RETURN ADDRESS
XXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXX

Mailing Date: MM/DD/YYYY

ANNA MEMBER
123 MAIN ST
ANYTOWN WI 55555

State of Wisconsin

Case #: 1234567890

ABC Agency
Phone: 987-654-3210
Fax: 555-555-5555
Online at access.wi.gov

The State of Wisconsin is an equal opportunity service provider. This letter contains information that affects your benefits. If you need this material in a different format because of a disability or if you need this letter translated or explained in your own language, please call 1-987-654-3210. These services are free.

Action Required:

Your Benefits are Due for Renewal

One or more people in your household need to complete a renewal to keep getting **BadgerCare Plus, Caretaker Supplement, and FoodShare** benefits. If they do not act by **Month Day, Year**, their benefits could end on **Month Day, Year**. Even if they get benefits back after losing them, there could be time when they are not covered.

As part of their renewal, **members must tell us about any changes in household or income**. They may also need to submit documents that confirm their information (see the "Proof Needed" section of this letter).

The people listed in the table below must complete a renewal to keep getting health care benefits.

Who	Benefit Plan	Action Needed	Take Action By
NAME 1	BadgerCare Plus	Complete renewal	Month Day, Year

Note: There may be other people in your household getting health care benefits who are not listed. They either do not need to renew their benefits now or we have already renewed their benefits for them based on the information we have on file.

No further changes to the letter

SAMPLE