WISCONSIN DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-10101 (01/2026)

WISCONSIN MEDICAID FOR THE ELDERLY, BLIND OR DISABLED APPLICATION PACKET

HOW TO APPLY

This is an application for health care benefits for people who are 65 years of age or older, blind or have a disability.

To apply for health care benefits, complete this application and return it to the following address or complete an application online at access.wi.gov. See below for more information about applying online.

Mail or Fax Applications and/or Proof/Verification to:

If you live in Milwaukee County:	If you **do not** live in Milwaukee County
MDPU 6055 N 64th St. Milwaukee, WI 53218	CDPU PO Box 5234 Janesville, WI 53547-5234
Fax: 888-409-1979	Fax: 855-293-1822

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

You will need to provide proof of some of your answers. For more information on what you will need to provide, see the Proof/Verification Section starting on page 5.

If you have questions about Medicaid, need help filling out this application or want to answer the questions in person or over the phone, contact your agency to set up an appointment. If you need the address and/or phone number of your agency, see page 7. Information is also available online at dhs.wi.gov/im-agency.

If you have a disability and need this information in an alternate format, or if you need it translated to another language, contact your agency. These services are free of charge.

APPLY ONLINE

ACCESS is an online tool that lets you apply for benefits, check the status of your benefits, report changes or complete your annual renewal. To visit ACCESS go to access.wi.gov. An online application is the same as a paper application.

LETTERS AVAILABLE THROUGH THE ACCESS WEBSITE

Members can get letters and information about their benefits online instead of by regular mail. To make this choice, the member needs to contact their agency, or log into their ACCESS account at access.wi.gov. If a member does not have an ACCESS account, they must create one to view their letters online.

HOW TO USE THIS FORM

1. Read the Important Information section and all the instructions before completing the application.
2. Print clearly. Use blue or black ink.
3. Write dates in the mm/dd/yyyy format. (Example: April 2, 1958, would be 04/02/1958.)
4. Enter information about you and/or your spouse.
5. Completely fill out the application. There may be a delay in Medicaid benefits if the application is not complete. (Use the checklist on page 24 to make sure your application is complete.) If your application is not complete, the agency will contact you for more information.

IMPORTANT INFORMATION

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

Legal Guardian, Conservator, or Power of Attorney

If you have a legal guardian of the estate, legal guardian of the person and the estate, conservator, or activated durable power of attorney for finances, 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.

When submitting this application, include the legal documentation authorizing the appointed legal guardian, conservator, or durable power of attorney for finances for the applicant.

A legal guardian of the person can act on your behalf with your Medicaid eligibility and benefits only if this power is granted in the court documents appointing the legal guardian of the person.

A power of attorney for health care does not have the ability to act on your behalf with your Medicaid eligibility and benefits.

Authorized Representative

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, found in this application packet. This allows your authorized representative to complete and sign the application for you. You can also get this form by calling 800-362-3002 or going to dhs.wi.gov/forwardhealth/representative-types.htm.

Application Date

Your application date is the date the Medicaid office gets your signed application. A decision on your Medicaid will be mailed to you within 30 days of your application date. Unsigned forms will be returned. It is important to apply as soon as possible since the date your benefits will begin, if you meet all program rules, is based on your application date.

Help Paying for Medical Expenses

If insurance has not paid for your medical expenses from the last three months, you can apply for health care coverage to pay those expenses. If you want help paying for health care for any of the past three months, complete the "Help Paying for Medical Expenses Request" page found in this application packet.

Personally Identifiable Information/Social Security Number

Personally identifiable information and Social Security Numbers are used only for the direct administration of the Medicaid program.

If someone in your household is not applying for Medicaid, you do not need to provide Social Security Number (SSN) information for that person. Any person who wants Wisconsin Medicaid, but does not provide their SSN or apply for one will not be eligible for benefits, pursuant to Wis. Stat. § 49.82(2).

If you are applying only for Emergency Services because of your immigration status, or you are a pregnant woman applying for BadgerCare Plus Prenatal Services, you do not need to provide SSN information.

Your SSN permits a computer check of your information with government agencies such as the Internal Revenue Service (IRS), Social Security Administration, Department of Revenue and the Department of

Workforce Development. In addition, the Department of Health 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).

Renewals

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

Estate Recovery

If you are enrolled in Medicaid, Wisconsin State law, with limited exceptions, requires the recovery of certain Medicaid benefits from your estate. The Estate Recovery Program Handbook, P-13032 provides you with information on estate recovery. You may get a copy of the brochure online (dhs.wi.gov/library/collection/P-13032), from your local agency or by contacting Member Services at 800-362-3002. Certain benefits you get in the community after age 55 and all Medicaid benefits you get while residing in a nursing home or while you are an inpatient in a hospital for 30 days or more, are recoverable. Also, if you reside in a nursing home or are institutionalized in a hospital, and are not expected to return home to live, a lien may be placed on your home. A lien may not be placed on your home if you, your spouse or certain other family members reside in the home.

Rights and Responsibilities

Rights

State and Federal laws guarantee rights for members, which include:

- The right to be treated with respect by state and county employees.
- The right to confidentiality of all information given to agencies to determine eligibility. (This does not prohibit the use of such records for program administration.)
- The right of access to agency's records and files relating to your case, except information obtained by the agency under a promise of confidentiality.
- The right to remain eligible for Medicaid benefits even if temporarily absent from the state, if you remain a Wisconsin resident.
- The right to a speedy determination of eligibility status and prior notice of proposed changes in such status.
- The right to emergency medical care.
- The right to request reasonable accommodation to participate in the program for a disability-related reason, or the right to request interpreters or translators to participate in the program.
- The right to appeal any action taken concerning your Medicaid application or ongoing benefits that you do not agree with by requesting a fair hearing.

Fair Hearing

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

- Your application for Medicaid 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 for a medical service 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 dhs.wi.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 dhs.wi.gov/library/collection/P-00079.

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

Responsibilities

Reporting Changes

Report to the agency **within 10 days:**

- Any changes in income of any member of your household.
- Any other change in the information you have given on your application that is required to be reported on the Medicaid Change Report form, F-10137, located in this application packet.

Changes can be reported online at access.wi.gov, by calling your agency or you can use the Medicaid Change Report form, F-10137, in this application packet. **Do not send this form with your application; keep it for future use**.

Verification/Proof

You will need to provide verification/proof of certain information. Some of these include:

Citizenship/Identity

Federal law requires that all U.S. citizens applying for, or getting Medicaid benefits must show proof of their U.S. citizenship and identity unless they are exempt. Exempt people include recipients of Social Security Disability Insurance (SSDI), Supplemental Security Income (SSI), Medicare, Foster Care, and Adoption Assistance. If you are applying for benefits, you will have at least 95 days, from the date of your application, to provide proof to the agency. If you have provided this information in the past, it may already be on file; your agency will let you know if more proof is needed.

We also verify with the U.S. Department of Homeland Security the immigration status of all immigrants who apply for benefits for themselves. Immigration status will not be verified with United States Citizenship and Immigration Services (USCIS) for people in your household who are not applying for assistance. If someone in your household is not applying for Medicaid, you do not need to answer this question for that person.

Note: Undocumented immigrants are only eligible for coverage of emergency health care services if they would otherwise be eligible for Medicaid.

Pregnant immigrants may be able to enroll in BadgerCare Plus Prenatal Services.

Examples of what you can use to prove both citizenship and identity are:

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

Examples of what you can use to prove citizenship are:

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

Examples of what you can use to prove identity are:

- State driver's license
- ID card issued by federal, state, or local government
- School ID card with photo
- U.S. military dependent ID card
- U.S. military ID card
- For children under age 18, a signed Statement of Identity form, F-10154 (dhs.wi.gov/library/collection/f-10154)

Assets

You will be required to provide proof of all your assets. Examples of proof documents include a copy of your bank statement showing the value of your bank account on the date the application is completed, property tax bill, vehicle title/registration, or something that shows the face value and cash value of your life insurance policy. If married and applying for Institutional Medicaid, an Asset Assessment will be required for both the applicant and spouse.

Other

Your worker may also ask for proof of the following:

- Medical expenses to meet a deductible
- Physician's certification (verbally or in writing) that the person is likely to return to the home or apartment within 6 months for institutionalized persons maintaining a home or property and who may be entitled to a home maintenance allowance. If allowed, expenses will need to be verified
- Documentation for power of attorney, legal guardianship, or conservator
- Disability

If you have these items available on the day you submit this application, provide a copy of them with your application. You will be contacted by the agency and be asked to provide proof of missing, conflicting or vague information, if the information would affect the decision about your Medicaid enrollment.

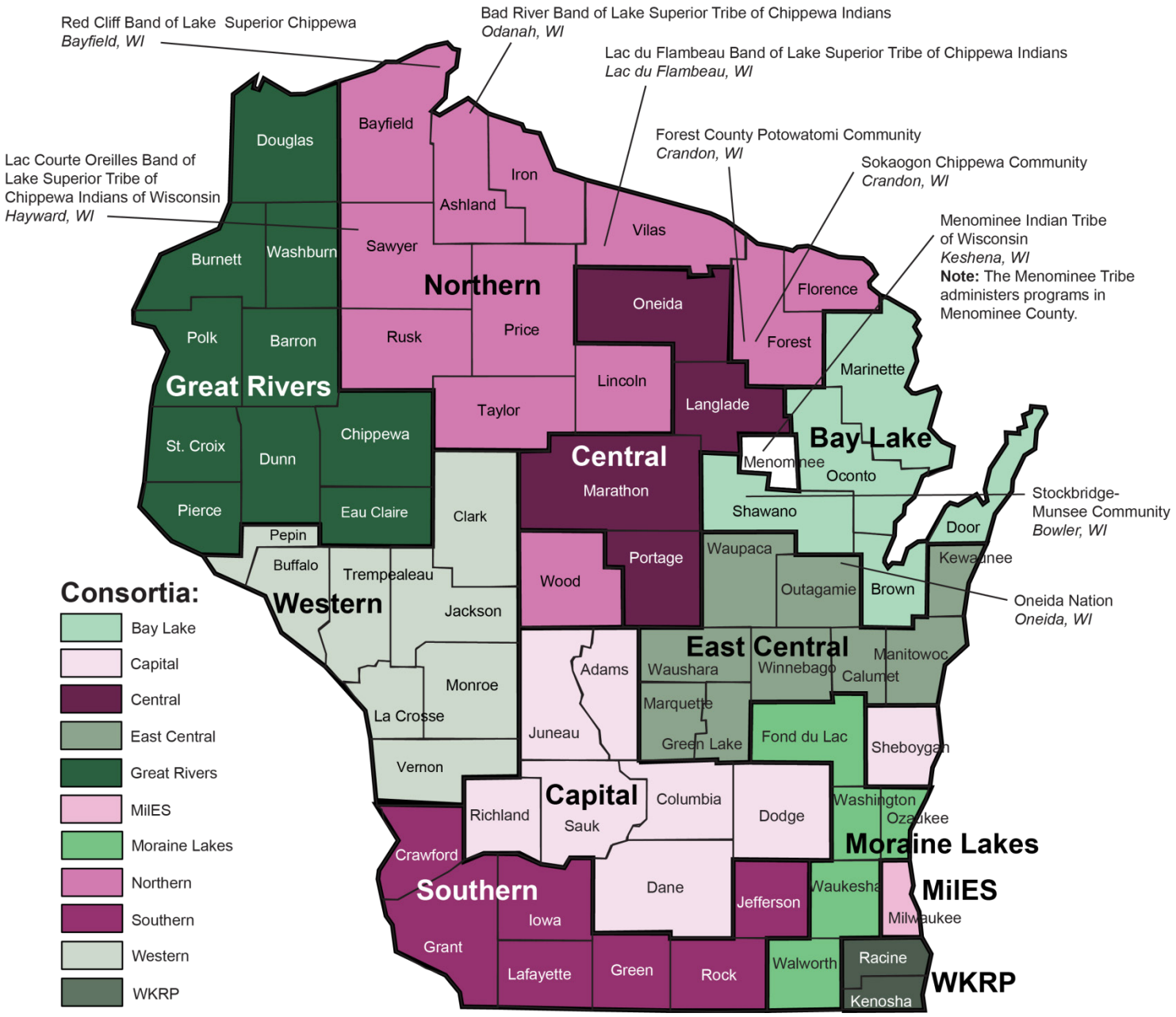
Do not send original documents in the mail. You may bring in original documents or send photocopies of these items with your application. If you are having trouble getting what you need to provide proof, contact your agency and ask for help.

Income Maintenance Consortiums and Tribal Agencies Contact Information

Income maintenance consortiums (often called agencies) and tribal agencies can help you with eligibility services for programs like Medicaid, BadgerCare Plus, and FoodShare. The table below lists income maintenance consortiums and tribal agencies alphabetically and includes telephone numbers as well as the counties that make up each consortium. If you have questions about your eligibility or case, call the consortium that represents your county or your tribal agency.

Bad River Band of Lake Superior Tribe of Chippewa Indians			**715-682-7127**
Bay Lake			**888-794-5747**
• Brown	• Marinette	• Shawano	
• Door	• Oconto		
Capital			**888-794-5556**
• Adams	• Dodge	• Sauk	
• Columbia	• Juneau	• Sheboygan	
• Dane	• Richland		
Central			**888-445-1621**
• Langlade	• Oneida		
• Marathon	• Portage		
East Central Income Maintenance Partnership			**888-256-4563**
• Calumet	• Manitowoc	• Waupaca	
• Green Lake	• Marquette	• Waushara	
• Kewaunee	• Outagamie	• Winnebago	
Forest County Potawatomi Community			**715-478-4433**
Great Rivers			**888-283-0012**
• Barron	• Dunn	• Polk	
• Burnett	• Eau Claire	• St. Croix	
• Chippewa	• Pierce	• Washburn	
• Douglas			
Lac Courte Oreilles Band of Lake Superior Tribe of Chippewa Indians of Wisconsin			**715-634-8934**
Lac du Flambeau Band of Lake Superior Tribe of Chippewa Indians			**715-588-4235**
Menominee Indian Tribe of Wisconsin			**715-799-5137**
Milwaukee Enrollment Services (MilES)			**888-947-6583**
Milwaukee			
Moraine Lakes			**888-446-1239**
• Fond du Lac	• Walworth	• Waukesha	
• Ozaukee	• Washington		
Northern			**888-794-5722**
• Ashland	• Iron	• Sawyer	
• Bayfield	• Lincoln	• Taylor	
• Florence	• Price	• Vilas	
• Forest	• Rusk	• Wood	
Oneida Nation			**800-216-3216**
Red Cliff Band of Lake Superior Chippewa			**715-779-3706**
Sokaogon Chippewa Community			**715-478-3265**
Southern			**888-794-5780**
• Crawford	• Iowa	• Lafayette	
• Grant	• Jefferson	• Rock	
• Green			
Stockbridge-Munsee Community			**715-793-4032**
Western Region for Economic Assistance			**888-627-0430**
• Buffalo	• La Crosse	• Trempealeau	
• Clark	• Monroe	• Vernon	
• Jackson	• Pepin		
Wisconsin's Kenosha Racine Partnership (WKRP)			**888-794-5820**
• Kenosha	• Racine		

Map of Income Maintenance Consortiums and Tribal Agencies



WISCONSIN DEPARTMENT of HEALTH SERVICES

Division of Medicaid Services
P-02342 (02/2019)

WISCONSIN MEDICAID FOR THE ELDERLY, BLIND OR DISABLED APPLICATION

Instructions: Before completing this form, read all instructions. Use black or blue ink only. Write all dates in the mm/dd/yyyy format (for example, April 2, 1958, would be 04/02/1958). If you need more space to write your answers, use an additional sheet of paper. Try to give us as much information as you can. If you do not give us some information now, we may have to ask for it before we can make a decision about your application.

Keep pages 1 through 8 and the Medicaid Change Report, F-10137, of this application packet for future use.

If you are completing this application for someone else, complete 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, found in this application packet, or attach legal documentation authorizing you as the appointed legal guardian, conservator, or durable power of attorney for finances for the applicant. Information provided on this application should be about the applicant, not the representative.

SECTION I – APPLICANT INFORMATION – In this section, we need you to tell us about yourself.

Name – Applicant (last, first, MI)		
Do you have any names you have previously used such as a married or maiden name? ☐ Yes ☐ No If yes, what are those names?		
Date of Birth	Social Security Number	Sex ☐ 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 **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 programs and benefits.*		
Are you a member, child, or grandchild of a member of an American Indian Tribe or an Alaska Native? ☐ Yes ☐ No	In what language do you want your letters printed? ☐ English ☐ Spanish	
Primary language spoken in your home	Are there any children under 18 in the home? ☐ Yes ☐ No	

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

Name of contact, if not the applicant	
Phone Number – Applicant ☐ Home ☐ Cell ☐ Work	Phone Number – Authorized Representative / Power of Attorney ☐ Home ☐ Cell ☐ Work
Other Number Where We Can Leave a Message	If you are deaf or hard of hearing and you have asked us to get in touch with you by phone, what method do you use? ☐ Relay ☐ TTY ☐ None

Email Address – Applicant	Email Address - Authorized Representative/Power of Attorney

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

☐ Yes ☐ No

*By homeless, we mean you do not have a long-term place to stay at night. You could be staying at a shelter or with a friend or relative or may not have a place to stay.

What is the best way to contact you during weekdays?

☐ Email ☐ Home Phone ☐ Cell Phone ☐ Other (explain)

What is the best time to call you during weekdays (for example, Monday after 3:00 p.m., Monday–Friday before 12 p.m.)?

You can get letters about your programs and benefits online. If you choose to get letters online:

- You will get an email every time you have a new letter to view. Log in to your ACCESS account to view your letters.
- You will not get copies of your letters in the regular mail. However, there are some letters that must always be sent by regular mail (such as forms that you must fill out and send back to us).

Do you want to get letters about your benefits online instead of by regular mail? ☐ Yes ☐ No

You can choose to get emails about your health services from our health care partners (for example, an HMO).

Only the primary person for a case (the person who is applying for benefits) may get information about health services for themselves and anyone in the home who is younger than age 19.

Other adults on a case who are older than age 18 will need to create their own ACCESS account to choose to get emails about health services from our health care partners.

Do you want to get email from our health partners? ☐ Yes ☐ No

SECTION 3 – ADDITIONAL APPLICANT INFORMATION – In this section we need additional information about you, the applicant.

Where are you currently living? If you live in a medical institution, use the name and address of the institution.

Street City State Zip Code

Is this also your mailing address? ☐ Yes ☐ No If you answered no, what is your mailing address?

Are you currently living in a nursing home, institution for mental disease (IMD), or hospital? ☐ Yes ☐ No

If yes, what is the date you were admitted? _____

Did you live in a nursing home, IMD, or hospital in the past? If so when? _____

Are you working with an Aging & Disability Resource Center (ADRC) to get long-term care services in your home or assisted living facility? ☐ Yes ☐ No

If you answered yes to either of the previous two questions, complete Section 20 in this packet.

Do you plan to keep living in Wisconsin? ☐ Yes ☐ No

Do you need help paying for health care you got in the last three months? ☐ Yes ☐ No

If you answered yes, complete Section 19 in this packet.

Marital Status

☐ Married ☐ Legally separated ☐ Annulled ☐ Divorced ☐ Widowed ☐ Never married

Are you a U.S. citizen? (See page 4)

☐ 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

SECTION 4 – SPOUSE INFORMATION – In this section, we will ask you general information about your spouse, if you are married, separated, or legally separated. Answer all questions in this section with your spouse's information. If you are not married, go to Section 5.

Name (last, first, MI)	
Social Security Number	Date of Birth
Other Names Previously Used, Such as a Maiden or Married Name	
Spouse's Address (if different from applicant's address) Street City State Zip Code	
Ethnicity* (optional) ☐ Hispanic or Latino ☐ Not Hispanic or Latino	
Race* (optional) ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Hawaiian/Other Pacific Islander ☐ White **You do not have to answer the ethnicity and race questions if you do not 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 benefits.*	
Is your spouse currently living in a nursing home, IMD, or hospital? ☐ Yes ☐ No If you answered yes and your spouse is applying for Medicaid, complete Section 20.	
If yes, what is the date your spouse was admitted? Did your spouse live in a nursing home, IMD, or hospital in the past? ☐ Yes ☐ No If yes, when?	
Is your spouse applying for Medicaid? ☐ Yes ☐ No If you answered "No", stop here and go to Section 5.	
Does your spouse plan to keep living in Wisconsin? ☐ Yes ☐ No	
Does your spouse need help paying for health care they got in the last three months? ☐ Yes ☐ No If you answered yes, complete Section 19 in this packet.	
Is your spouse working with an ADRC to get long-term care services in their home or assisted living facility? ☐ Yes ☐ No If you answered yes, complete Section 20 in this packet.	

Is your spouse a member, child, or grandchild of a member of an American Indian Tribe or an Alaska Native? ☐ Yes ☐ No
Is your spouse a U.S. citizen? (See page 4) ☐ Yes ☐ No *If no, complete the following questions:*
What is your spouse's Alien Registration or USCIS number?
When did your spouse come to the U.S. to live?
Does your spouse have a sponsor? ☐ Yes ☐ No
Is your spouse on active duty in the U.S. military 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

SECTION 5 – DISABILITY INFORMATION

Applicant

Have you been determined blind or disabled by the Social Security Administration?	☐ Yes	☐ No
If not, would you like us to send you a Disability Application Form?	☐ Yes	☐ No
Have you received Supplemental Security Income (SSI) in the past?	☐ Yes	☐ No
If you are disabled and not currently working, are you interested in participating in the Health and Employment Counseling (HEC) program as a part of an effort to find work?	☐ Yes	☐ No

Spouse

Has your spouse been determined blind or disabled by the Social Security Administration?	☐ Yes	☐ No
If not, would you like us to send you a Disability Application Form?	☐ Yes	☐ No
Has your spouse received SSI in the past?	☐ Yes	☐ No
If your spouse is disabled and not currently working, is your spouse interested in participating in the Health and Employment Counseling (HEC) program as part of an effort to find work?	☐ Yes	☐ No

SECTION 6 – ASSETS

In this section, list all assets owned by you and/or your spouse. Include assets owned jointly with any other person. Do not include the value of personal household belongings (televisions, furniture, appliances). Do not list motor vehicle information in this section as we will ask for that in Section 9. Assets include items such as cash, checking or savings accounts, prepaid debit cards, 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, tools, livestock, farm machinery, Keogh plans or other tax shelters, personal property being held for investment purposes, health savings accounts, etc.

NOTE: You will be asked to provide proof of your assets. See page 5 for more information. Use an additional sheet of paper if more room is needed.

Type of Asset (See above.)	Name of Owner(s)	Current Dollar Amount	Bank / Financial Institution Name and Account Number
		$	
		$	
		$	
		$	
		$	
		$	

Do any of the accounts listed include money that is set aside for burial? ☐ Yes ☐ No	
If so, which account(s)?	How much?

SECTION 7 – BURIAL ASSETS

List all burial assets owned by you and/or your spouse. You will be asked to provide proof of your assets. Use an additional sheet of paper if more room is needed.

Type of Burial Asset	Name of Owner(s)	Value
Burial insurance ☐ Yes ☐ No		$
Irrevocable burial trust* ☐ Yes ☐ No *This means it cannot be returned or changed.		$
Other ☐ Yes ☐ No **Note:** Other examples could be a headstone, casket, vault, marker, or opening and closing costs.		$

SECTION 8 – ANNUITY OWNERSHIP

Do you or your spouse own an annuity? ☐ Yes ☐ No
Did you or your spouse purchase an annuity on or after 01/01/2009? ☐ Yes ☐ No
Did you or your spouse make any substantive changes on or after 01/01/2009 to any annuity that either you or your spouse own, regardless of when it was purchased? ☐ Yes ☐ No A substantive change would be an addition to principal, an elective withdrawal, a distribution change request, a change in ownership or other similar action. **Note:** If you answered yes, to any of the questions above, you will be required to provide and verify additional information about this annuity in order to qualify for Medicaid Institutional/Long-Term Care Services.
I, the applicant and my spouse acknowledge that we are naming the State of Wisconsin as a remainder beneficiary on my/our annuity, by virtue of the provision of Medicaid Institutional/Long-Term Care services. This assignment provision will apply to any annuity purchased by me or my spouse, on or after 01/01/2009, or any annuity owned by me or my spouse, regardless of the purchase date, for which a substantive change and/or transaction has occurred on or after 01/01/2009. The State of Wisconsin will be named as the remainder beneficiary in my/our annuity in the first position or if I am married or have a minor and/or disabled child, the State of Wisconsin will be named as a remainder beneficiary in the next position after my spouse and/or minor or disabled child.

SECTION 9 – VEHICLE INFORMATION

List all motor vehicles owned by you and/or your spouse, if married. Include vehicles owned jointly with another person. Use an additional sheet of paper if more room is needed.

Vehicle 1

Type of Vehicle	Year	Make	Model
Amount Owed on Vehicle $		Fair Market Value* $	

Vehicle 2

Type of Vehicle	Year	Make	Model
Amount Owed on Vehicle $		Fair Market Value* $	

*By fair market value, we mean the price you could sell the vehicle for right now. Looking up the vehicle's Blue Book value online (www.kbb.com/whats-my-car-worth) is a good way to find this out.

Section 10 – Real Estate Information

List all real estate owned by you and/or your spouse, if married. Include all real estate, whether the property is located in the State of Wisconsin or not, owned solely or jointly with another person. Include any rental property owned.

Property 1

Owner(s) of property			
Address – Street	City	State	Zip Code
Amount owed on property $	Fair Market Value* $		

Property 2

Owner(s) of Property			
Address – Street	City	State	Zip Code
Amount Owed on Property $	Fair Market Value* $		

*By fair market value, we mean the price you could sell the property for right now. You may be able to find this on your property taxes or on a recent appraisal if you have had one.

SECTION 11 — LIFE INSURANCE

Please tell us about any life insurance you and/or your spouse have.

Do you and/or your spouse have any life insurance policies? ☐ Yes ☐ No
If yes, complete the section below. If no, stop and go to Section 12.

Name of Owner(s)	Name of life insurance company	Type: (whole life, term, etc.)	Cash Surrender Value* $	Face Value** $
			$	$
			$	$

*By cash surrender value, we mean the amount you will get if you cancel the policy.
**By face value, we mean the minimum benefit paid out upon death. In most cases, this is the amount written on the policy.

SECTION 12 – JOB INCOME AND WAGES

In this section, we need to know about any job income or wages you and/or your spouse get from employment. List the gross income for each job. By gross, we mean the amount earned before taxes and deductions. Do not list self-employment in this section, we will ask you about self-employment in Section 13.

Job 1

Are you and/or your spouse employed? ☐ Yes ☐ No If yes, answer the following questions. If no, stop here and go to Section 14.

Who has a job? ☐ You ☐ Your spouse	Date Employment Began
Employer Name and Address	Gross Monthly Earnings Expected This Month $
	Gross Monthly Earnings Expected Next Month $
Hours worked each week?	How much are you paid each hour? $

How often are you paid?
☐ Each week ☐ Every other week ☐ Twice each month ☐ Once a month

Are you paid a salary? ☐ Yes ☐ No If "yes," how much are you paid each pay period? $

Do you get tips or compensation other than your hourly wages or salary? ☐ Yes ☐ No
If "yes," how much do you get each pay period? $

Job 2

Who has a job? ☐ You ☐ Your spouse	Date Employment Began
Employer Name and Address	Gross Monthly Earnings Expected This Month $
	Gross Monthly Earnings Expected Next Month $
Hours worked each week?	How much are you paid each hour? $
How often are you paid? ☐ Each week ☐ Every other week ☐ Twice each month ☐ Once each month	
Are you paid a salary? ☐ Yes ☐ No If "yes," how much are you paid each pay period? $	
Do you get tips or compensation other than your hourly wages or salary? ☐ Yes ☐ No If "yes," how much do you get each pay period? $	
Note: If you have any other jobs or wages from a job, you can use an additional sheet of paper and attach it to this application.	

SECTION 13 – SELF-EMPLOYMENT

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

Self-Employment 1

Are you and/or your spouse self-employed? ☐ Yes ☐ No If yes, answer the questions below. If no, go to Section 14.	
Who is self-employed? ☐ You ☐ Your spouse	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

Are you and/or your spouse self-employed? ☐ Yes ☐ No If yes, answer the questions below. If no, go to Section 15.	
Who is self-employed? ☐ You ☐ Your spouse	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?	

SECTION 14 – IN-KIND INCOME INFORMATION

In this section, tell us if you and/or your spouse currently receive items in-kind (such as goods, services, or food) in return for work. Be sure to list the number of hours you work in exchange for goods, services, or food. If you volunteer but do not get anything in exchange for your work, these hours are not considered in-kind.

In-Kind Income 1

Are you and/or your spouse working in exchange for goods, services, or food instead of money? ☐ Yes ☐ No	☐ You ☐ Your spouse
Date you/your spouse started getting goods, services, or food in exchange for work:	
How many hours of work do you/your spouse provide in exchange for goods, services, or food, per month? _____You	_____Your Spouse

In-Kind Income 2

Are you and/or your spouse working in exchange for goods, services, or food instead of money? ☐ Yes ☐ No	☐ You ☐ Your spouse
Date you/your spouse started getting goods, services, or food in exchange for work:	
How many hours of work do you/your spouse provide in exchange for goods, services, or food, per month? _____You	_____Your Spouse

SECTION 15 – OTHER TYPES OF INCOME

In this section, tell us if you and/or your spouse receive any other types of income (other than a current job or self-employment). Examples of other income may include, but are not limited to payments from an annuity or trust, alimony/maintenance, charity, child support, disability/sick pay, interest/dividends, pension/retirement, worker's compensation, money from another person, interest on loan/promissory note repayments, rental income, severance pay, Supplemental Security Income (SSI), Social Security, Veterans Benefits, unemployment insurance, etc. List the gross amount, before taxes and deductions.

Type of Income	Who Gets Income	Gross Monthly Amount	Company Name / Address
	☐ You ☐ Spouse	$	
	☐ You ☐ Spouse	$	
	☐ You ☐ Spouse	$	
	☐ You ☐ Spouse	$	
	☐ You ☐ Spouse	$	
	☐ You ☐ Spouse	$	

SECTION 16 – OUT-OF POCKET MEDICAL EXPENSES

List the types of out-of-pocket medical expenses you and/or your spouse have such as co-payments or the cost of over-the-counter drugs. You must indicate if the item is an impairment related work expense. By impairment related work expense, we mean any item you or your spouse needs due to your impairment in order to do your job. The expense cannot be one that a similar worker without a disability would have, such as uniforms. Do not list medical insurance premiums or items for which you are reimbursed.

Expense 1

Do you and/or your spouse have any medical expenses? ☐ Yes ☐ No If yes, complete the information below. If no, stop and go to Section 18.			
Type of Medical Expense	Amount of Expense $	Who has the expense? ☐ You ☐ Your spouse	How often paid?
Is this an impairment-related work expense? ☐ Yes ☐ No			

Expense 2

Type of Medical Expense	Amount of Expense $	Who has the expense? ☐ You ☐ Your spouse	How often paid?
Is this an impairment-related work expense? ☐ Yes ☐ No			

SECTION 17 – OTHER ALLOWABLE EXPENSES

In this section, tell us about any other allowable expenses you and/or your spouse have. Allowable expenses may include court ordered family support/alimony, court ordered attorney and guardian fees, court ordered child support, and other support obligations.

Who has an Expense	What is the Expense	Amount of Expense	How Often Paid
		$	
		$	
		$	

SECTION 18 – HEALTH INSURANCE

You must report any third party that may be liable to pay for medical care for you and/or your spouse, including private health insurance, nursing home/long-term care insurance, Medicare or Medi-GAP insurance. You must give information as requested. This also includes any insurance that may be available through an employer group health plan or long-term care policy.

Do you have Medicare Part A or Part B coverage? ☐ Yes ☐ No				
Medicare ID Number	Part A Start Date	Part A Premium	Part B Start Date	Part B Premium
		$		$
Does your spouse have Medicare Part A or Part B coverage? ☐ Yes ☐ No				
Medicare ID Number	Part A Start Date	Part A Premium	Part B Start Date	Part B Premium
		$		$

Do you and/or your spouse have Medicare Part D coverage? ☐ Yes ☐ No			
Who has the coverage?	Name of Plan	Start Date	Monthly Premium Amount
			$
			$

If you and/or your spouse are applying for Medicaid and are eligible for Medicare, your agency will check to see if you and/or your spouse are eligible to have Medicaid pay for your Medicare premiums through the Medicare Savings Program. Please contact your agency if you are not interested in or have questions about the Medicare Savings Program.

If eligible, would you and/or your spouse like the State of Wisconsin to pay your Medicare premiums?
☐ Yes ☐ No

Are you covered by any health insurance policies? ☐ Yes ☐ No			
Name – Policy Owner	Date Coverage Began	Premium Amount $	How Often Paid
Policy/Insurance Number		Group Number	
Name and Address of Insurance Company			

Is your spouse covered by any health insurance policies? ☐ Yes ☐ No			
Name of Policy Owner	Date Coverage Began	Premium Amount $	How Often Paid
Policy/Insurance Number		Group Number	
Name and Address of Insurance Company			
Have you or your spouse received medical bills due to an accident or do you have an accident claim pending? ☐ Yes ☐ No If yes, check all that apply. ☐ Incurred bills ☐ Claim or settlement pending			

SECTION 19 – HELP PAYING FOR MEDICAL EXPENSES REQUEST

If insurance has not paid for your medical expenses from the last three months, you can apply for health care coverage to pay those expenses. If you meet all program rules in those months, you can get health care coverage benefits starting up to three months before your application month. The application month is the month in which your agency gets your application.

When you apply for health care benefits in prior months, you must provide all of the needed information for those prior months and you must meet all program rules for those months. If you want help paying for health care for any of the three months before your application month, make sure you checked the "Yes" box in Section 3 of the application where this question is asked and complete this form.

If there are any changes in the three months before your application month, list the changes below for each month. These changes may include: your address, who lives in the household, income, assets, vehicles, insurance, etc.

What is the date you want your health care coverage to begin? **Note:** This date cannot be more than three months before the month you apply.

Month Prior to Application

Are you asking for help paying for medical expenses from the month prior to the month you are applying?
☐ Yes ☐ No
If yes, is the information you provided in your application the same in that month? ☐ Yes ☐ No If no, describe the changes.

Two Months Prior to Application

Are you asking for help paying for medical expenses from two months prior to the month you are applying?
☐ Yes ☐ No
If yes, is the information you provided in your application the same in that month? ☐ Yes ☐ No If no, describe the changes.

Three Months Prior to Application

Are you asking for help paying for medical expenses from three months prior to the month you are applying? ☐ Yes ☐ No

If yes, is the information you provided in your application the same in that month? ☐ Yes ☐ No If no, describe the changes.

SECTION 20 – LONG-TERM CARE INFORMATION

Complete this section if you or your spouse are currently residing in a nursing home, Institution for Mental Disease (IMD), or hospital, or you or your spouse are asking for long-term care services in your home.

A. Intent to Return Home

If you are currently living in a nursing home, IMD, hospital, or assisted living facility, do you plan to return to your home sometime in the future? ☐ Yes ☐ No

If your spouse is currently living in a nursing home, IMD, hospital, or assisted living facility, does he/she intend to return to the home sometime in the future? ☐ Yes ☐ No

B. Request for Community Waivers

Are you applying for Medicaid to get services in your home or assisted living facility? ☐ Yes ☐ No

Is your spouse applying for Medicaid to get services in the home or assisted living facility? ☐ Yes ☐ No

C. Income Allocation

If you are married, you may be eligible to give some of your income to your spouse up to a maximum amount. This is called an income allocation. If you are married and both you and your spouse are applying for long-term care services, you must choose who will allocate the income.

Who will allocate income? ☐ You ☐ Your spouse

Do you or your spouse want to allocate the maximum allowed portion of income? ☐ Yes ☐ No

If "No", how much do you or your spouse want to allocate $

Note: If you do not want to allocate the maximum allowed portion of your income but do not tell us how much you want to allocate or leave the dollar amount blank, we will assume you do not want to allocate any income to your spouse.

D. RESOURCE/INCOME TRANSFER

Please tell us about any income or resources you and/or your spouse have given away or sold for less than fair market value in the last five years. Examples of resources include cash and cash gifts, real estate, stocks or bonds, etc. This includes any amounts you have gifted to minors, such as money you have put in a college fund for your grandchild. You must report these amounts below. Use an additional sheet of paper if more room is needed.

Check all that apply. In the last five years, did you and/or your spouse:

- ☐ Yes ☐ No Sell any assets for less than fair market value*?
- ☐ Yes ☐ No Trade assets or income?
- ☐ Yes ☐ No Transfer or give away assets or income?
- ☐ Yes ☐ No Establish or fund a trust?
- ☐ Yes ☐ No Decline or refuse to accept an inheritance?
- ☐ Yes ☐ No Purchase an annuity, life estate in another person's home, promissory note, loan or mortgage?

If you answered yes to any of the questions above, fill out the asset and income information below. If you answered no, go to Section E.

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

Asset or Income 1

Type of Asset or Income	Date Given Away or Sold	Value of Asset or Income $
What did you get in return? _____ Who was asset given/sold to? _____		

Asset or Income 2

Type of Asset or Income	Date Given Away or Sold	Value of Asset or Income $
What did you get in return? _____ Who was asset given/sold to? _____		

E. SHELTER/UTILITY COST

In this section, tell us about your household expenses. Some of these may include, but are not limited to mortgage/rent, property taxes, condominium fees, homeowner/renter insurance, water or sewer bills, gas/electric bills, and heating cost. If it is a shared expense, be sure to list the actual amount paid per person.

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

F. LONG-TERM CARE INSURANCE

Do you have private long-term care insurance? ☐ Yes ☐ No			
Name – Policy Holder	Date Coverage Began	Premium Amount $	How Often Paid
Policy/Insurance Number	Group Number		
Name and Address of Insurance Company			
Does your spouse have private long-term care insurance? ☐ Yes ☐ No			
Name of Policy Holder	Date Coverage Began	Premium Amount $	How Often Paid
Policy/Insurance Number	Group Number		
Name and Address of Insurance Company			

SECTION 21 – CHECKLIST

Please read and check each off before you mail your application. This could save time in processing your application.

- ☐ Read the Rights and Responsibilities Section.
- ☐ Complete all applicable sections of the application.
- ☐ Enclose with your application any current proof documents, additional documentation or sheets of paper used to complete the application. If requesting help paying for medical expenses from the past three months, be sure to include verification for those months.
- ☐ Include a copy of your immigration status documents, if you are not a U.S. citizen.
- ☐ If you have a legal guardian of the estate, legal guardian of the person and the estate, conservator, or activated durable power of attorney for finances, attach the legal documentation authorizing the appointed legal guardian, conservator, or power of attorney for the applicant. If you have an authorized representative, attach the Appoint, Change, or Remove an Authorized Representative form (F-10126A for a Person or F-10126B for an Organization).
- ☐ Complete the Help Paying for Medical Expenses Request section if you want help paying for medical expenses from the past three months.
- ☐ Complete the Long-Term Care Information section if you are requesting coverage for long-term care services.
- ☐ Keep pages 1 through 8 and the Medicaid Change Report, F-10137, of this application packet for future use.
- ☐ Sign and date the application form.

SECTION 22 – SIGNATURE

By signing the application, you are authorizing the local agency and the Wisconsin Department of Health Services to request any information that is appropriate and necessary for the proper administration of the Medicaid program under Wisconsin law. Any person, including financial institutions, credit reporting agencies or educational institutions may release this information, unless it is prohibited or restricted by law. Your authorization remains in effect until one of the following:

- Your Medicaid application is denied.
- Your Medicaid eligibility ends.
- You inform the Department of Health Services in writing that you wish to end your authorization.

Also, your signature on the application means that you understand the questions and statements on this application form and the penalties for giving false information or breaking the rules. By signing the application, you are certifying, under penalty of perjury and false swearing, that all of your answers are correct and complete to the best of your knowledge, including information provided about the immigration and citizenship status of each household member applying for benefits. Also, you understand and agree to provide documents to prove what you have said.

If you are married and are applying for Long-Term Care Medicaid because you are residing in a medical institution or asking for long-term care services in your home, your spouse is known as a Community Spouse.

A Community Spouse must sign the application to be considered a valid application for Long-Term Care Medicaid. Your spouse may be able to have additional assets and income without affecting your Medicaid eligibility. Both you and your spouse must sign your application for Long-Term Care Medicaid or your application will be denied. Your spouse has 30 days from your Medicaid application date to sign the application.

SIGNATURE – Applicant/Representative/Guardian/Power of Attorney/Conservator	Date Signed
SIGNATURE – Applicant/ Community Spouse/Representative/Guardian/ Power of Attorney/Conservator	Date Signed
SIGNATURE – Witness (Needed if signed with an “X” above)	Date Signed
SIGNATURE – Witness (Needed if signed with an “X” above)	Date Signed

Note: The applicant’s signature must be witnessed by two people, if signed with an “X.”

Mail or Fax Applications and/or Proof/Verifications

If you live in Milwaukee County:

MDPU
6055 N 64th St.
Milwaukee WI 53218

Fax: 888-409-1979

If you **do not** live in Milwaukee County

CDPU
PO Box 5234
Janesville, WI 53547-5234

Fax: 855-293-1822

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

STATE OF WISCONSIN
DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-10126A (03/2024)

REP

APPOINT, CHANGE, OR REMOVE AN AUTHORIZED REPRESENTATIVE: PERSON

Fill out and submit the Appoint, Change, or Remove an Authorized Representative: Person form, F-10126A, to appoint, change, or remove a person as your authorized representative.

To appoint an **organization** as your authorized representative, fill out and submit the Appoint, Change, or Remove and Authorized Representative: Organization form, F-10126B, instead.

If you have a legal guardian of the estate, legal guardian of the person and the estate, or conservator, that person must appoint an authorized representative for you if you want someone besides them to be your authorized representative. If you have an activated durable power of attorney for finances, you or your power of attorney can appoint an authorized representative.

A legal guardian of the person can appoint an authorized representative for you only if the court documents appointing the legal guardian of the person grants the guardian the authority to act on your behalf with your eligibility and benefits in public assistance programs.

A power of attorney for health care does not have the ability to act on your behalf to appoint an authorized representative.

The personally identifiable information provided on this form will only be used for the direct administration of Wisconsin Medicaid, BadgerCare Plus, FoodShare, Family Planning Only Services, and Caretaker Supplement.

Authorized Representative Information

An authorized representative is a person who is familiar with your household's circumstances and that you trust to act on your behalf. Anyone can serve as your authorized representative **except** for the following:

- People who are disqualified for an intentional FoodShare program violation cannot serve as an authorized representative during their disqualification period unless no one else is able to serve as an authorized representative.
- Homeless meal providers cannot serve as an authorized representative for a homeless food unit. (A food unit is one or more people who live together and buy and make food together.)
- Agency employees who help determine eligibility or benefits may not serve as an authorized representative. Special written approval may be given for them to serve as an authorized representative in certain circumstances.
- Retailers who are authorized to accept FoodShare benefits may not serve as an authorized representative.

Once appointed, your authorized representative may do any or all of the following on your behalf:

- Apply for or renew benefits
- Report changes to your information
- Work with your agency on any matters related to your benefits
- File grievances and appeals about your eligibility for programs you are applying for or are enrolled in

You can also choose to have your authorized representative get copies of letters about your eligibility and benefits, get your ForwardHealth card, work with ForwardHealth Member Services and your HMO (health maintenance organization) on your behalf, and file grievances and appeals about your health care services (for example, treatment and bills).

You do **not** need to have an authorized representative to apply for or get benefits.

The authorized representative you appoint on this form can act on your behalf for **any** of the following programs: Wisconsin Medicaid, BadgerCare Plus, FoodShare, Family Planning Only Services, and/or Caretaker Supplement. If you are enrolled in any of these programs **and** Wisconsin Works (W-2), your authorized representative may also act on your behalf for W-2.

The authorized representative you appoint on this form **cannot** act on your behalf for the Wisconsin Shares Child Care Subsidy Program. If you are applying for Wisconsin Shares, you need to apply for yourself.

Form Instructions

If required information is missing on this form, including any of the signatures, the form will be considered incomplete, and your authorized representative **cannot** act on your behalf.

Section 1 — You need to complete Section 1. You will need to choose if you are appointing, changing, or removing an authorized representative. You will also need to provide your name and date of birth so we can identify you. If you are appointing or changing an authorized representative, choose if you want your authorized representative to get copies of your letters. If you are also applying for or are enrolled in a health care program, choose if you want to let your authorized

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representative take more actions on your behalf. Make sure you read and agree to the protected health information authorization before you check Yes. Next, read the statements of understanding. If you agree, sign and date the form.

Section 2 — Your authorized representative needs to complete Section 2. Your authorized representative will need to provide their name and contact information. They will also need to read the statements of understanding and sign and date the form if they agree to the statements.

Section 3 — If you are appointing or changing an authorized representative, you will need to have someone besides your authorized representative watch you sign this form. This person is called a witness. If you sign this form with an "X," then two witnesses must watch you sign the form. The witness or witnesses will need to provide their name, signature, and the date they signed the form.

Form Submission
You can submit your completed form in one of the following ways:

Online

Scan all pages of the form to ACCESS. You can do this through your ACCESS account, which you can log into at access.wi.gov. (**Note:** If you do not have an ACCESS account, you can go to access.wi.gov and create one.)

Note: You can only scan forms to ACCESS at certain times. If you are unable to scan the form to ACCESS, submit the form using one of the other ways.

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

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.

In Person

Take the form to your agency. Your agency contact information is on the Wisconsin Department of Health Services (DHS) website at dhs.wi.gov/im-agency.

For more information about authorized representatives, go to the DHS website at www.dhs.wisconsin.gov/forwardhealth/representative-types.htm.

SECTION 1 To Be Filled Out by Applicant/Member

I am:

☐ Appointing an authorized representative. You must fill out **all** of Section 1.

☐ Changing my authorized representative. You must fill out **all** of Section 1. Make sure you write in the name of your new authorized representative in Part B.

☐ Removing my authorized representative. You must fill out **Part A and E** of Section 1. Leave Part B and C blank.

Part A: Personal Information

Name — Applicant/Member (Last, First, Middle Initial)

Date of Birth	Case Number (if you have one)

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Part B: Authorization Information

I appoint the following person to be my authorized representative:

I want my authorized representative to get copies of letters about my eligibility and benefits.

☐ Yes ☐ No

Part C: Additional Authorization Information — Health Care Programs Only (Optional)

I am applying for or am enrolled in a **health care program** (for example, Wisconsin Medicaid, BadgerCare Plus, or Family Planning Only Services) and want my authorized representative to do all of the following:

- Get my ForwardHealth card instead of me.
- Enroll me in an HMO.
- Talk to ForwardHealth Member Services or my HMO about a bill, service, or other medical information, including protected health information. Make sure you read and agree to the protected health information authorization below before you check Yes.
- File grievances and appeals about my health care services (for example, treatment and bills).

  ☐ Yes ☐ No

Authorization for Use and Disclosure of Protected Health Information
By checking **Yes** above, I am authorizing the Wisconsin Department of Health Services and its contractors, including HMOs, to disclose (share) my protected health information with my authorized representative.

The information that I am authorizing to be shared may include the following types of information: claims, medical records, substance abuse care, reproductive care, mental health, communicable diseases, pharmacy services, HIV/AIDS, dental records, and developmental disabilities.

The information is being shared so my authorized representative can help me manage my health care benefits.

I understand that any information used or shared based on this authorization could be reshared by the person or entity receiving the information and will no longer be protected by federal privacy regulations.

I understand that this authorization is voluntary and that I may refuse to authorize the release of my protected health information by checking No above. Checking No will not affect the provision of treatment, payment, enrollment in a health plan, or eligibility for benefits unless the authorization is necessary for determining eligibility for the program or enrollment in the program.

This authorization will continue until I remove the authorized representative on this form from being my authorized representative or let my agency know that I do not want my authorized representative to have access to my protected health information any longer. I can let my agency know in writing about this at any time; however, removing the authorization will not affect protected health information that has already been shared.

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Part D: Statements of Understanding

I understand and agree that:

- I have the right to choose any person I want to be my authorized representative.
- I can change or remove my authorized representative at any time. I must let my agency know in writing that I want to change or remove my authorized representative.
- I do not have to tell a person that I am removing them as my authorized representative.
- The authorized representative listed on this form will stay my authorized representative until I change or remove them.
- My authorized representative will have access to my personal information, such as my Social Security number, financial statements, and medical information, to help me manage my eligibility. If I agreed to the protected health information authorization above, I understand that my authorized representative will also have access to this information to help me manage my health care services (for example, treatment and medical bills).
- I must provide my authorized representative with true and accurate information.
- I am responsible for errors and incorrect information that my authorized representative reports. I understand that if either my authorized representative or I give false information or withhold information, I may:
  - Have to pay back benefits I should not have gotten.
  - Be fined.
  - Be banned from a program.
  - Be prosecuted for fraud.
- By signing this form, I am saying that I understand and agree to the statements above.

Part E: Signature and Date

SIGNATURE — Applicant/Member	Date Signed

SECTION 2 To Be Filled Out by Authorized Representative

Part A: Contact Information

Name — Authorized Representative (Last, First, Middle Initial)

Street Address

City	State	Zip Code

Phone Number (include area code)	Email Address (optional)

REP

Part B: Statements of Understanding

I understand and agree that:

- As an authorized representative, I am limited to doing any or all of the following on the applicant's or member's behalf:
  - Applying for or renewing benefits
  - Reporting changes
  - Working with the applicant's or member's agency on any benefit-related matters
  - Filing eligibility-related grievances and appeals
- I am expected to be familiar with the applicant's or member's circumstances.
- The applicant or member can remove me from being their authorized representative at any time.
- The applicant or member does not need to notify me that I have been removed from serving as their authorized representative.
- I am the applicant's or member's authorized representative until they request a different authorized representative or choose not to have an authorized representative.
- I must provide truthful and accurate information.
- If I provide inaccurate or false information, the applicant or member may need to repay any health care benefits received in error.
- If I intentionally violate program rules, I must repay any FoodShare benefits that were misused or received in error.
- I must comply with applicable state and federal laws concerning conflicts of interest and confidentiality of information.
- By signing this form, I am saying that I understand and agree to the statements above.
- By signing this form, I am saying that I will serve as the authorized representative for the applicant or member listed in Section 1.

Part C: Signature and Date

SIGNATURE — Authorized Representative	Date Signed

SECTION 3 To Be Filled Out by Witness(es)

Name — Witness (Last, First, Middle Initial)

SIGNATURE — Witness	Date Signed

Name — Witness (Last, First, Middle Initial) (if applicant/member signed with an X)

SIGNATURE — Witness	Date Signed

STATE OF WISCONSIN
DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-10126B (03/2024)

REP

APPOINT, CHANGE, OR REMOVE AN AUTHORIZED REPRESENTATIVE: ORGANIZATION

Fill out and submit the Appoint, Change, or Remove an Authorized Representative: Organization form, F-10126B, to appoint, change, or remove an organization as your authorized representative. To change the organization's contact person, either you or the organization must contact your agency. Your agency contact information is on the Wisconsin Department of Health Services (DHS) website at dhs.wi.gov/im-agency.

To appoint a **person** as your authorized representative, fill out and submit the Appoint, Change, or Remove an Authorized Representative: Person form, F-10126A, instead.

If you have a legal guardian of the estate, legal guardian of the person and the estate, or conservator, that person must appoint an authorized representative for you if you want someone besides them to be your authorized representative. If you have an activated durable power of attorney for finances, you or your power of attorney can appoint an authorized representative.

A legal guardian of the person can appoint an authorized representative for you only if the court documents appointing the legal guardian of the person grants the guardian the authority to act on your behalf with your eligibility and benefits in public assistance programs.

A power of attorney for health care does not have the ability to act on your behalf to appoint an authorized representative.

The personally identifiable information provided on this form will only be used for the direct administration of Wisconsin Medicaid, BadgerCare Plus, FoodShare, Family Planning Only Services, and Caretaker Supplement.

Authorized Representative Information
An authorized representative is an organization that is familiar with your household's circumstances and that you trust to act on your behalf. Anyone can serve as your authorized representative **except** for the following:

- People who are disqualified for an intentional FoodShare program violation cannot serve as an authorized representative during their disqualification period unless no one else is able to serve as an authorized representative.
- Homeless meal providers cannot serve as an authorized representative for a homeless food unit. (A food unit is one or more people who live together and buy and make food together.)
- Agency employees who help determine eligibility or benefits may not serve as an authorized representative. Special written approval may be given for them to serve as an authorized representative in certain circumstances.
- Retailers who are authorized to accept FoodShare benefits may not serve as an authorized representative, except for Drug and Alcohol treatment centers that are authorized retailers.

Once appointed, your authorized representative may do any or all of the following on your behalf:

- Apply for or renew benefits
- Report changes to your information
- Work with your agency on any matters related to your benefits
- File grievances and appeals about your eligibility for programs you are applying for or are enrolled in

You can also choose to have your authorized representative get copies of letters about your eligibility and benefits.

You do **not** need to have an authorized representative to apply for or get benefits. To apply for FoodShare while staying in a Drug and Alcohol treatment center, an authorized organization representative must apply on your behalf.

The authorized representative you appoint on this form can act on your behalf for **any** of the following programs: Wisconsin Medicaid, BadgerCare Plus, FoodShare, Family Planning Only Services, and/or Caretaker Supplement. If you are enrolled in any of these programs **and** Wisconsin Works (W-2), your authorized representative may also act on your behalf for W-2.

The authorized representative you appoint on this form **cannot** act on your behalf for the Wisconsin Shares Child Care Subsidy Program. If you are applying for Wisconsin Shares, you need to apply for yourself.

REP

Form Instructions
If required information is missing on this form, including any of the signatures, the form will be considered incomplete, and your authorized representative **cannot** act on your behalf.

Section 1 — You need to complete Section 1. You will need to choose if you are appointing, changing, or removing an authorized representative. You will also need to provide your name and date of birth so we can identify you. If you are appointing or changing an authorized representative, choose if you want your authorized representative to get copies of your letters. Next, read the statements of understanding. If you agree, sign and date the form.

Section 2 — A person who can act on behalf of the organization needs to complete Section 2. The person will need to provide the organization's name and contact information as well as their own. The person will also need to read the statements of understanding and sign and date the form if the organization and contact person agree to the statements.

Section 3 — If you are appointing or changing an authorized representative, you will need to have someone besides your authorized representative watch you sign this form. This person is called a witness. If you sign this form with an "X," then two witnesses must watch you sign the form. The witness or witnesses will need to provide their name, signature, and the date they signed the form.

Form Submission
You can submit your completed form in one of the following ways:

Online

Scan all pages of the form to ACCESS. You can do this through your ACCESS account, which you can log into at access.wi.gov. (**Note:** If you do not have an ACCESS account, you can go to access.wi.gov and create one.)

Note: You can only scan forms to ACCESS at certain times. If you are unable to scan the form to ACCESS, submit the form using one of the other ways.

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

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.

In Person

Take the form to your agency. Your agency contact information is on the DHS website at dhs.wi.gov/im-agency.

For more information about authorized representatives, go to the DHS website at www.dhs.wisconsin.gov/forwardhealth/representative-types.htm.

REP

SECTION 1 To Be Filled Out by Applicant/Member

I am:

☐ Appointing an authorized representative. You must fill out **all** of Section 1.

☐ Changing my authorized representative. You must fill out **all** of Section 1. Make sure you write in the name of your new authorized representative in Part B.

☐ Removing my authorized representative. You must fill out **Part A and D** of Section 1. Leave Part B blank.

Part A: Personal Information

Name — Applicant/Member (Last, First, Middle Initial)

Date of Birth	Case Number (if you have one)

Part B: Authorization Information

I appoint the following organization to be my authorized representative:

I want my authorized representative to get copies of letters about my eligibility and benefits. Please note that the letters will be sent to the organization's contact person.

☐ Yes ☐ No

Part C: Statements of Understanding

I understand and agree that:

- I have the right to choose any organization I want to be my authorized representative.
- I can change or remove my authorized representative at any time. I must let my agency know in writing that I want to change or remove my authorized representative.
- I do not have to tell an organization that I am removing it as my authorized representative.
- The authorized representative listed on this form will stay my authorized representative until I change or remove them.
- Drug and Alcohol treatment center authorized representatives will be removed upon discharge. Submitting this document to end the authorization is optional.

REP

- My authorized representative will have access to my personal information, such as my Social Security number, financial statements, and medical information to help me manage my eligibility.

- I must provide my authorized representative with true and accurate information.

- I am responsible for errors and incorrect information that my authorized representative reports. I understand that if either my authorized representative or I give false information or withhold information, I may:
  - Have to pay back benefits I should not have gotten.
  - Be fined.
  - Be banned from a program.
  - Be prosecuted for fraud.

- By signing this form, I am saying that I understand and agree to the statements above.

Part D: Signature and Date

SIGNATURE — Applicant/Member	Date Signed

REP

SECTION 2 To Be Filled Out by Authorized Representative

Part A: Contact Information

Name — Organization

Street Address

City	State	Zip Code	Phone Number (include area code)

Name — Organization Contact (Last, First, Middle Initial)

Job Title — Organization Contact	Email Address — Organization Contact (optional)

Part B: Statements of Understanding

I understand and agree that:

- I am authorized to act on behalf of the organization listed in Section 2, Part A.
- As an authorized representative, the organization is limited to doing any or all of the following on the applicant's or member's behalf:
  - Applying for or renewing benefits
  - Reporting changes
  - Working with the applicant's or member's agency on any benefit-related matters
  - Filing eligibility-related grievances and appeals
- The organization is expected to be familiar with the applicant's or member's circumstances.
- The organization must report to the applicant's or member's agency any changes to the contact listed in Section 2, Part A.
- The applicant or member can remove the organization from being their authorized representative at any time.
- The applicant or member does not need to notify the organization that it has been removed from serving as their authorized representative.
- The organization is the applicant's or member's authorized representative until they request a different authorized representative or choose not to have an authorized representative.
- The organization and anyone acting on its behalf must provide truthful and accurate information.
- If the organization provides inaccurate or false information, the applicant or member may need to repay any health care benefits received in error.
- If the organization intentionally violates program rules, it must repay any FoodShare benefits that were misused or received in error.

REP

- The organization and anyone acting on its behalf must comply with applicable state and federal laws and regulations, including 42 C.F.R. Part 431, Subpart F; 42 C.F.R. § 447.10; 45 C.F.R. § 155.260(f); and 7 CFR 273.2(n)(4), concerning conflicts of interest and confidentiality of information.

- By signing this form, I am saying that I understand and agree to the statements above on behalf of the organization listed in Section 2, Part A.

- By signing this form, I am saying that the organization listed in Section 2, Part A will serve as the authorized representative for the applicant or member listed in Section 1.

Part C: Signature and Date

SIGNATURE — Organization Contact	Date Signed

SECTION 3 To Be Filled Out by Witness(es)

Name – Witness (Last, First, Middle Initial)

SIGNATURE — Witness	Date Signed

Name — Witness (Last, First, Middle Initial) (if applicant/member signed with an X)

SIGNATURE — Witness	Date Signed

WISCONSIN DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-10137 (06/2023)

CHG

WISCONSIN MEDICAID CHANGE REPORT

If you are receiving Medicaid, you must report any changes in the make up of your household (if anyone moves in or out of your household, if anyone gets married, becomes pregnant, or gives birth to a child), a change in address, income, assets or employment status **within 10 days.** If this report does not provide enough room to document a change, attach a sheet of paper with the additional information written on it to this report. You may also report changes online at access.wi.gov, by telephone or in person.

If you fail to report any changes or provide false information, you may be fined, have to pay back any Medicaid benefits you received that you should not have (even if you did not use your card), be prosecuted or all three. You may be required to provide proof of any changes you report.

Personally identifiable information will be used only for the direct administration of the Medicaid program.

Your Name	Case Number	Worker Name

SECTION 1 - CHANGE IN ADDRESS

If you have moved, you must report your new address.

Date of Change		New Telephone Number	
New Address - Street	City	State	Zip Code

SECTION 2 - CHANGE IN HOUSEHOLD COMPOSITION

You must report if anyone moves in or out of your household, if anyone gets married, becomes pregnant or gives birth to a baby (include information about the person who gave birth and the newborn.)

Name(s) (Last, First, MI)		Date of Change
Social Security Number (SSN)*	Date of Birth	Relationship to Case Head
Describe the Change		

*Providing or applying for an SSN is voluntary; however, any person who wants Wisconsin Medicaid but does not want to provide their SSN or apply for one will not be eligible for benefits, pursuant to Wisconsin Statutes section 49.82(2).

SECTION 3 - CHANGE IN ASSETS

You must report changes in your household's cash, bank accounts, bonds, stocks or other assets.

Name of Owner (Last, First, MI)		Date of Change
Type of Asset	Describe the Change	New Value or Amount $

Administrative Rule DHS 102.01 (6)

CHG

SECTION 4 – CHANGE IN RESOURCES/INCOME

You must report any income or resources you and/or your spouse have given away or sold for less than fair market value. Examples of resources include cash and cash gifts, real estate, stocks or bonds, an inheritance, etc.

Type of asset or income	Date sold or given away	Value of asset or income $
What did you get in return?		

SECTION 5 – CHANGE IN VEHICLES

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

Name of Owner(s) (last, first, MI)			Date of Change
Type of Vehicle	Make	Model	Year
Describe Change (bought, sold, etc.)	Amount Received $	Fair Market Value* $	Amount Owed $

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

SECTION 6 - CHANGE IN INCOME

You must report a change in your gross income amount, a new source of income, changes in your employment status (part-time to full-time or full-time to part-time, loss of employment), changes in salary or rate of pay, changes in the amount of Social Security, Unemployment Insurance, Worker's Compensation, Veterans benefits, or any other change in the amount of money your household gets.

Name (Last, First, MI)	Date Income Changed
Source of Income	Monthly Amount $
How Often Paid ☐ Each Week ☐ Every Other Week ☐ Twice Each Month ☐ Once Each Month	

SECTION 7 - OTHER CHANGES

You must report any other changes that may affect your Medicaid eligibility. Examples of other changes include someone getting or dropping health insurance, someone becoming disabled or recovering from a disability. A change could also be a change in expenses such as an increase or decrease in health insurance premiums, medical costs or shelter costs.

Describe change	
Do you expect that the changes reported on this form will remain the same next month? ☐ Yes ☐ No If no, explain.	Date of Change

CHG

SECTION 8 – SIGNATURE

☐ Yes ☐ No I understand that there are penalties for hiding information or giving false information.	
☐ Yes ☐ No I understand that I may have to pay back any benefits I receive because I do not fully report changes in my circumstances (even if I do not use my Medicaid card).	
☐ Yes ☐ No I agree to provide proof of any changes, if asked to do so.	
☐ Yes ☐ No My answers on this report are correct and complete to the best of my knowledge.	
SIGNATURE – Applicant/Representative/Guardian/Power of Attorney/Conservator	Date Signed
Telephone Number (including area code)	

If this report does not provide enough room to document a change, attach a sheet of paper with the additional information written on it to this report.

Mail or Fax Applications, Forms and/or Proof/Verifications

If you live in Milwaukee County:

MDPU
6055 N. 64th St.
Milwaukee, WI 53218

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

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

RESET FORM

Supplemental Nutrition Assistance Program (SNAP) and Food Distribution Program on Indian Reservations (FDPIR) state or local agencies, and their subrecipients, must post the following Nondiscrimination Statement:

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), 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.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, from any USDA office, by calling (833) 620-1071, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to:

1. **mail:**
   Food and Nutrition Service, USDA
   1320 Braddock Place, Room 334
   Alexandria, VA 22314; or
2. **fax:**
   (833) 256-1665 or (202) 690-7442; or
3. **email:**
   FNSCIVILRIGHTSCOMPLAINTS@usda.gov

This institution is an equal opportunity provider.

02/15/2023

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, 201 E. Washington Ave., Room E200B, 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).