an application for BadgerCare Plus and Family Planning Only Services. You can apply:

- Online at access.wi.gov. Click Apply now.
- By mail or fax: Complete this application, mail or fax it to:

  If you live in Milwaukee County:

  MDPU
  PO Box 05676
  Milwaukee WI 53205
  Fax: 1-888-409-1979

  If you do not live in Milwaukee County

  CDPU
  PO Box 5234
  Janesville, WI 53547-5234
  Fax: 1-855-293-1822

- By phone or in-person: You will need to call your agency to set up an appointment to apply by phone or in-person.

If you need help filling out this application or want to answer the questions in person or by telephone, contact your agency. To get the address or phone number of your agency, call 800-362-3002 or go to www.dhs.wisconsin.gov/forwardhealth/imagency/index.htm.

If you have a disability or need this information interpreted/translated or in a different format, contact your agency. These services are free.

ACCESS - 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.

On ACCESS, you can also apply for FoodShare Wisconsin, which is a program that helps people buy nutritious food. For more information about FoodShare, go to www.dhs.wisconsin.gov/forwardhealth/resources.htm.

HOW TO USE THIS FORM — CHECK LIST

- ❑ Read the Important Information, the Rights and Responsibilities sections before you apply.
- ❑ Keep pages 1 through 6 and the Information Change Report, F-10183, in this application packet, for future changes.
- ❑ Print clearly, using blue or black ink.
- ❑ Read any instructions, before you answer the question.
- ❑ Complete all sections of the application that apply to you and your family. You may have a delay in getting BadgerCare Plus benefits if the application is not complete.

  If more room is needed, use an additional sheet of paper or the blank sheets at the end of the application.
- ❑ Enter information about all the people living in your home. List all children who live in the home with you at least 40% of the time.
- ❑ You may need to provide proof of some of your answers. See the Verification/Proof Section on page 4, to see what you will need to provide. Enclose with your application any proof, additional documentation or sheets of paper used to complete the application. Please send copies. Do not send originals.
- ❑ You may have an authorized representative apply for you. To appoint an authorized representative, fill out either the Appoint, Change, or Remove an Authorized Representative: Person form, F-10126A, or the Appoint, Change, or Remove an Authorized Representative: Organization form, F-10126B. This will allow your authorized representative to complete and sign the application for you. To get this form, call 800-362-3002, or go to www.dhs.wisconsin.gov/forwardhealth/representative-types.htm.
- ❑ Sign the application and any attachments that require a signature. Applications and/or attachments without a signature will be returned.
- ❑ If you want to apply for FoodShare, complete the FoodShare Wisconsin Registration form, F-16019A, in this application packet.

IMPORTANT INFORMATION

The following is important information you will need to know about applying for BadgerCare Plus.

- It is important to apply as soon as possible as your application date is the date the agency gets your signed application.
- Most pregnant women and people with income below certain limits, who have medical bills in any of the three months before their application date, may be able to get “backdated coverage.” If you’d like to request backdated coverage, fill out Attachment 7: Request for Backdated Coverage form and send it in with your completed application.
- If you are enrolled in BadgerCare Plus, you will need to complete a renewal with your agency every 12 months to stay enrolled.
- Your application for BadgerCare Plus is also an application for help with paying for private health insurance through the federal Health Insurance Marketplace. If you do not meet the rules to enroll in BadgerCare Plus or Medicaid, your information may be sent to the Marketplace. If this happens, the Marketplace will contact you and let you know if you are able to get help with paying for private health insurance. To learn more about the Marketplace, visit healthcare.gov or call 1-800-318-2596 or 1-855-889-4325 (TTY).

ACCESS TO EMPLOYER GROUP HEALTH INSURANCE

If employer-sponsored health insurance is available, some children and pregnant women might not be able to get BadgerCare Plus.

The Department of Health Services will check this information with your employer before you are enrolled.

BADGERCARE PLUS DEDUCTIBLE

If you are a pregnant woman who is a U.S. citizen or qualifying immigrant and you have income over 300% of the Federal Poverty Level (FPL) or if your child is not able to enroll because he or she is over the income limit or has access to employer-sponsor health insurance where the employer pays 80% or more of the premium, you may still be able to enroll by meeting a deductible.

For a pregnant woman a deductible is the difference between your family’s net income and 300% of the federal poverty level over a six-month period. For children, a deductible is the difference between your family’s net income and 150% of the federal poverty level over a six-month period. For example, if your monthly income is $100 over the 150% federal poverty level, you would have to pay a deductible of $600, to be able to get benefits. ($100 X 6 months = $600). For current income guidelines, call 800-362-3002 or go to www.dhs.wisconsin.gov/forwardhealth/resources.htm.

OTHER MEDICAL COVERAGE

As a condition of BadgerCare Plus enrollment, you must report to the agency any third party who may be liable to pay for medical care for yourself and your family. You must cooperate by giving information as requested. This also includes any insurance that may be available through an absent parent or an employer's group health insurance.

PERSONALLY IDENTIFIABLE INFORMATION/ SOCIAL SECURITY NUMBER (SSN)

Personally identifiable information and Social Security Numbers are used only for the direct administration of the BadgerCare Plus programs.

If someone in your household is not applying for BadgerCare Plus, you do not need to provide a Social Security Number (SSN) or immigration information for that person. Any person who wants BadgerCare Plus, must provide their SSN or apply for one pursuant to Wis. Stat. § 49.82(2).

If you are applying for BadgerCare Plus and do not have an SSN due to religious beliefs or because of your immigration status, leave the SSN field blank.

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, Department of Transportation and the Department of Workforce Development. In addition, the Department of Health Services will match your name and SSN with information provided by health insurance carriers to determine if you have other health insurance.

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

CHILD SUPPORT COOPERATION

In some situations, you must cooperate with the Child Support Agency to establish paternity. This means you must help the agency locate an absent parent, legally name the absent parent and/or enforce medical support liability orders. If you do not cooperate with the Child Support Agency and do not have a good reason to not cooperate, your benefits may end if you are an adult and are not pregnant.

RECOVERY OF BADGERCARE PLUS

Wisconsin state law provides for the recovery of certain BadgerCare Plus benefits you get in error. The law also requires the recovery of certain Medicaid benefits from your estate or the estate of your surviving spouse. The Wisconsin Estate Recovery Program Handbook (P-13032) provides you with information on estate recovery. You may get a copy of the publication from your agency, by contacting Member Services at 800-362-3002 or at www.dhs.wisconsin.gov/publications/p1/p13032.pdf. Certain benefits you get in the community after age 55 and all benefits you get after age 55 while you are participating in a long-term care program, living in a nursing home or while you are an inpatient in a hospital for 30 days or more, are recoverable.

RIGHTS

State and federal laws guarantee rights for anyone applying for or enrolled in BadgerCare Plus. These rights include the right to:

- Be treated with respect by state and county employees.
- Confidentiality of all information given to local agencies to determine enrollment. (This does not prohibit the use of such information for program administration.)
- Have access to agency records and files relating to your case, except information obtained by the local agency under a promise of confidentiality.
- The right to remain enrolled in BadgerCare Plus even if temporarily absent from the state, if you remain a Wisconsin resident.
- Be notified if you can be enrolled in BadgerCare Plus within 30 days from the day the agency receives your application for BadgerCare Plus.
- Be notified in advance of changes in your benefits or enrollment status.
- Ask for 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.
- Appeal any action taken concerning your BadgerCare Plus application or on-going benefits that you do not agree with by asking for a Fair Hearing.

FAIR HEARING

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

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

You may request a fair hearing by writing to:

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

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

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

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

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

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

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

RESPONSIBILITIES

Report Public Assistance Fraud — Go to www.reportfraud.wisconsin.gov or call 877-865-3432 (toll-free).

You have the responsibility to provide truthful and complete information on this application, attachments, or any other form(s) needed for BadgerCare Plus and Family Planning Only Services enrollment.

REPORTING CHANGES

BadgerCare Plus

If you are enrolled in BadgerCare Plus, you must report these changes within 10 days:

- You move to a new address or out of state and become a resident of that state (see Note below).
- Anyone moves in or out of your home, or becomes pregnant or gives birth.
- Your living arrangement changes (example: you go into a nursing home or other institution).
- Your monthly income goes over the program limit for your family size.
- You get married or divorced.
- You have a change in health insurance coverage.
- You have a change in expected tax filing status or tax dependents.
- You no longer have a tax-related deduction you told us about.

If you have a change in income and your gross monthly income goes over the program limit for your family size, you must report the change by the 10th day of the next month.

The program income limit for your family size will be on letters titled "About Your Benefits." You should always look at your latest letter for the program income limit for your family size.

Family Planning Only Services

If you are enrolled in Family Planning Only Services, you only need to report these changes, within 10 days:

- You move to a new address or out of state.
- Your living arrangement changes (example: you are incarcerated, you go into a nursing home or other institution).

Note: If you move out of state and do not report this move within 10 days, you will be required to pay back the BadgerCare Plus program for any payments they made to your HMO. For example, if BadgerCare Plus paid your HMO $475 each month, the amount of overpayment you would have to repay BadgerCare Plus is $475 for each month the HMO was paid, even if you did not use your ForwardHealth card.

HOW TO REPORT CHANGES

Report changes online at access.wi.gov, by calling your agency, or using the Information Change Report, F-10183, in this application packet.

VERIFICATION/PROOF

You may need to provide proof of certain information. The following are examples of proof.

PROOF OF CITIZENSHIP/IDENTITY

People applying for BadgerCare Plus or Family Planning Only Services may need to give proof of their identity, citizenship, and/or immigration status. If you have already provided proof of U.S. citizenship and/or identity, you do not need to provide it again.

U.S. CITIZENS

If you are a U.S. citizen, examples of what you can use to prove citizenship and identity are in List 1:

List 1

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

If you do not have one of the items in List 1, you must give one item from List 2 and one from List 3.

List 2

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

List 3

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

If you have these items available on the day you submit your application (paper or online at access.wi.gov), include them with your application. You may be contacted by the agency and be asked to provide proof of missing, conflicting, or vague information if the information would affect the decision about your BadgerCare Plus or Family Planning Only Services enrollment. If you are applying for benefits, you may have at least 95 days from the date of your application to provide proof to the agency if it is asked for.

IMMIGRANTS

If you are an immigrant applying for BadgerCare Plus, you may be asked to send a copy of your USCIS documentation showing your immigration status.

Note: Undocumented immigrants can only get coverage for emergency health care services. Pregnant immigrants may be able to enroll in BadgerCare Plus Prenatal Services.

PROOF OF INCOME

Job Income and Wages

Some applicants who have a job must give proof of their income. This information can be provided on the Employer Verification of Earnings form (EVF-E), or you can use check stubs you have gotten in the last 30 days. If you want to get a form, call your agency. If enrolled, you may be asked to provide proof of this information at your annual renewal and when you change jobs.

Self-Employment

You must provide proof of any self-employment income for any family member who is self-employed. You may use copies of your tax forms to provide this proof.

Other Income

You may need to provide proof of any other income your family gets (example, pensions, disability pay, unemployment from another state, etc.).

OTHER PROOF

Your worker may ask for other proof. Below are some examples of other items for which you may need to provide proof.

- Medical expenses to meet a deductible.
- Documentation for Power of Attorney and Guardianship.
- Assets. (Only for those applying for the Medicare Savings Program.)

If you need help getting any required proof, contact your agency and ask for help.

OTHER PROGRAMS

Medicare Savings Program

If you or someone in your home is receiving Medicare Parts A and/or B, he or she may be able to get help paying their Medicare premiums, copays and deductibles.

This is called the Medicare Savings Program. To see if you can enroll in the program, you will need to complete Attachment 8: Assets and provide proof of these assets.

FoodShare Wisconsin

FoodShare helps people with limited money buy the food they need for good health.

To apply for FoodShare, complete the FoodShare Wisconsin Registration form, F-16019A, in this application packet or go to access.wi.gov and click Apply now.

To learn more about FoodShare Wisconsin, visit www.dhs.wisconsin.gov/forwardhealth/resources.htm.

MINIMUM VALUE STANDARD PLANS

Minimum Value Standard means that the plan pays at least 60 percent of the total benefit costs allowed by that plan.

Your employer should be able to tell you if they offer a minimum value standard plan (MVSP).

Some employers are required to give their employees a letter that says whether their plan meets the minimum value standard. Or, you can go to https://marketplace.cms.gov/applications-and-forms/employer-coverage-tool.pdf to get a form you can give to the employer to help you get more information.

If your employer does offer a plan that meets the minimum value standard, the questions in the Minimum Value Standard Plans section on Attachment 5b, have to do with the lowest-cost, employee-only plan that meets the minimum value standard. Employee-only means a plan that only covers the person who is employed. This is not a plan that covers other members of the employee's family.

Even if you are enrolled in a plan that costs more than the lowest-cost employee only plan, you should still tell us about the lowest-cost plan in Attachment 5b.

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

The Department of Health Services:

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

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

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

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

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

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

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

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BADGERCARE PLUS APPLICATION

Instructions

- Use blue or black ink
- Write all dates in the MM/DD/YY format (example 04/02/58)
- Use an additional sheet of paper or the blank pages at the end of this application if more room is needed.
- Keep pages 1 – 6 and the Information Change Report, F-10183, for future use.

For Agency Use Only	
Case Number	Date Received

SECTION 1 – APPLICANT INFORMATION

In this section we will ask about you, the applicant.

Name – Applicant (last, first, MI)	Date of Birth (mm/dd/yy)
Name at Birth and/or Previous Names	Social Security Number

Address

City	State	Zip Code

Mailing address, if different from above

City	State	Zip Code

Are you applying for BadgerCare Plus?	Are you applying for Family Planning Only Services?
☐ Yes ☐ No	☐ Yes ☐ No

Do you need help paying for health care in any of the previous three months, for anyone in your home?

☐ Yes ☐ No

If you check yes, complete the Request for Backdated Coverage form (Attachment 7) in this packet.

Sex	What language do you want your letters printed in?	What language is spoken in your home?
☐ Male ☐ Female	☐ English ☐ Spanish	

Ethnicity* (optional)

☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race* (optional, choose one or more)

☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American

☐ Hawaiian/Other Pacific Islander ☐ White

** You don't have to answer the ethnicity and race questions if you don't want to. We're asking these questions to help improve our programs and make sure they do not discriminate based on ethnicity or race. Your answers will not be used to make a decision about your benefits.*

Is anyone in your home blind, disabled, or unable to work due to illness or injury?

☐ Yes ☐ No

Are you homeless now or have you been homeless in the last 12 months?

☐ Yes ☐ No

What is your marital status?

☐ Annulled ☐ Divorced ☐ Legally Separated ☐ Married ☐ Never Married ☐ Single ☐ Widowed

Are you a member, child, or grandchild of a member of an American Indian Tribe or an Alaska Native?

☐ Yes ☐ No

If yes, complete Attachment 9.

Are you eligible to receive services from Indian Health Services, a tribal clinic, or an urban Indian health program?

☐ Yes ☐ No

Have you received services from Indian Health Services, a tribal clinic, or an urban Indian health program?

☐ Yes ☐ No

Answer the following questions only if you are applying for BadgerCare Plus or Family Planning Only Services.

Are you a U.S. citizen?

☐ Yes ☐ No

If no, complete the following questions:

What is your Alien Registration or USCIS number?

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

Do you have a sponsor?

☐ Yes ☐ No

Are you on active duty in the U.S. military or an honorably discharged veteran, married to someone on active duty or an honorably discharged veteran, the surviving spouse of a veteran, or the child of someone on active duty or an honorably discharged veteran?

☐ Yes ☐ No

Tax Filing

Is anyone planning to file taxes jointly with someone outside of your home, or claim any tax dependents who are not living in your home?

☐ Yes ☐ No

If yes, complete Attachments 1 and 6.

SECTION 2 – CONTACT INFORMATION

Tell us how we can contact you.

Telephone Number		Type of telephone ☐ Home ☐ Cell ☐ Work
Other Telephone Number	Who does this number belong to? ☐ Self ☐ Friend ☐ Neighbor ☐ Relative	What is this person's name?

Email Address

What is the best way and time to contact you during weekdays?

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SECTION 3 – OTHER FAMILY MEMBERS

Tell us about all other people in the home, even if they are not applying. You don't have to answer the ethnicity and race questions if you don't want to. We're asking these questions to help improve our programs and make sure they do not discriminate based on ethnicity or race. Your answers will not be used to make a decision about your benefits. List all children who live in the home with you at least 40% of the time. Include any child you are responsible for the care of, who is out of the home for six months or less. Also include any child that has been removed from your home and placed in foster care or with a relative. Use an additional sheet of paper if more room is needed.

Name – Spouse or Other Adult (last, first, MI)	Date of Birth (mm/dd/yy)
Name at Birth	Social Security Number

Applying for BadgerCare Plus?	Applying for Family Planning Only Services?
☐ Yes ☐ No	☐ Yes ☐ No
Sex	Relationship to Applicant
☐ Male ☐ Female	

Ethnicity (optional): ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (optional, choose one or more)
☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American
☐ Hawaiian/Other Pacific Islander ☐ White

Are you homeless now or have you been homeless in the last 12 months? ☐ Yes ☐ No

What is your marital status?
☐ Annulled ☐ Divorced ☐ Legally Separated ☐ Married ☐ Never Married ☐ Single ☐ Widowed

Are you a member, child or grandchild of a member of an American Indian Tribe or an Alaska Native?
☐ Yes ☐ No
If yes, complete Attachment 9.

Are you eligible to receive services from Indian Health Services, a tribal clinic, or an urban Indian health program?
☐ Yes ☐ No

Have you received services from Indian Health Services, a tribal clinic, or an urban Indian health program?
☐ Yes ☐ No

Answer the following questions only if you are applying for BadgerCare Plus or Family Planning Only Services.

Are you a U.S. citizen?
☐ Yes ☐ No
If no, complete the following questions:

What is your Alien Registration or USCIS number?

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

Do you have a sponsor? ☐ Yes ☐ No

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

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Name – Child 1 (last, first, MI)	Date of Birth (mm/dd/yy)
Name at Birth	Social Security Number

Applying for BadgerCare Plus?	Applying for Family Planning Only Services?
☐ Yes ☐ No	☐ Yes ☐ No
Sex	Relationship to Applicant
☐ Male ☐ Female	

Ethnicity (optional)
☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (optional, choose one or more)
☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American
☐ Hawaiian/Other Pacific Islander ☐ White

What is your marital status?
☐ Annulled ☐ Divorced ☐ Legally Separated ☐ Married ☐ Never Married ☐ Single ☐ Widowed

Are you a member, child or grandchild of a member of an American Indian Tribe or an Alaska Native?
☐ Yes ☐ No
If yes, complete Attachment 10.

Are you eligible to receive services from Indian Health Services, a tribal clinic, or an urban Indian health program?
☐ Yes ☐ No

Have you received services from Indian Health Services, a tribal clinic, or an urban Indian health program?
☐ Yes ☐ No

Is this child in foster care or living with a relative?
☐ Yes ☐ No

Answer the following questions only if you are applying for BadgerCare Plus or Family Planning Only Services.

Are you a U.S. citizen?
☐ Yes ☐ No
If no, complete the following questions:

What is your Alien Registration or USCIS number?

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

Do you have a sponsor? ☐ Yes ☐ No

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

APP

Name – Child 2 (last, first, MI)	Date of Birth (mm/dd/yy)
Name at Birth	Social Security Number

Applying for BadgerCare Plus?	Applying for Family Planning Only Services?
☐ Yes ☐ No	☐ Yes ☐ No
Sex	Relationship to Applicant
☐ Male ☐ Female	

Ethnicity (optional)
☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (optional, choose one or more)
☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American
☐ Hawaiian/Other Pacific Islander ☐ White

What is your marital status?
☐ Annulled ☐ Divorced ☐ Legally Separated ☐ Married ☐ Never Married ☐ Single ☐ Widowed

Are you a member, child or grandchild of a member of an American Indian Tribe or an Alaska Native?
☐ Yes ☐ No
If yes, complete Attachment 9.

Are you eligible to receive services from Indian Health Services, a tribal clinic, or an urban Indian health program?
☐ Yes ☐ No

Have you received services from Indian Health Services, a tribal clinic, or an urban Indian health program?
☐ Yes ☐ No

Is this child in foster care or living with a relative?
☐ Yes ☐ No

Answer the following questions only if you are applying for BadgerCare Plus or Family Planning Only Services.

Are you a U.S. citizen?
☐ Yes ☐ No
If no, complete the following questions:

What is your Alien Registration or USCIS number?

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

Do you have a sponsor? ☐ Yes ☐ No

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

APP

Name – Child 3 (last, first, MI)	Date of Birth (mm/dd/yy)
Name at Birth	Social Security Number

Applying for BadgerCare Plus?	Applying for Family Planning Only Services?
☐ Yes ☐ No	☐ Yes ☐ No
Sex	Relationship to Applicant
☐ Male ☐ Female	

Ethnicity (optional)
☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (optional, choose one or more)
☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American
☐ Hawaiian/Other Pacific Islander ☐ White

What is your marital status?
☐ Annulled ☐ Divorced ☐ Legally Separated ☐ Married ☐ Never Married ☐ Single ☐ Widowed

Are you a member, child or grandchild of a member of an American Indian Tribe or an Alaska Native?
☐ Yes ☐ No
If yes, complete Attachment 9.

Are you eligible to receive services from Indian Health Services, a tribal clinic, or an urban Indian health program?
☐ Yes ☐ No

Have you received services from Indian Health Services, a tribal clinic, or an urban Indian health program?
☐ Yes ☐ No

Is this child in foster care or living with a relative?
☐ Yes ☐ No

Answer the following questions only if you are applying for BadgerCare Plus or Family Planning Only Services.

Are you a U.S. citizen?
☐ Yes ☐ No
If no, complete the following questions:

What is your Alien Registration or USCIS number?

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

Do you have a sponsor? ☐ Yes ☐ No

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

APP

Name – Child 4 (last, first, MI)	Date of Birth (mm/dd/yy)
Name at Birth	Social Security Number

Applying for BadgerCare Plus?	Applying for Family Planning Only Services?
☐ Yes ☐ No	☐ Yes ☐ No
Sex	Relationship to Applicant
☐ Male ☐ Female	

Ethnicity (optional)
☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (optional, choose one or more)
☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American
☐ Hawaiian/Other Pacific Islander ☐ White

What is your marital status?
☐ Annulled ☐ Divorced ☐ Legally Separated ☐ Married ☐ Never Married ☐ Single ☐ Widowed

Are you a member, child or grandchild of a member of an American Indian Tribe or an Alaska Native?
☐ Yes ☐ No
If yes, complete Attachment 9.

Are you eligible to receive services from Indian Health Services, a tribal clinic, or an urban Indian health program?
☐ Yes ☐ No

Have you received services from Indian Health Services, a tribal clinic, or an urban Indian health program?
☐ Yes ☐ No

Is this child in foster care or living with a relative?
☐ Yes ☐ No

Answer the following questions only if you are applying for BadgerCare Plus or Family Planning Only Services.

Are you a U.S. citizen?
☐ Yes ☐ No
If no, complete the following questions:

What is your Alien Registration or USCIS number?

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

Do you have a sponsor? ☐ Yes ☐ No

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

APP

SECTION 4 – OTHER INFORMATION

You must answer yes or no for each question listed below. If you answer yes, you must go to the following Attachments and complete the section indicated.

A. Do you or anyone in your home want to apply for FoodShare?

☐ Yes ☐ No

If yes, complete the FoodShare Wisconsin Registration form, F-16019A, in this application packet.

B. Is anyone in your home planning to file a tax return for income received this year?

☐ Yes ☐ No

If yes, complete Attachment 6, Tax Information. If you are applying only for Family Planning Only Services, you do not need to complete Attachment 6, Tax Information.

C. Does anyone pay alimony, higher education expenses, deductible self-employment tax, student loan interest, etc.?

☐ Yes ☐ No

If yes, complete Attachment 1, Tax Deductions

D. Was anyone in your home in foster care, court-ordered Kinship Care, or a subsidized guardianship on his or her 18th birthday?

☐ Yes ☐ No

If yes, name of person(s) _____

E. Is anyone in your home pregnant?

☐ Yes ☐ No

If yes, complete Attachment 2, Pregnant Women.

F. Do any children under age 18, (including unborn children) have a natural or adoptive mother or father who is not living in the home?

☐ Yes ☐ No

If yes, is there a reason you do not want to provide information about an absent parent?

☐ Yes ☐ No

G. Will anyone in your home get income from a job this month or in the next month?

☐ Yes ☐ No

If yes, complete Attachment 3, Employment.

H. If your child is found to be over the income limit or has access to employer-sponsored health insurance where the employer pays at least 80% of the premium, do you want to enroll your child in a BadgerCare Plus Deductible? (For more information on BadgerCare Plus Deductible, see page 2.)

☐ Yes ☐ No

If yes, what is the child's name(s)? _____

I. Is anyone in your home self-employed?

☐ Yes ☐ No

If yes, complete Attachment 4a, Self-Employment.

J. Does anyone in your home get income from a source other than a job? Examples of this income include Social Security, maintenance/alimony, Unemployment Insurance, disability or sick pay, etc. If yes, complete Attachment 4b, Other Income.

☐ Yes ☐ No

K. Does anyone have medical or health insurance now, or in the previous three months?

☐ Yes ☐ No

If yes, complete Attachment 5a, Health Insurance.

APP

L. Can anyone in your home get health insurance through an employer but has NOT signed up for it?

☐ Yes ☐ No

If yes complete attachment 5b.

M. Does anyone in your home get Medicare Part A and/or Part B?

☐ Yes ☐ No

If yes and this person would like to apply for the Medicare Savings Program, complete Attachment 8, Assets.

N. Does anyone expect their income to change from month to month?

☐ Yes ☐ No

If yes, complete Attachment 10, Yearly Income.

SECTION 5 – SIGNATURE

Please read the following statements before signing. If you don't understand any part of this application, contact your agency.

Under penalties of law and/or perjury, I declare I have read and understand this application and any attachments and to the best of my knowledge, the information I have given is true, correct and complete. I understand the penalties for giving false information or breaking the rules. I understand I will have to provide proof that what I have said is true. I understand I will have to repay any benefits paid on my behalf that are issued incorrectly due to my failure to report changes or provide complete and correct information.

I understand my rights as well as my responsibilities and agree to abide by them.

I know that federal rules state any information I have given must be reviewed and verified by state staff. Also, I understand that I must cooperate fully with state and federal workers if my case is reviewed. No additional permission by me is needed to get any proof or other information.

I know that BadgerCare Plus does not pay medical costs that a third party, such as a private health insurance company or someone who injures me, is supposed to pay. I therefore assign and give my rights to any payments from a liable third party to the Wisconsin Department of Health Services up to the payment amount that BadgerCare Plus has made for my medical care. This assignment applies to any of my minor children. These payments may include payments from hospital and health insurance policies or payments received as a settlement from an accident.

I understand that my signature authorizes the local agency and the Wisconsin Department of Health Services to request any information that is appropriate and necessary for the proper administration of BadgerCare Plus as authorized under Wisconsin law.

I understand that if I do not meet the rules to enroll in BadgerCare Plus and/or Medicaid, the agency may send my information to the federal Health Insurance Marketplace. The Marketplace will use this information to see if I can get help with paying for private health insurance.

SIGNATURE – Applicant or Authorized Representative	Date Signed

APP

ATTACHMENT 1 – TAX DEDUCTIONS

Check the boxes to tell us which tax deductions you expect to take on your tax return for this year. You can check "Yes" for anyone who has the expense (for example, student loan interest), even if they are not planning to file taxes.

Type of Tax Deduction	Who gets this deduction?	How much?	How often?
Alimony Paid ☐ Yes ☐ No			
Higher Education Expenses ☐ Yes ☐ No			
Deductible Self-Employment Tax ☐ Yes ☐ No			
Student Loan Interest ☐ Yes ☐ No			

These are less common tax deductions:

Type of Tax Deduction	Who gets this deduction?	How much?	How often?
Domestic Production Activities Deduction ☐ Yes ☐ No			
Fee-based Officials' Tax-deductible Expenses ☐ Yes ☐ No			
Individual Retirement Account Contribution ☐ Yes ☐ No			
Loss from Sale of Business Property ☐ Yes ☐ No			
Military Reserve Tax-Deductible Expenses ☐ Yes ☐ No			
Net Operating Loss (NOL) ☐ Yes ☐ No			
Out-of-Pocket Costs for a Job-Related Move ☐ Yes ☐ No			
Penalties for Early Withdrawal of Savings ☐ Yes ☐ No			
Performance Artists' Tax-Deductible Expenses ☐ Yes ☐ No			
Self-Employed Health Insurance Plan Contribution ☐ Yes ☐ No			
Self-Employed Retirement Plan Contribution ☐ Yes ☐ No			
Teachers' Tax-Deductible Expenses ☐ Yes ☐ No			
Other Allowable Write-In Deductions ☐ Yes ☐ No Describe deduction: _____			

APP

ATTACHMENT 2 – PREGNANT WOMEN

If more room is needed for any section, use an extra sheet of paper.

PREGNANT WOMAN		
Name of pregnant woman	Due date (mm/dd/yy)	If multiple births, number of babies expected.
Name of pregnant woman	Due date (mm/dd/yy)	If multiple births, number of babies expected.
Name of pregnant woman	Due date (mm/dd/yy)	If multiple births, number of babies expected.

APP

ATTACHMENT 3 – EMPLOYMENT

EMPLOYMENT

Complete this section for anyone in your home that will get income or in-kind income from a job this month or in the next month. By in-kind income we mean a job that pays only in goods or services instead of money. For example, someone who gets free housing in exchange for work. ***Use an additional sheet of paper if more room is needed.***

Job 1 – Name of employed person (last, first, MI)	Date employment started

Employer name

Employer Address

City	State	Zip Code

Is this person on strike? ☐ Yes ☐ No	How many hours does this person work each week?

Is this person on strike? ☐ Yes ☐ No	If hourly, how much each hour? $	If salary, how much each pay period? $

Does this person get cash and/or tips? ☐ Yes ☐ No	If yes, how much per pay period? $
Does this person get bonuses and/or commissions? ☐ Yes ☐ No	If yes, how much per pay period? $

How often is this person paid?
☐ Weekly ☐ Every 2 weeks ☐ Twice each month ☐ Once a month
☐ Other, explain: _____

Job Type ☐ Permanent ☐ Temporary	Job Title ☐ Manager ☐ Staff

If employment ended, date ended (mm/dd/yy)	Date of last paycheck	Amount of last paycheck $

Is this person a migrant worker?
☐ Yes ☐ No

List all pre-tax deductions this employed person has taken out of his or her paychecks for this job.

Type of Pre-tax Deduction	How much?	How often?
Child Care Savings Account ☐ Yes ☐ No	$	
Group Life Insurance ☐ Yes ☐ No	$	
Health Insurance Premiums ☐ Yes ☐ No	$	
Health Savings Account ☐ Yes ☐ No	$	
Parking and Transit Costs ☐ Yes ☐ No	$	

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Retirement Contributions ☐ Yes ☐ No	$	

Job 2 – Name of employed person (last, first, MI)	Date employment started (mm/dd/yy)

Employer name
Employer Address

City	State	Zip Code

Is this person on strike? ☐ Yes ☐ No	How many hours does this person work each week?

Is this person on strike? ☐ Yes ☐ No	If hourly, how much each hour? $	If salary, how much each pay period? $

Does this person get cash and/or tips? ☐ Yes ☐ No	If yes, how much per pay period? $
Does this person get bonuses and/or commissions? ☐ Yes ☐ No	If yes, how much per pay period? $

How often is this person paid?
☐ Weekly ☐ Every 2 weeks ☐ Twice each month ☐ Once a month
☐ Other, explain: _____

Job Type ☐ Permanent ☐ Temporary	Job Title ☐ Manager ☐ Staff

If employment ended, date ended (mm/dd/yy)	Date of last paycheck	Amount of last paycheck $

Is this person a migrant worker?
☐ Yes ☐ No

List all pre-tax deductions this employed person has taken out of his or her paychecks for this job.

Type of Pre-tax Deduction	How much?	How often?
Child Care Savings Account ☐ Yes ☐ No	$	
Group Life Insurance ☐ Yes ☐ No	$	
Health Insurance Premiums ☐ Yes ☐ No	$	
Health Savings Account ☐ Yes ☐ No	$	
Parking and Transit Costs ☐ Yes ☐ No	$	
Retirement Contributions ☐ Yes ☐ No	$	

APP

Job 3 – Name of employed person (last, first, MI)	Date employment started (mm/dd/yy)
Employer name	
Employer Address	

City	State	Zip Code

Is this person on strike? ☐ Yes ☐ No	How many hours does this person work each week?

Is this person on strike? ☐ Yes ☐ No	If hourly, how much each hour? $	If salary, how much each pay period? $

Does this person get cash and/or tips? ☐ Yes ☐ No	If yes, how much per pay period? $
Does this person get bonuses and/or commissions? ☐ Yes ☐ No	If yes, how much per pay period? $

How often is this person paid?
☐ Weekly ☐ Every 2 weeks ☐ Twice each month ☐ Once a month
☐ Other, explain: _____

Job Type ☐ Permanent ☐ Temporary	Job Title ☐ Manager ☐ Staff

If employment ended, date ended (mm/dd/yy)	Date of last paycheck	Amount of last paycheck $

Is this person a migrant worker?
☐ Yes ☐ No

List all pre-tax deductions this employed person has taken out of his or her paychecks for this job.

Type of Pre-tax Deduction	How much?	How often?
Child Care Savings Account ☐ Yes ☐ No	$	
Group Life Insurance ☐ Yes ☐ No	$	
Health Insurance Premiums ☐ Yes ☐ No	$	
Health Savings Account ☐ Yes ☐ No	$	
Parking and Transit Costs ☐ Yes ☐ No	$	
Retirement Contributions ☐ Yes ☐ No	$	

APP

ATTACHMENT 4A – SELF-EMPLOYMENT

SELF-EMPLOYMENT

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

Self-Employment 1

Name of Self-Employed Person	Business Name
Business Address	
Business Ownership Type: ☐ Partnership ☐ S corporation ☐ Sole proprietorship ☐ I don't know	
Business Type (for example, a farm, home day care)	Date Business Started
Has this business filed taxes? ☐ Yes ☐ No If yes, for what tax year did the business last file taxes?	
Has the business had a significant change in income or expenses? ☐ Yes ☐ No ☐ I don't know	
On average, how much does this business make each month? Please give us the income received before expenses are taken out. $	
On average, what are the total expenses this business has each month? $	
On average, how many hours per month does this person work for this business?	

Self-Employment 2

Name of Self-Employed Person	Business Name
Business Address	
Business Ownership Type: ☐ Partnership ☐ S corporation ☐ Sole proprietorship ☐ I don't know	
Business Type (for example, farm, home day care)	Date Business Started
Has this business filed taxes? ☐ Yes ☐ No If yes, for what tax year did the business last file taxes?	
Has the business had a significant change in income or expenses? ☐ Yes ☐ No ☐ I don't know	
On average, how much does this business make each month? Please give us the income received before expenses are taken out. $	
On average, what are the total expenses this business has each month? $	
On average, how many hours per month does this person work for this business?	

APP

ATTACHMENT 4B – OTHER INCOME

OTHER INCOME

Please list below all other income you and/or your family members get each month (except for Child Support, Supplemental Security Income, Workers Compensation, Veterans Benefits and gifts/money from another person).

Type of income	Name of person who gets this income (first, last, MI)	Gross monthly amount
		$
		$
		$
		$
		$
		$
		$
		$
		$
		$
		$
		$
		$

APP

ATTACHMENT 5A – HEALTH INSURANCE

HEALTH INSURANCE

Complete the following if anyone has medical or health insurance now, or in the previous three months.

Name – Policyholder	Policy number	Begin Date

Name of Plan (for example "Silver Plan")

Name of Insurance Company

Insurance Company Address

City	State	Zip Code

Who is or was covered under this policy (family member's names)?

Has this coverage ended in the last three months?
☐ Yes ☐ No

If yes, what is the date the coverage ended?	Why did the coverage end?

Does this insurance cover services from a doctor?
☐ Yes ☐ No

Is/was this insurance provided by a current employer?
☐ Yes ☐ No

If no, tell us the source of the insurance:

☐ COBRA Continuation Coverage
☐ Private Insurance Plan
☐ Past Employment
☐ Peace Corps
☐ Retiree Health Plan
☐ TRICARE
☐ Veterans Health Administration Programs

If yes, answer all of the remaining questions on this page.

If the insurance is through a current or past employer, what is the employer's name?

What is the employer's address?

What is the employer's Federal Employer Identification Number (FEIN), if known?

Is this insurance through a state employee benefit plan?	Does this insurance cover services from a doctor?
☐ Yes ☐ No	☐ Yes ☐ No

Minimum Value Standard Plans (For more information about Minimum Value Standard Plans, see page 5.)

Does this employer offer a plan that meets the minimum value standard?
☐ Yes ☐ No ☐ Do not know

What is the name of the lowest-cost employee-only plan offered by this employer?

How much are the monthly premiums?	How often do these premiums need to be paid?
$	☐ Weekly ☐ Every Two Weeks ☐ Monthly

Plan Changes (Tell us more about changes that this employer may make to the health insurance if offers next year.)

Will this employer continue to offer health insurance next year?
☐ Yes ☐ No ☐ Do not know

Will there be any change in premiums for the lowest-cost employee-only plan that meets the minimum value standard?
☐ Yes ☐ No ☐ Do not know

How much will this plan's new premiums be?	How often do these premiums need to be paid?
$ ☐ Do not know	☐ Weekly ☐ Every Two Weeks ☐ Monthly

Name – Policyholder	Policy number	Begin Date

Name of Plan (for example "Silver Plan")

Name of Insurance Company

Insurance Company Address

City	State	Zip Code

Who is or was covered under this policy (family member's names)?

Has this coverage ended in the last three months?
☐ Yes ☐ No

If yes, what is the date the coverage ended?	Why did the coverage end?

Does this insurance cover services from a doctor?
☐ Yes ☐ No

Is/was this insurance provided by a current employer?
☐ Yes ☐ No

If no, tell us the source of the insurance:

☐ COBRA Continuation Coverage
☐ Private Insurance Plan
☐ Past Employment
☐ Peace Corps
☐ Retiree Health Plan
☐ TRICARE
☐ Veterans Health Administration Programs

If yes, answer all of the remaining questions on this page.

If the insurance is through a current or past employer, what is the employer's name?

What is the employer's address?

What is the employer's Federal Employer Identification Number (FEIN), if known?

Is this insurance through a state employee benefit plan?	Does this insurance cover services from a doctor?
☐ Yes ☐ No	☐ Yes ☐ No

Minimum Value Standard Plans (For more information about Minimum Value Standard Plans, see page 5.)

Does this employer offer a plan that meets the minimum value standard?
☐ Yes ☐ No ☐ Do not know

What is the name of the lowest-cost employee-only plan offered by this employer?

How much are the monthly premiums?	How often do these premiums need to be paid?
$	☐ Weekly ☐ Every Two Weeks ☐ Monthly

Plan Changes (Tell us more about changes that this employer may make to the health insurance if offers next year.)

Will this employer continue to offer health insurance next year?
☐ Yes ☐ No ☐ Do not know

Will there be any change in premiums for the lowest-cost employee-only plan that meets the minimum value standard?
☐ Yes ☐ No ☐ Do not know

How much will this plan's new premiums be?	How often do these premiums need to be paid?
$ ☐ Do not know	☐ Weekly ☐ Every Two Weeks ☐ Monthly

APP

ATTACHMENT 5B – OTHER HEALTH INSURANCE OPTIONS

OTHER HEALTH INSURANCE OPTIONS

If you do not meet the rules to enroll in BadgerCare Plus, your information may be sent to the Marketplace (also called the Exchange). They will use the answers to these and other questions to make a decision about whether you can get help paying for private health insurance. You do not have to answer these questions now, but it could help you get an answer faster if your information is sent to the Marketplace.

Your answers will not be used for making a decision about your BadgerCare Plus benefits.

List the names of those who could get health insurance from a job right now, but have NOT signed up for that insurance.

Does anyone outside of the home have insurance from a job that would cover anyone in the home but have NOT signed up for that insurance?

☐ Yes ☐ No

If yes, what is that person's name? _____

Answer the following question about the employer who offers health insurance.

Name of Employer	Federal Employer ID Number (FEIN) (if known)
Is this insurance offered through a state employee benefit plan? ☐ Yes ☐ No	Employer Telephone (including area code)

Employer Address (Street)

City	State	Zip Code

Name – Contact person at employer who can answer questions about the health insurance offered

Contact Telephone Number (including area code)	Contact Email Address

Signing Up for Insurance (Tell us why you have not signed up for this insurance.)

What is the reason you did not sign up for this health insurance?

☐ There is a waiting or probationary period ☐ Other, explain: _____

Will you sign up for this health insurance in the next 3 months? ☐ Yes ☐ No	If yes, what is the date the insurance will start?

Minimum Value Standard Plans (For more information about Minimum Value Standard Plans, see page 5.)

Does this employer offer a plan that meets the minimum value standard?

☐ Yes ☐ No ☐ Do not know

What is the name of the lowest-cost employee-only plan offered by this employer?

How much are the monthly premiums? $	How often do these premiums need to be paid? ☐ Weekly ☐ Every Two Weeks ☐ Monthly

APP

ATTACHMENT 6 – TAX INFORMATION

TAX FILER

List information for each person in your household who expects to file taxes for income he or she will get this year. If you are married and file jointly, you only need to complete one section for both filers.

Name Tax Filer 1	Name of Spouse (if married and filing jointly)

Tax Filing Status

☐ Singe or Head of Household ☐ Married Filing Jointly ☐ Married Filing Separately

Will this tax filer be claimed as a dependent by someone outside of the home?

☐ Yes ☐ No

Tax Dependents: List the dependents this tax filer will be claiming on his or her taxes. Use an additional sheet of paper if more room is needed.

Name of Tax Dependent	Date of Birth
Social Security Number	Sex ☐ Male ☐ Female

Is this dependent expected to have more than $12,400 in earned income this year?

☐ Yes ☐ No

Is this dependent expected to have more than $1,100 in unearned income this year? (Do not include Child Support, Social Security, Supplemental Security Income, Worker's Compensation, Veterans Benefits or gifts / money from another person.)

☐ Yes ☐ No

Is this tax dependent living outside of the home? ☐ Yes ☐ No	Is this tax dependent deceased? ☐ Yes ☐ No

Name of Tax Dependent	Date of Birth
Social Security Number	Sex ☐ Male ☐ Female

Is this dependent expected to have more than $12,400 in earned income this year?

☐ Yes ☐ No

Is this dependent expected to have more than $1,100 in unearned income this year? (Do not include Child Support, Social Security, Supplemental Security Income, Worker's Compensation, Veterans Benefits or gifts / money from another person.)

☐ Yes ☐ No

Is this tax dependent living outside of the home? ☐ Yes ☐ No	Is this tax dependent deceased? ☐ Yes ☐ No

Name of Tax Dependent	Date of Birth
Social Security Number	Sex ☐ Male ☐ Female

Is this dependent expected to have more than $12,400 in earned income this year?

☐ Yes ☐ No

APP

Is this dependent expected to have more than $1,100 in unearned income this year? (Do not include Child Support, Social Security, Supplemental Security Income, Worker's Compensation, Veterans Benefits or gifts / money from another person.)

☐ Yes ☐ No

Is this tax dependent living outside of the home?	Is this tax dependent deceased
☐ Yes ☐ No	☐ Yes ☐ No

Name of Tax Dependent	Date of Birth
Social Security Number	Sex ☐ Male ☐ Female

Is this dependent expected to have more than $12,400 in earned income this year?

☐ Yes ☐ No

Is this dependent expected to have more than $1,100 in unearned income this year? (Do not include Child Support, Social Security, Supplemental Security Income, Worker's Compensation, Veterans Benefits or gifts / money from another person.)

☐ Yes ☐ No

Is this tax dependent living outside of the home?	Is this tax dependent deceased?
☐ Yes ☐ No	☐ Yes ☐ No
Name Tax Filer 2	Name of Spouse (if married and filing jointly)

Tax Filing Status

☐ Singe or Head of Household ☐ Married Filing Jointly ☐ Married Filing Separately

Will this tax filer be claimed as a dependent by someone outside of the home?

☐ Yes ☐ No

Tax Dependents: List the dependents this tax filer will be claiming on his or her taxes. Use an additional sheet of paper if more room is needed.

Name of Tax Dependent	Date of Birth
Social Security Number	Sex ☐ Male ☐ Female

Is this dependent expected to have more than $12,400 in earned income this year?

☐ Yes ☐ No

Is this dependent expected to have more than $1,100 in unearned income this year? (Do not include Child Support, Social Security, Supplemental Security Income, Worker's Compensation, Veterans Benefits or gifts / money from another person.)

☐ Yes ☐ No

Is this tax dependent living outside of the home?	Is this tax dependent deceased?
☐ Yes ☐ No	☐ Yes ☐ No
Name of Tax Dependent	Date of Birth
Social Security Number	Sex ☐ Male ☐ Female

APP

Is this dependent expected to have more than $12,400 in earned income this year?
☐ Yes ☐ No

Is this dependent expected to have more than $1,100 in unearned income this year? (Do not include Child Support, Social Security, Supplemental Security Income, Worker's Compensation, Veterans Benefits or gifts / money from another person.)
☐ Yes ☐ No

Is this tax dependent living outside of the home?	Is this tax dependent deceased?
☐ Yes ☐ No	☐ Yes ☐ No

Name of Tax Dependent	Date of Birth
Social Security Number	Sex ☐ Male ☐ Female

Is this dependent expected to have more than $12,400 in earned income this year?
☐ Yes ☐ No

Is this dependent expected to have more than $1,100 in unearned income this year? (Do not include Child Support, Social Security, Supplemental Security Income, Worker's Compensation, Veterans Benefits or gifts / money from another person.)
☐ Yes ☐ No

Is this tax dependent living outside of the home?	Is this tax dependent deceased?
☐ Yes ☐ No	☐ Yes ☐ No

Name of Tax Dependent	Date of Birth
Social Security Number	Sex ☐ Male ☐ Female

Is this dependent expected to have more than $12,400 in earned income this year?
☐ Yes ☐ No

Is this dependent expected to have more than $1,100 in unearned income this year? (Do not include Child Support, Social Security, Supplemental Security Income, Worker's Compensation, Veterans Benefits or gifts / money from another person.)
☐ Yes ☐ No

Is this tax dependent living outside of the home?	Is this tax dependent deceased?
☐ Yes ☐ No	☐ Yes ☐ No

APP

ATTACHMENT 7 – REQUEST FOR BACKDATED COVERAGE

If you are requesting backdated coverage, complete, sign and return this attachment with your application. Coverage can only be backdated for three months. Please Note: Requesting backdated coverage does not guarantee you will be enrolled for the months requested.

If the information on the application form is different for any of the three months before your application month, list the differences below for each month that you are requesting backdated coverage. Your application month is the month your application is received by the local agency. Differences may include: address, people in your household, income, health insurance. You must provide proof of income for any of the three months you are requesting backdated coverage.

What is the date you want coverage to begin?

1. For what month are you requesting backdated coverage?

Is any information included in your application different in this month from the application month?

☐ Yes ☐ No

If "Yes", describe the changes.

If your income was different, what was your total gross family income for this month?

2. For what month are you requesting backdated coverage?

Is any information included in your application different in this month from the application month?

☐ Yes ☐ No

If "Yes", describe the changes.

If your income was different, what was your total gross family income for this month?

3. For what month are you requesting backdated coverage?

Is any information included in your application different in this month from the application month?

☐ Yes ☐ No

If "Yes", describe the changes.

If your income was different, what was your total gross family income for this month?

SIGNATURE – Applicant / Authorized Representative	Date Signed

APP

ATTACHMENT 8 – ASSETS (FOR MEDICARE SAVINGS PROGRAMS ONLY)

This form should be completed only if someone in your home receives Medicare Part A and/or Part B and you want to apply for the Medicare Savings Program (also called Medicare Premium Assistance or Buy-In program). You must list all your family's assets. 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. 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 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. 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	Account Number
		$		
		$		
		$		

BURIAL ASSETS

List all burial assets.

Type of Burial Asset	Name of Owner(s)	Value
Burial Insurance: ☐ Yes ☐ No		$
Irrevocable Burial Trust: ☐ Yes ☐ No		$
Other: ☐ Yes ☐ No		$

VEHICLE INFORMATION

List all motor vehicles. Include vehicles owned jointly with another person.

Vehicle 1				**Vehicle 2**			
Type of vehicle	Year	Make	Model	Type of vehicle	Year	Make	Model
Amount owed on vehicle $		Fair Market Value* $		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.

LIFE INSURANCE

Tell us about any life insurance you and/or your family has.

Do you or any family member have any life insurance policies? ☐ Yes ☐ No

If yes, complete the section below.

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

APP

ATTACHMENT 9 – AMERICAN INDIAN OR ALASKA NATIVE FAMILY MEMBER

FEDERALLY RECOGNIZED TRIBE

Is anyone a member of a federal recognized tribe?

☐ Yes ☐ No

If yes, list them below.

Person's Name	Name of Tribe

NON-GAMING TRIBAL INCOME

Some tribal income types may not be counted for BadgerCare Plus. List any income (amount and how often) reported on your application that includes money from these sources:

- Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties
- Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations)
- Money from selling things that have cultural significance

Tribal per capita payments from gaming activities are counted for BadgerCare Plus, so you should not list them here.

Name of Person Who Receives Income	Amount Received	Type of Income	How Often Paid
	$		
	$		
	$		
	$		
	$		

APP

ATTACHMENT 10 – YEARLY INCOME

Complete only if someone's income changes from month to month. If you do not know the exact amount, use your best guess, or write "I don't know."

Name of Person	What is the expected income for this year?	What is the expected income for next year?
	$	$
	$	$
	$	$
	$	$

STATE OF WISCONSIN
DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-10154 (07/08)

ID

STATEMENT OF IDENTITY FOR CHILDREN UNDER 18 YEARS OF AGE

This Statement may be used only to meet the new Medicaid/BadgerCare Plus/Family Planning Only Services proof of **identity** rule for children under 18 years of age. This statement may not be used to meet the Medicaid, BadgerCare Plus/ Family Planning Only Services proof of citizenship rule.

Instructions: In the space provided below, list all the children under age 18 in your household for whom you are a parent, guardian or caretaker relative. For each child you list, include the child's date of birth and place of birth (city, state and country). **Complete, sign and return this statement to your agency.**

Child's Full Name (First, MI, Last)	Date of Birth	Place of Birth (City, State, Country)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		

Personally identifiable information will be used only for the direct administration of Family Planning Only Services, Medicaid and BadgerCare Plus programs.

By signing this statement, I certify, under penalty of perjury and false swearing, that the information I have given is correct and complete to the best of my knowledge. I understand that the local agency may contact other persons or organizations, to confirm the accuracy of my statement.

SIGNATURE _____ Date Signed _____
(Parent, Guardian or Caretaker Relative)

Print Name _____ Case Number _____
(Parent, Guardian or Caretaker Relative)

STATE OF WISCONSIN
DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-10183 (05/2017)

INFORMATION CHANGE REPORT

BadgerCare Plus
If you are enrolled in BadgerCare Plus, you must report the following types of changes no later than 10 days after the change has occurred:

- You move to a new address or out of state.
- Someone moves in or out of your home, becomes pregnant, or gives birth.
- Your living arrangement changes (for example, you are incarcerated or you go into a nursing home or other institution).
- You get married or divorced.
- Someone in your home has a change in health insurance.
- Someone in your home has a change in expected tax filing status or tax dependents or no longer has a tax deduction that he or she previously reported.

If you have a change in income that makes your gross monthly income go over the BadgerCare Plus program limit, you must report that change by the 10th day of the next month.

When you enroll in BadgerCare Plus or if you have a change in benefits, you will get a notice in the mail with the program limits for your family size. You should always look at your latest notice for the most current information.

Family Planning Only Services
If you are enrolled in Family Planning Only Services, you must report only the following types of changes no later than 10 days after the change has occurred:

- You move to a new address or out of state.
- Your living arrangement changes (for example, you are incarcerated or you go into a nursing home or other institution).

You can report the changes noted above using this form, by calling your agency, or online at ACCESS.wi.gov. If you use this form to report your changes, once you have completed and signed the form, you should mail or fax it to:

If you live in Milwaukee County:
MDPU
PO Box 05676
Milwaukee WI 53205
Fax: 1-888-409-1979

If you **do not** live in Milwaukee County
CDPU
PO Box 5234
Janesville, WI 53547-5234
Fax: 1-855-293-1822

If this form does not provide enough room to describe a change, attach a sheet of paper with the additional information.

CHG

Name – Member (Last, First MI)	Case Number or Social Security Number

CHANGE IN ADDRESS
Use this section to report a new address if you moved.

New Street Address		
City	State	Zip Code
New Phone Number	Date of Change (mm/dd/yy)	

CHANGE IN HOUSEHOLD
Use this section to report if someone moved in or out of your home, got married, became pregnant, or gave birth. If someone became pregnant, tell us who it is, the due date, and the number of expected babies.

Name (Last, First MI)		Social Security Number
Date of Birth (mm/dd/yy)	Relationship to You	Date of Change (mm/dd/yy)
Describe the Change		

CHANGE IN INCOME
Use section A to report changes in income from a job or self-employment or from sources other than a job, such as Social Security or unemployment insurance. Fill out section B if someone in your home lost a job or section C if someone in your home got a new job.

A. Changes in Income From Any Source

Name (Last First MI)	Source of Income
What changed?	

Date of Change (mm/dd/yy)	New Income Amount $	How often is it paid?

B. Loss of Job

Name (Last, First MI)		
Name – Employer		
Date Job Ended (mm/dd/yy)	Date of Final Paycheck (mm/dd/yy)	Amount of Final Paycheck $

CHG

C. New Job

Name (Last, First MI)	Date Job Started (mm/dd/yy)
Name – Employer	Phone Number

Street Address – Employer

City	State	Zip Code

Is this person on strike? ☐ Yes ☐ No		Hours Worked Each Week	
☐ Paid by the hour	Amount Per Hour $	☐ Paid a salary	Amount Per Pay Period $
Does this person get cash and/or tips? ☐ Yes ☐ No		If Yes – Amount Per Pay Period $	
Does this person get bonuses and/or commissions? ☐ Yes ☐ No		If Yes – Amount Per Pay Period $	

How often is this person paid?
☐ Weekly ☐ Every 2 weeks ☐ Twice each month ☐ Once a month ☐ Other – Explain Below

Job Type ☐ Permanent ☐ Temporary	Job Title ☐ Manager ☐ Staff	Is this person a migrant worker? ☐ Yes ☐ No

List all pre-tax deductions this person has taken out of his or her paychecks for this job.

Type of Pretax Deduction	How much?	How often?
☐ Child care savings account	$	
☐ Group life insurance	$	
☐ Health insurance premiums	$	
☐ Health savings accounts	$	
☐ Parking and transit costs	$	
☐ Retirement contributions	$	

CHANGE IN TAX INFORMATION

Use this section to report if someone in your home had a change in expected tax filing status or tax dependents. If the person is married and filing jointly, you only need to complete the information for one of the spouses. If you need more room, attach a sheet of paper with the additional information.

Name (Last, First MI)	Name – Spouse if Filing Jointly (Last, First MI)

Is this person expecting to file taxes for income he or she will get this year?
☐ Yes ☐ No

CHG

If yes, what is his or her tax filing status?

☐ Single ☐ Married filing jointly ☐ Married filing separately

Will this tax filer be claimed as a dependent by someone outside of the home?

☐ Yes ☐ No

List the dependents this person will be claiming on his or her taxes.

Name – Tax Dependent (Last, First MI)

Date of Birth (mm/dd/yy)	Social Security Number	Sex ☐ Male ☐ Female

Is this tax dependent expected to have more than $6,300 in earned income this year?

☐ Yes ☐ No

Is this tax dependent expected to have more than $1,050 in unearned income this year? (Do not include child support, Social Security, Supplemental Security Income, workers compensation, or veterans benefits.)

☐ Yes ☐ No

Is this tax dependent living outside of the home? ☐ Yes ☐ No	Is this tax dependent deceased? ☐ Yes ☐ No

Name – Tax Dependent (Last, First MI)

Date of Birth (mm/dd/yy)	Social Security Number	Sex ☐ Male ☐ Female

Is this tax dependent expected to have more than $6,300 in earned income this year?

☐ Yes ☐ No

Is this tax dependent expected to have more than $1,050 in unearned income this year? (Do not include child support, Social Security, Supplemental Security Income, workers compensation, or veterans benefits.)

☐ Yes ☐ No

Is this tax dependent living outside of the home? ☐ Yes ☐ No	Is this tax dependent deceased? ☐ Yes ☐ No

Name – Tax Dependent (Last, First MI)

Date of Birth (mm/dd/yy)	Social Security Number	Sex ☐ Male ☐ Female

Is this tax dependent expected to have more than $6,300 in earned income this year?

☐ Yes ☐ No

Is this tax dependent expected to have more than $1,050 in unearned income this year? (Do not include child support, Social Security, Supplemental Security Income, workers compensation, or veterans benefits.)

☐ Yes ☐ No

Is this tax dependent living outside of the home? ☐ Yes ☐ No	Is this tax dependent deceased? ☐ Yes ☐ No

CHG

OTHER CHANGES
Use this space to report other changes.

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 get 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 – Member	Date Signed (mm/dd/yy)

WISCONSIN DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-16019A (07/2020)

APP

FOODSHARE WISCONSIN REGISTRATION

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

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

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

Name – Applicant (Last, First, Middle Initial)		Social Security Number (optional)
Date of Birth (mm/dd/yy – optional)	Phone Number (optional)	Are You Currently Homeless? ☐ Yes ☐ No
Street Address		
City	State	Zip Code
SIGNATURE – Applicant or Authorized Representative	Date Signed (mm/dd/yy)	

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

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

Answer the following questions to be considered for faster service.

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

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

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

Check the utilities your household is required to pay, and check "Yes" or "No" if the utility is used to heat your home.

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

Check the utilities your household is required to pay.

☐ Phone ☐ Water ☐ Sewer ☐ Trash removal ☐ Installation ☐ Air conditioning surcharge ☐ Other:_____

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

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

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

Mail or fax applications and/or proof to:

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

Or fax: 888-409-1979

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

Or fax: 855-293-1822

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

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

FOODSHARE WISCONSIN IMPORTANT INFORMATION

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

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

As a FoodShare member, you have rights and responsibilities. Your rights include:

- The right to be notified of your enrollment status within 30 days of applying.
- The right to get benefits within seven days if you qualify for immediate help.
- The right to be treated with respect and not be discriminated against because of age, sex, race, color, disability, religious creed, national origin, or political beliefs.

You are responsible for:

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

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

For more information about your rights and responsibilities, go to www.dhs.wisconsin.gov/library/F-10150B.htm.

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

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

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

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

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

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

This institution is an equal opportunity provider.

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

FAIR HEARING
You have the right to a fair hearing if you disagree with any agency action. You may request a fair hearing verbally by calling 608-266-7709. You can also send the Request for Fair Hearing form or a letter requesting a hearing by fax to 608-264-9885 or by mail to:

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

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

The Request for Fair Hearing form may be downloaded at www.dhs.wisconsin.gov/forwardhealth/resources.htm, or you can call the agency listed on your letter to request a hearing.

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

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

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

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

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

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

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

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

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

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

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

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

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

QUALITY CONTROL REVIEW
Your FoodShare case may be randomly selected by the Wisconsin Department of Health Services for a quality control review. A FoodShare quality control review is a review of your FoodShare case to make sure the agency that enrolled you in FoodShare issued your benefits correctly and is following the rules set by the federal government. Federal law states that you must cooperate with the quality control review. If you do not give the information requested and do not cooperate with the review, your FoodShare case may be closed. If this happens, you will be told how long your case may be closed.

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

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

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

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

WORK REGISTRATION REQUIREMENT SANCTION

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

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

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

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

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

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

WORK REQUIREMENT FOR ABLE-BODIED ADULTS AGES 18 THROUGH 49

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

There are four ways to meet the work requirement:

1. Work at least 80 hours each month.
2. Take part in an allowable work program at least 80 hours each month, such as:
   a. FoodShare Employment and Training (FSET).
   b. W-2.
   c. Certain programs under the Workforce Innovation and Opportunity Act (WIOA).
3. Have an in-kind job (paid with goods instead of money) or volunteer at least 80 hours each month.

4. Have a combination of work, an in-kind job, volunteer, or take part in an allowable work program for a total of 80 hours each month.

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

You may be considered exempt and may not need to meet the work requirement if any of the following is true:

- You are living with a child under age 18 who is part of the same FoodShare household.
- You are the primary caregiver for a person who cannot care for himself or herself.
- You are the primary caregiver for a dependent child under age 6.
- You are physically or mentally unable to work. This includes being homeless long term. Being homeless long term means you will not have a regular place to stay for the next 30 nights.
- You are pregnant.
- You are receiving or have applied for unemployment insurance.
- You are taking part in an alcohol or other drug abuse (AODA) treatment or rehabilitation program.
- You are enrolled in an institution of higher learning at least half time.
- You are age 18 or older attending high school at least half time.
- You are enrolled in W-2 and complying with W-2 requirements.
- You are working 30 or more hours per week or are earning wages equal to 30 or more hours per week at the federal minimum wage.

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

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

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

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

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

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

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

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

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

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

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

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

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

Other Income
(for example, unemployment insurance, disability insurance, Social Security, retirement, veterans benefits, military allotments)
- Award letter
- Copy of last check

The following items may be required to get a credit.

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

Child Support
(received or paid in a state other than Wisconsin)
- Court order papers or other record of payment
- Payment record from other state

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

Medical Costs and Expenses
Medical costs and expenses include, but are not limited to, the following:
- Hospital, medical, dental, and vision services
- Premiums for health insurance, Medicare premiums, and costs for prescriptions drug plans
- Prescription and over-the-counter medicine
- Nursing home and home health services
- Medical equipment and supplies
- Transportation and lodging costs to get medical care
- Related cost for a specially trained service animal
- Lifeline/Medic Alert costs if prescribed by a health care professional
- Billing statement
- Itemized receipts
- Medicine or pill bottle with price on label
- Health insurance policy showing premium, coinsurance, copayments, or deductible
- Statement from pharmacy
- Repayment agreement with provider
- Statement from doctor verifying over-the-counter drug was prescribed
- Bill for services of a visiting nurse, homemaker, or home health aide
- Lodging and/or transportation receipts for obtaining medical treatment or services
- Bill or receipts for animal food, training, or veterinarian services for a specially trained service animal

WISCONSIN DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-16019B (07/2020)

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FOODSHARE WISCONSIN APPLICATION

This application is for FoodShare only. This is not an application for Medicaid, BadgerCare Plus, Wisconsin Shares, or Wisconsin Works (W-2). You can apply for Medicaid, BadgerCare Plus, and Wisconsin Shares online at access.wi.gov at the same time you are applying for FoodShare. To apply for W-2, you must contact your agency. These programs can provide you help with the cost of health care or child care or finding a job as part of W-2.

How to Use This Form

1. Print clearly. Use blue or black ink.
2. Fill out the application completely. If you need more room to provide your answer, use a blank sheet of paper. Return your application to **your agency**. To get the address of your agency, go to www.dhs.wisconsin.gov/forwardhealth/resources.htm or call Member Services at 800-362-3002.
3. If you need help filling out this application, contact your agency.
4. You may have an authorized representative apply for you. To appoint an authorized representative, fill out either the Appoint, Change, or Remove an Authorized Representative: Person form, F10126A, or the Appoint, Change, or Remove an Authorized Representative: Organization form, F10126B. This will allow your authorized representative to complete and sign the application for you. To get this form, call 800-362-3002, or go to www.dhs.wisconsin.gov/forwardhealth/representative-types.htm.

SECTION 1 – CONTACT INFORMATION

Please tell us how we can contact you. Include the area code for all phone numbers.

Phone Number	Type of Phone ☐ Home ☐ Cell ☐ Work	
Other Phone Number	Who does this number belong to? ☐ Self ☐ Friend ☐ Neighbor ☐ Relative	What is this person's name?
Email Address		
What is the best way and time to contact you during the weekdays?		

SECTION 2 – APPLICANT INFORMATION

If you are completing this application for someone else, answer the rest of the questions as if you were that person.
Note: You don't have to answer race and ethnicity questions if you don't want to. We are asking these questions to help improve our programs and make sure they do not discriminate based on ethnicity or race. Your answers will not be used to make a decision about your programs and benefits.

Name – Applicant (Last, First Middle Initial)	Date of Birth (mm/dd/yy)	Social Security Number
Street Address		
City	State	Zip Code
Are you currently homeless? ☐ Yes ☐ No		
Mailing Address – if different from your residence (include street or PO box)		
City	State	Zip Code

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Sex ☐ Male ☐ Female	Marital Status ☐ Married ☐ Single ☐ Divorced
U.S. Citizen (only for those applying) ☐ Yes ☐ No	Ethnicity (optional) ☐ Hispanic or Latino ☐ Not Hispanic or Latino
Race (optional, choose one or more) ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Hawaiian/Other Pacific Islander ☐ White	
In which language do you want FoodShare letters printed?	Primary Language Spoken in Your Home

SECTION 3 – HOUSEHOLD INFORMATION

If more room is needed, use a blank sheet of paper to answer these questions. **Note**: You don't have to answer race and ethnicity questions if you don't want to. We are asking these questions to help improve our programs and make sure they do not discriminate based on ethnicity or race. Your answers will not be used to make a decision about your programs and benefits.

Name – Spouse or Other Adult (Last, First Middle Initial)		Is this person applying for FoodShare? ☐ Yes ☐ No
Date of Birth (mm/dd/yy)	Social Security Number (if applying)	
Sex ☐ Male ☐ Female	Marital Status ☐ Married ☐ Single ☐ Divorced	
U.S. Citizen (only for those applying) ☐ Yes ☐ No	Ethnicity (optional) ☐ Hispanic or Latino ☐ Not Hispanic or Latino	
Race (optional, choose one or more) ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Hawaiian/Other Pacific Islander ☐ White		
Relationship to Applicant	Do you share food with this person? ☐ Yes ☐ No	Do you provide care for this person? ☐ Yes ☐ No

Name – Child 1 (Last, First Middle Initial)		Is this person applying for FoodShare? ☐ Yes ☐ No
Date of Birth (mm/dd/yy)	Social Security Number (if applying)	
Sex ☐ Male ☐ Female	Marital Status ☐ Married ☐ Single ☐ Divorced	
U.S. Citizen (only for those applying) ☐ Yes ☐ No	Ethnicity (optional) ☐ Hispanic or Latino ☐ Not Hispanic or Latino	
Race (optional, choose one or more) ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Hawaiian/Other Pacific Islander ☐ White		
Relationship to Applicant	Do you share food with this person? ☐ Yes ☐ No	Do you provide care for this person? ☐ Yes ☐ No

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Name – Child 2 (Last, First Middle Initial)		Is this person applying for FoodShare? ☐ Yes ☐ No
Date of Birth (mm/dd/yy)	Social Security Number (if applying)	
Sex ☐ Male ☐ Female	Marital Status ☐ Married ☐ Single ☐ Divorced	
U.S. Citizen (only for those applying) ☐ Yes ☐ No	Ethnicity (optional) ☐ Hispanic or Latino ☐ Not Hispanic or Latino	
Race (optional, choose one or more) ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Hawaiian/Other Pacific Islander ☐ White		
Relationship to Applicant	Do you share food with this person? ☐ Yes ☐ No	Do you provide care for this person? ☐ Yes ☐ No

Name – Child 3 (Last, First Middle Initial)		Is this person applying for FoodShare? ☐ Yes ☐ No
Date of Birth (mm/dd/yy)	Social Security Number (if applying)	
Sex ☐ Male ☐ Female	Marital Status ☐ Married ☐ Single ☐ Divorced	
U.S. Citizen (only for those applying) ☐ Yes ☐ No	Ethnicity (optional) ☐ Hispanic or Latino ☐ Not Hispanic or Latino	
Race (optional, choose one or more) ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Hawaiian/Other Pacific Islander ☐ White		
Relationship to Applicant	Do you share food with this person? ☐ Yes ☐ No	Do you provide care for this person? ☐ Yes ☐ No

SECTION 4 – STUDENT INFORMATION
If more room is needed, use a separate sheet of paper.

Is there anyone 18–49 years of age attending school? ☐ Yes ☐ No If no, go to Section 5.	Name – Student (Last, First Middle Initial)
Name of School	The student is enrolled: ☐ Part time ☐ Full time
Is the student employed at least 20 hours per week? ☐ Yes ☐ No	Is the student caring for a child under 6 years of age? ☐ Yes ☐ No
Is the student enrolled in an education program that will be completed in two years or less and will lead to employment? ☐ Yes ☐ No	
Is the student caring for a child 6–12 years of age where adequate day care is not available? ☐ Yes ☐ No	

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Is the student a single parent caring for a child less than 12 years of age and attending school full time?
☐ Yes ☐ No

Is the student participating in a federally or state-funded work study program?
☐ Yes ☐ No

Is the student unable to work due to a temporary or permanent disability?
☐ Yes ☐ No

Is the student attending school due to placement through Workforce Innovation and Opportunity Act (WIOA), W-2, or FoodShare Employment and Training (FSET)?
☐ Yes ☐ No

SECTION 5 – ADDITIONAL HOUSEHOLD INFORMATION

Has anyone been found totally disabled by the Social Security Administration, Veterans Administration, or Railroad Retirement Board?
☐ Yes ☐ No

Name (Last, First Middle Initial)	Date of Disability Determination (mm/dd/yy)

Has anyone been convicted of a drug felony? ☐ Yes ☐ No	Name (Last, First Middle Initial)	Date of Conviction (mm/dd/yy)

Is anyone a fleeing felon or in violation of probation/parole? ☐ Yes ☐ No	Name (Last, First Middle Initial)

SECTION 6 – ABSENT PARENT INFORMATION

Do any children have a biological or adoptive mother or father who is not living at home?
☐ Yes ☐ No

Name of Absent Parent (Last, First Middle Initial)	Social Security Number	Date of Birth (mm/dd/yy)

Name(s) of Child(ren)	Relationship to Child(ren) ☐ Mother ☐ Father

Date Parent Left Household (mm/dd/yy)	Date Last Contact With Parent (mm/dd/yy)

Court Order of Divorce / Paternity

Case Number	County	State

Reason for Parent's Absence

Name of Absent Parent (Last, First Middle Initial)	Social Security Number	Date of Birth (mm/dd/yy)

Name(s) of Child(ren)	Relationship to Child(ren) ☐ Mother ☐ Father

APP

Date Parent Left Household (mm/dd/yy)	Date Last Contact With Parent (mm/dd/yy)

Court Order of Divorce / Paternity

Case Number	County	State

Reason for Parent's Absence

SECTION 7 – ASSETS

Asset information is only needed if you are applying for emergency benefits or a household of individuals who are elderly, are blind, or have a disability. List all assets owned by the applicant(s). Include assets owned jointly with anyone else. Do not include the value of personal household belongings. Available assets mean any asset that can be cashed at any time. Assets include items such as cash, checking or savings accounts, certificates of deposit, trust funds, stocks, bonds (not set aside for education, or funeral expenses), interest in annuities, U.S. savings bonds, property agreements, contracts for deeds, timeshares, rental property, life estates, or personal property being held for investment purposes.

Type of Asset	**Name of the Owner(s)**	**Current Value**	**Description (such as name of bank or financial institution, account number)**
Cash		$	
Checking Account		$	
Savings Account		$	
Other Type of Asset		$	
Other Type of Asset		$	
Other Type of Asset		$	

SECTION 8 – EMPLOYMENT/JOB INCOME AND WAGES

Enrollment in FoodShare is based on total household income. Do not list self-employment in this section. Self-employment will be entered in Section 10. If more room is needed, use a separate sheet of paper.

Is anyone listed below a migrant worker? ☐ Yes ☐ No	Is any household member working? If yes, answer questions below for each household member who is working. ☐ Yes ☐ No
Name of Person Working	Date Employment Began (mm/dd/yy)
Employer Name and Address	
How Often Paid ☐ Weekly ☐ Biweekly ☐ Once per month	Number of Hours in Pay Period
How Much Paid Per Hour $	Gross Earnings (before taxes) Per Pay Period $

APP

Name of Person Working	Date Employment Began (mm/dd/yy)
Employer Name and Address	
How Often Paid ☐ Weekly ☐ Biweekly ☐ Once per month	Number of Hours in Pay Period
How Much Paid Per Hour $	Gross Earnings (before taxes) Per Pay Period $

SECTION 9 – LOSS OF EMPLOYMENT

Has anyone recently ended employment? If yes, complete the rest of Section 9.
☐ Yes ☐ No

Name (Last, First Middle Initial)	Date Job Ended (mm/dd/yy)
Employer Name and Address	
Reason Employment Ended ☐ Quit ☐ Fired ☐ Laid off ☐ Other	Has this person applied for unemployment insurance? ☐ Yes ☐ No

SECTION 10 – SELF-EMPLOYMENT INCOME
Please tell us about any self-employment income you and/or anyone in your home gets. If more room is needed or more than one person is self-employed, use a separate sheet of paper.

Is anyone in your home self-employed? If yes, complete the rest of Section 10.
☐ Yes ☐ No

Name of Self-Employed Person	Business Name
Business Address	Business Ownership Type ☐ Partnership ☐ S Corporation ☐ Sole Proprietorship ☐ I don't know
Business Type (for example, a farm, home day care)	Date Business Started

Has this business filed taxes? ☐ Yes ☐ No

If yes, for what tax year did the business last file taxes?

Has the business had a significant change in income or expenses?
☐ Yes ☐ No ☐ I don't know

On average, how much does this business make each month? Please give us the income received before expenses are taken out. $

On average, what are the total expenses this business has each month? $

On average, how many hours per month does this person work for this business?

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SECTION 11 – IN-KIND OR VOLUNTEER INCOME OTHER INCOME
Please tell us about any in-kind (getting goods, food, or services in exchange for work) or volunteer work you and/or anyone in your home does. If more room is needed, use a separate sheet of paper.

Name – Person or organization who gives goods, services, or food in exchange for work or services		
Street Address		Phone Number
City	State	Zip
What is the service or work done in exchange for goods, services, or food?		
How many hours each month are provided?	Date Service Started	
Name – Person or organization you volunteer with		
Street Address		Phone Number
City	State	Zip
How many hours each month do you volunteer?	Date Service Started	

SECTION 12 – OTHER INCOME
If more room is needed, use a separate sheet of paper.

Does anyone in your household receive other income? If yes, complete the section below for each income type.
☐Yes ☐No

Type of Income		**Name – Who Gets This Income**	**Gross Monthly Amount**
Social Security	☐Yes ☐No		$
Supplemental Security Income (SSI)	☐Yes ☐No		$
Alimony/child support	☐Yes ☐No		$
Workers/unemployment compensation	☐Yes ☐No		$
Disability/sick pay	☐Yes ☐No		$
Interest/dividends	☐Yes ☐No		$
Veterans benefits	☐Yes ☐No		$
Other: _____	☐Yes ☐No		$

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SECTION 13 – EXPENSES

Dependent Care: Does anyone pay for child or adult care so they can work, look for work, go to school, or receive training?

☐ Yes ☐ No

Who pays for child/adult care?	Who is paid?	Who is it for?
Amount $	How Often Paid ☐ Weekly ☐ Biweekly ☐ Once per month	

Child Support: Is anyone court ordered to pay child support?

☐ Yes ☐ No

Who pays child support?	Who is paid?	Who is it for?
Amount $	How Often Paid ☐ Weekly ☐ Biweekly ☐ Once per month	

Medical Expenses: Does any household member who is elderly or has a disability have out-of-pocket medical costs? See page 7 of the FoodShare Wisconsin Registration for examples.

☐ Yes ☐ No

Who is the expense for?	What are the expenses?
Amount $	How Often Paid ☐ Weekly ☐ Biweekly ☐ Once per month

Shelter Costs: Does anyone in the household have shelter costs (for example, rent, mortgage, property taxes)?

☐ Yes ☐ No

Who pays the expense?	Amount Household Pays Monthly $

What is the expense for?

☐ Rent/lot rent ☐ Mortgage ☐ Property tax
☐ Homeowner's insurance ☐ Mobile home loan payment ☐ Special assessment

Utility Costs:
Does anyone in the household pay for utilities?

☐ Yes ☐ No

If you pay rent, is heat included in the rent?

☐ Yes ☐ No

Check the box(es) for the utilities your household is required to pay and if the utility is used to heat your home.

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

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

☐ Phone ☐ Water ☐ Sewer ☐ Trash removal ☐ Installation ☐ Air conditioning surcharge ☐ Other:_____

Do you receive housing assistance (Section 8 or other subsidized public housing)?

☐ Yes ☐ No

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SECTION 14 – RIGHTS AND RESPONSIBILITIES

Fair Hearings: I understand I have the right to file a fair hearing request to appeal any action taken concerning my application or ongoing benefits if I do not agree with that action. I understand I can ask for a fair hearing by calling 608-266-7709 or by sending a letter or Request for Fair Hearing form by fax to 608-264-9885 or by mail to:

Department of Administration
Division of Hearings and Appeals
PO Box 7875
Madison, WI 53708-7875

I can download a Request for Fair Hearing form at www.dhs.wisconsin.gov/forwardhealth/resources.htm. I may also contact the agency office where I applied and ask for a fair hearing verbally or in writing. I understand I can refer to the ForwardHealth Enrollment and Benefits handbook (P-00079) for more information.

YOU HAVE THE RIGHT TO A WRITTEN NOTICE from this agency before any action is taken to end or reduce your FoodShare benefits. For most actions, you will get a letter at least 10 days before the action is taken.

YOU HAVE THE RIGHT TO:

- Get an application and have your application accepted right away.
- Have an adult who knows your situation help you apply for and manage your FoodShare benefits.
- Get your FoodShare benefits within 30 days after you apply if you meet the requirements.
- Get FoodShare benefits within 7 days if you meet the requirements for faster service.
- Not be discriminated against because you are elderly or because of sex, race, color, disability, religious creed, national origin, or political beliefs.
- Have your civil rights upheld.
- Be treated with respect by agency staff.
- Have your private information kept private.
- Ask your agency to explain anything you do not understand.
- Be told in advance if your FoodShare benefits are going to be reduced or will end and the reason for the change.
- See agency records and files relating to you but not information gotten from a confidential source.
- Be given a copy of FoodShare rules.
- Ask for a fair hearing if you do not agree with a decision made by your agency. A fair hearing gives you the chance to tell a hearing officer why you think the decision about your application or benefits was wrong.

YOU ARE RESPONSIBLE FOR:

- Answering all questions completely and honestly when you apply for FoodShare benefits. You will be signing your name to certify, under penalty of perjury, that all your answers are true.
- Providing proof you are asked for.
- Reporting changes in household income over 130% of the federal poverty level. This amount will be listed on your letters. You can also find the current federal poverty level at www.dhs.wisconsin.gov/foodshare/fpl.htm.
- Reporting when the work hours of a household member with time-limited FoodShare benefits drop below 80 hours per month.
- Not making changes to a QUEST card or any FoodShare documents.
- Not selling, trading, or giving away your FoodShare benefits, documents, or QUEST cards.
- Using FoodShare benefits only to buy eligible items.

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

Reporting Changes: I understand that if I get benefits I should not have by not reporting when my household's income goes above 130% of the federal poverty level and when the work hours of a household member with time-limited FoodShare benefits drop below 80 hours per month that I may have to pay back the benefits and may also be prosecuted for fraud, which is a felony.

Expenses: I understand that expenses I report, such as shelter, utilities, child care, child support, or medical costs, may affect the level of FoodShare benefits my household receives. I understand that not reporting or providing proof of an expense means that I do not want to receive a deduction for this expense.

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Income Reduction: I understand that I am not required to report a reduction or loss of income; however, I may be entitled to a higher FoodShare benefit if I do. I understand that as long as I do not report a reduction in my household's monthly income or the loss of any household income, I will not receive any resulting increase in my FoodShare benefit.

Immigration Status: I understand that I and all other people living in my household who apply for FoodShare must be citizens or in a satisfactory immigration status to get benefits. I understand that the immigration status of any person in my household applying for benefits will be verified with USCIS; this information provided to USCIS may affect my household's eligibility and amount of benefits. I understand that my status will **not** be verified with USCIS if I am not requesting assistance for myself or if I state that I am an immigrant without satisfactory immigration status.

Any person, including any financial institution, credit reporting agency, employer, or educational institution, is authorized to release this information, according to Wis. Stat. § 49.22 (2) (2m): "The department may request from any person any information it determines appropriate and necessary for the administration of programs carrying out the purposes of 7USC 2011 to 2029. Any person in this state shall provide this information within seven days after receiving a request under this subsection."

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, including information provided about the citizenship status of each household member applying for benefits, are correct and complete to the best of my knowledge. 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.

By signing this application, I am acknowledging that I have read and understand the rights and responsibilities as stated above.

SIGNATURE – Applicant or Authorized Representative	Date Signed (mm/dd/yy)

Use these pages if more room is needed.

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