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**WISCONSIN DEPARTMENT OF HEALTH SERVICES**
Division of Medicaid Services
F-02733 (06/2023)

# REQUEST FOR COMMUNITY SPOUSE SIGNATURE

**INSTRUCTIONS:** If you reside or plan to reside in a medical institution (such as a nursing home) for 30 days or more, or if you need nursing-home level of care that can be provided in your home, you can apply for Long-Term Care Medicaid. Long-Term Medicaid programs include: Institutional Medicaid, Family Care, Family Care Partnership, Program for All-Inclusive Care for the Elderly (PACE), and Include, Respect, I Self-Direct (IRIS).

If you are applying for Long-Term Care Medicaid and are married, your spouse is known as a community spouse. Both you and your spouse must sign your application for Long-Term Care Medicaid or your application will be denied. If your spouse did not sign your application, you can use this form to submit your spouse's signature and complete your application. Your spouse can also call your local county or tribal income maintenance agency to provide the signature by phone. Your agency contact information is on the Wisconsin Department of Health Services website at www.dhs.wisconsin.gov/forwardhealth/imagency/index.htm.

**How to Submit this Form**
Submit your completed form in one of the following ways **within 10 days of getting this form**:

- **Mobile app.** Use the MyACCESS mobile app to take a photo of all the pages of the form and submit them
- **Online.** You can use the ACCESS website to submit an electronic copy of this form online. Visit access.wi.gov.
- **Fax.**
  - If you live in **Milwaukee County**, fax the form to 888-409-1979.
  - If you do **not** live in Milwaukee County, fax the form to 855-293-1822.
- **Mail.**
  - If you live in **Milwaukee County**, mail the form to:
    MDPU
    6055 N. 64th St.
    Milwaukee, WI 53218
  - If you do **not** live in Milwaukee County, mail the form to:
    CDPU
    P.O. Box 5234
    Janesville, WI 53547
- **In Person.** Take the form to your agency. Your agency contact information is on the Wisconsin Department of Health Services website at www.dhs.wisconsin.gov/forwardhealth/imagency/index.htm.

## SECTION 1 Applicant Information

| Name – Person Applying (Last, First, Middle Initial) | Phone Number |
|---|---|
| | |

| Case Number (if known) | Date of Birth |
|---|---|
| | |

Name – Community Spouse (Last, First, Middle Initial)

| Street Address | Phone Number |
|---|---|
| | |

| City | State | Zip |
|---|---|---|
| | | |

**Note:** Continue to the next page to complete Section 2 of this form.

**SSF**

## SECTION 2 Spouse Signature

By signing this form, I certify that I understand and acknowledge the following statements:

- The county or tribal local agency and the Wisconsin Department of Health Services are authorized to request any information that is appropriate and necessary for the proper administration of the Medicaid program authorized under Wisconsin law.
- I may need to provide proof of my answers. Also, by signing this application I am authorizing any other person or organization, including any financial or educational institutions, to provide the agency information or proof needed to determine if I can get benefits and the level of those benefits.
- This local county or tribal agency cannot discriminate on the basis of race, color, national origin, sex, age, disability, or religious or political beliefs.
- If I have a disability, I may request information about my benefits in an alternate format.
- I assign and give up rights to any payments from a liable third party to the Wisconsin Department of Health Services up to the payment amount that was made for my medical care. These payments may include payments from hospital and health insurance policies or payments received as a settlement from an accident.
- There are penalties for giving false information or breaking the rules. I will have to repay any benefits that are issued incorrectly due to a failure to report changes or to provide complete and correct information.

| **SIGNATURE** – Community Spouse | Date Signed |
|---|---|
| Print name | |

| **SIGNATURE** – Representative/Guardian/Power of Attorney/Conservator* | Date Signed |
|---|---|
| Print name | |

* If you are signing as a Power of Attorney or Legal Guardian on behalf of the Community Spouse, include supporting documentation when submitting this document.

This institution is an equal opportunity provider.