WISCONSIN DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-16019 (10/2024)

APP

WISCONSIN FOODSHARE APPLICATION

INSTRUCTIONS

Provide your name, address, and signature to set the date your benefits can start. This is called "setting your filing date."

You have a choice of submitting only the information on this page (name, address, signature) or completing the full application.

If you need benefits right away, fill out the Priority FoodShare section and submit it with the first page. This may allow you to receive food benefits within seven days of application.

With all applications, you must complete an interview with your agency over the phone or in person. Completing a full application can reduce the time it takes to complete the interview, and certification process.

You have the right to submit your application at any time. Your application is processed as soon as possible but no later than 30 days from the date it's received.

If you had FoodShare benefits that stopped within the last 30 days, you may be eligible to reopen your FoodShare benefits. Contact your agency to reopen your FoodShare benefits without completing new forms.

You can apply online or by phone! Call your local agency or apply online at access.wi.gov. If you apply online, you can complete FoodShare and health care applications at the same time.

Name – Applicant (First, Middle, Last)		
Street Address		
City	State	ZIP Code
SIGNATURE – Applicant or Authorized Representative	Date Signed (mm/dd/yyyy)	

MAIL OR FAX APPLICATIONS

If you live in Milwaukee County:

MDPU
6055 North 64th Street
Milwaukee, WI 53218

Or fax: 888-409-1979

If you do not live in Milwaukee County:

CDPU
PO Box 5234
Janesville, WI 53547-5234

Or fax: 855-293-1822

If you have a disability and need an alternate format or translation, please contact your agency. To get the phone number of your agency, go to www.dhs.wisconsin.gov/forwardhealth/imagency/index.htm or call Member Services at 800-362-3002. Translation and TTY services are free of charge.

You may have an authorized representative complete and sign this form for you. To appoint an authorized representative, either fill out the Appoint, Change, or Remove an Authorized Representative: Person form, *F10126A*, or the Appoint, Change, or Remove an Authorized Representative: Organization form, *F10126B*. To get this form, call 800-362-3002, or go to www.dhs.wisconsin.gov/forwardhealth/representative-types.htm.

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OPTIONAL: PRIORITY FOODSHARE

If you need help right away, applying for priority FoodShare could get you benefits within seven days of setting your filing date. Fill out this page and send it with the first page or the rest of the application to see if you are eligible.

You are eligible for priority benefits if any of the following are true:

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

Name – Applicant (First, Middle, Last)

Street Address

City	State	ZIP Code

Answer the following questions to be considered for faster service.

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

Check the boxes for any utilities your household is required to pay and if the utility is used to heat your home.

Do you pay this utility?	Used for Heat	Do you pay this utility?	Used for Heat?
☐ Gas (natural)	☐ Yes ☐ No	☐ Fuel oil/kerosene	☐ Yes ☐ No
☐ Electric	☐ Yes ☐ No	☐ Coal	☐ Yes ☐ No
☐ Liquid propane gas	☐ Yes ☐ No	☐ Wood	☐ Yes ☐ No

Check the boxes for any utilities your household is required to pay.

☐ Phone ☐ Water ☐ Sewer ☐ Trash removal ☐ Air conditioning surcharge ☐ Other

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OPTIONAL: FULL APPLICATION

SECTION 1 – CONTACT INFORMATION

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

Phone Number	Type of Phone ☐ Home ☐ Cell ☐ Work	
Other Phone Number	Who does this number belong to? ☐ Self ☐ Family ☐ Other	What is this person's name?

Email Address

How would you like to get your letters? ☐ Postal Mail ☐ Email – ACCESS

Do you have a separate mailing address that is different from where you are living?
☐ Yes ☐ No

If yes, please write the address where you receive mail.

Street Address

City	State	ZIP Code

Are you currently homeless?*
☐ Yes ☐ No

*Homeless means that you do not have a long-term place to stay at night. This includes staying at a shelter, with a friend or family member, or having no place to stay.

If you are homeless skip the address question. If you are currently homeless and do not have a mailing address, your mail will go to your local agency.

What is the best way and time to contact you?

SECTION 2 — APPLICANT INFORMATION

If you are completing this application for someone else, answer the rest of the questions as if you were that person.

Providing a Social Security Number, if you have one, is required by law for each person seeking benefits. It is used to help determine eligibility and benefit amounts. If you do not have a Social Security Number, you can apply for one at www.ssa.gov/number-card.

Note: You don't have to answer ethnicity and race questions if you don't want to. We are asking these questions to help improve our programs and make sure they do not discriminate based on ethnicity or race. Your answers will not be used to make a decision about your program eligibility and benefit amount.

Social Security Number	Date of Birth (mm/dd/yyyy)
Sex ☐ Male ☐ Female	Marital Status ☐ Married ☐ Single ☐ Divorced
U.S. Citizen ☐ Yes ☐ No	Ethnicity (optional) ☐ Hispanic or Latino(a) ☐ Not Hispanic or Latino(a) ☐ I don't know ☐ I prefer not to answer

Race (optional) check all that apply
☐ American Indian/Alaska Native ☐ Asian ☐ I don't know
☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other
☐ Black/African American ☐ I prefer not to answer

Primary Language Spoken in Your Home	What language do you want FoodShare letters printed in?

SECTION 3 – HOUSEHOLD INFORMATION

Complete this section for people who live with you. If more room is needed, use a blank sheet of paper, and include it with the application.

Providing a Social Security Number (SSN) is required by law for each person seeking public benefits. It is used to help determine eligibility and benefit amounts. If you do not know the SSN for someone that lives with you, or they do not have one, still include them in this section.

Note: You don't have to answer ethnicity and race questions if you don't want to. We are asking these questions to help improve our programs and make sure they do not discriminate based on ethnicity or race. Your answers are not used to decide program eligibility and benefit amount.

Person 1 (Applicant)

Name (First, Middle Initial, Last)	Does this person want FoodShare? ☐ Yes ☐ No
Date of Birth (mm/dd/yyyy)	Social Security Number
Sex ☐ Male ☐ Female	Marital Status ☐ Married ☐ Single ☐ Divorced
U.S. Citizen ☐ Yes ☐ No	Ethnicity (optional) ☐ Hispanic or Latino(a) ☐ Not Hispanic or Latino(a) ☐ I don't know ☐ I prefer not to answer

Race (optional) check all that apply
☐ American Indian/Alaska Native ☐ Asian ☐ I don't know
☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other
☐ Black/African American ☐ I prefer not to answer

Relationship to Applicant	Do you buy food and eat most of your meals with this person? ☐ Yes ☐ No	Do you provide care for this person? ☐ Yes ☐ No

Person 2

Name (First, Middle Initial, Last)	Does this person want FoodShare? ☐ Yes ☐ No
Date of Birth (mm/dd/yyyy)	Social Security Number
Sex ☐ Male ☐ Female	Marital Status ☐ Married ☐ Single ☐ Divorced
U.S. Citizen ☐ Yes ☐ No	Ethnicity (optional) ☐ Hispanic or Latino(a) ☐ Not Hispanic or Latino(a) ☐ I don't know ☐ I prefer not to answer

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Race (optional), check all that apply:
☐ American Indian/Alaska Native ☐ Asian ☐ I don't know
☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other
☐ Black/African American ☐ I prefer not to answer

Relationship to Applicant	Do you buy food and eat most of your meals with this person? ☐ Yes ☐ No	Do you provide care for this person? ☐ Yes ☐ No

Person 3

Name (First, Middle Initial, Last)	Does this person want FoodShare? ☐ Yes ☐ No

Date of Birth (mm/dd/yyyy)	Social Security Number
Sex ☐ Male ☐ Female	Marital Status ☐ Married ☐ Single ☐ Divorced
U.S. Citizen ☐ Yes ☐ No	Ethnicity (optional) ☐ Hispanic or Latino(a) ☐ Not Hispanic or Latino(a) ☐ I don't know ☐ I prefer not to answer

Race (optional), check all that apply:
☐ American Indian/Alaska Native ☐ Asian ☐ I don't know
☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other
☐ Black/African American ☐ I prefer not to answer

Relationship to Applicant	Do you buy food and eat most of your meals with this person? ☐ Yes ☐ No	Do you provide care for this person? ☐ Yes ☐ No

Person 4

Name (First, Middle Initial, Last)	Does this person want FoodShare? ☐ Yes ☐ No

Date of Birth (mm/dd/yyyy)	Social Security Number
Sex ☐ Male ☐ Female	Marital Status ☐ Married ☐ Single ☐ Divorced
U.S. Citizen ☐ Yes ☐ No	Ethnicity (optional) ☐ Hispanic or Latino(a) ☐ Not Hispanic or Latino(a) ☐ I don't know ☐ I prefer not to answer

Race (optional), check all that apply:
☐ American Indian/Alaska Native ☐ Asian ☐ I don't know
☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other
☐ Black/African American ☐ I prefer not to answer

Relationship to Applicant	Do you buy food and eat most of your meals with this person? ☐ Yes ☐ No	Do you provide care for this person? ☐ Yes ☐ No

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SECTION 4 – STUDENT INFORMATION

If more room is needed, use a separate sheet of paper.

Is there anyone 18-49 years of age in your household going to a post-secondary school (example: technical college or university)? ☐ Yes ☐ No If no, go to Section 5.	Are the classes taken outside of a regular curriculum? Special classes not part of the regular curriculum can include remedial education, continuing or community education, professional development, English for Speakers of Other Languages (ESOL/ESL), and workforce development. ☐ Yes ☐ No If no, go to Section 5.
Name of School	The student is enrolled: ☐ Less than half time ☐ Half time or more ☐ Full time ☐ Other

Name of Student Attending Post-Secondary School (First, Middle Initial, Last)

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

Enrolled in Wisconsin Works (W-2) or other TANF-funded program under Title IV of the Social Security Act.
☐ Yes ☐ No

Is the student employed at least 20 hours per week? ☐ Yes ☐ No	Is the student self-employed? ☐ Yes ☐ No

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

Is the student working in a paid on the job training program?
☐ Yes ☐ No

Is the student caring for a child younger than 6 years old?
☐ Yes ☐ No

Is the student caring for a child 6-12 years old and adequate childcare is not available?
☐ Yes ☐ No

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

Is the student attending school due to placement through Workforce Innovation and Opportunity Act (WIOA), Trade Act of 1974 (TAA), W-2, FoodShare Employment and Training (FSET), or another employment and training program?
☐ Yes ☐ No

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SECTION 5 – ADDITIONAL HOUSEHOLD INFORMATION

Is anyone in your household found to be totally disabled by the Social Security Administration, Veterans Administration, or Railroad Retirement Board?
☐ Yes ☐ No

Name of Person(s) Who is Disabled (First, Middle Initial, Last)	Date of Disability Determination (mm/dd/yyyy)

Is anyone in your household unable to work because of illness or injury (mental or physical)?
☐ Yes ☐ No

Name of Person(s) Who is Unable to Work (First, Middle Initial, Last)	Date of Determination for the Person Unable to Work (mm/dd/yyyy)

Is anyone in your household pregnant? ☐ Yes ☐ No	Name of Person(s) Who is Pregnant (First, Middle Initial Last)

Is anyone in your household an 18-24 year-old who was in foster care, a subsidized guardianship, or court-ordered kinship care when they turned 18? ☐ Yes ☐ No	Name of Person(s) Who is an 18—24-Year-old Who was in Foster Care, a Subsidized Guardianship, or Court-Ordered Kinship Care, When They Turned 18 (First, Middle Initial, Last)

Is anyone in your household a veteran of the US military who was discharged for any reason? ☐ Yes ☐ No	Name of Person(s) Who is a Veteran (First, Middle Initial, Last)

Does anyone in your household regularly participate in a substance use disorder program (this does not include Alcoholics Anonymous or Narcotics Anonymous programs)? ☐ Yes ☐ No	Name of Person(s) Who is Participating in Treatment (First, Middle Initial, Last)

Is anyone in your household the primary caretaker for a child under the age of 6 or another person who is unable to care for themselves (living in or out of the home)? ☐ Yes ☐ No	Name of Person(s) Who is Providing Care (First, Middle Initial, Last)

Does anyone in your household participate in a work program? For example, dislocated workers programs, Wisconsin Works (W-2), or Tribal TANF? ☐ Yes ☐ No	Name of Person(s) Who is Participating in a Work Program (First, Middle Initial, Last)

Has anyone in your household been convicted of a drug related felony in the last five years? ☐ Yes ☐ No	Name of Person Convicted of a Drug-Related Felony (First, Middle Initial, Last)	Date of Conviction (mm/dd/yyyy)

Is anyone in your household fleeing from a felony or in violation of probation or parole? ☐ Yes ☐ No	Name of Person Fleeing From a Felony or is in Violation of Probation or Parole (First, Middle Initial, Last)

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SECTION 6 – ASSETS

Asset information is needed only if you are applying for emergency benefits or are part of a household of individuals who are elderly, blind, or have a disability.

List all assets owned by the applicant(s). Include assets owned jointly with anyone else. Available assets mean any asset that can be cashed at any time.

List items such as cash, checking or savings accounts, prepaid debit cards, certificates of deposit (CDs), trust funds, stocks, bonds (not set aside for education or funeral expenses), interest in annuities, U.S. savings bonds, property agreements, contracts for deeds, timeshares, rental property, life estates, or personal property being held for investment purposes. Do not include the value of personal household belongings.

Type of Asset	Name of the Owner(s)	Current Value	Description (such as name of bank or financial institution, include other type of asset here)
Cash		$	
Checking Account		$	
Savings Account		$	
Other Type of Asset		$	
Other Type of Asset		$	
Other Type of Asset		$	

SECTION 7 – EMPLOYMENT/JOB INCOME AND WAGES

FoodShare enrollment is based on total household gross (before taxes or deductions) income. Self-employment is entered in Section 9. If more room is needed, use a separate sheet of paper.

Is any household member working?
☐ Yes ☐ No
If yes, answer the following questions for each household member who is working.

Is anyone a migrant worker?
☐ Yes ☐ No

Person 1

Name of Person Working (First, Middle Initial, Last)	Date Employment Began (mm/dd/yyyy)

Employer Name

Employer Address

How often is this person paid (select from below)?
☐ Weekly ☐ Biweekly (Every other week) ☐ Once per Month ☐ Semi-Monthly (Two times per month)
☐ Other, provide details:

Number of hours per paycheck?	Gross earnings (before taxes or deductions) per paycheck $

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Is this person paid hourly?
☐ Yes ☐ No If yes, how much is this person paid each hour? $

Is this person paid a salary?
☐ Yes ☐ No If yes, how much is this person's salary? $

Does this person get tips or compensation other than their hourly wages or salary?
☐ Yes ☐ No If yes, how much does this person get each pay period? $

Person 2

Name of Person Working (First, Middle Initial, Last)	Date Employment Began (mm/dd/yyyy)

Employer Name

Employer Address

How often is this person paid (select from below)?
☐ Weekly ☐ Biweekly (Every other week) ☐ Once per Month ☐ Semi-Monthly (Two times per month)
☐ Other

Number of hours per paycheck?	Gross Earnings (Before taxes or deductions) per Paycheck $

Is this person paid hourly?
☐ Yes ☐ No If yes, how much is this person paid each hour? $

Is this person paid a salary?
☐ Yes ☐ No If yes, how much is this person's salary? $

Does this person get tips or compensation other than their hourly wages or salary?
☐ Yes ☐ No If yes, how much does this person get each pay period? $

SECTION 8 – LOSS OF EMPLOYMENT

Has anyone in your household recently ended employment?
☐ Yes ☐ No If yes, complete the rest of Section 8.

Name of Person Who Lost Employment (First, Middle Initial, Last)	Date the Job Ended (mm/dd/yyyy)

Employer Name and Address

Reason Their Employment Ended ☐ Quit ☐ Fired ☐ Laid off ☐ Other: _____	Has this person applied for unemployment insurance? ☐ Yes ☐ No If yes, when did this person apply for unemployment (mm/dd/yyyy)?

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SECTION 9 – SELF-EMPLOYMENT INCOME

Please tell us about any self-employment income you and/or anyone in your household gets. Include income received even if the person does not file taxes. Examples of self-employment include owning a business, rental property, or any exchange of goods or services for money. If more room is needed or more than one person is self-employed, use a separate sheet of paper.

Is anyone in your household self-employed?
☐ Yes ☐ No If yes, complete the rest of Section 9.

Name of the Self-Employed Person (First, Middle Initial, Last)	Business Name

Business Address

Business Ownership Type
☐ Partnership ☐ S Corporation ☐ Sole Proprietorship ☐ Corporation ☐ Other ☐ I Don't Know

Business Type (farming, 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 since last filing taxes?
☐ Yes ☐ No ☐ I Don't Know

On average, how much gross income 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 10 – IN-KIND OR VOLUNTEER INCOME, OTHER INCOME

Please tell us about any in-kind (getting goods, services, or food in exchange for work) or volunteer work anyone in your household does. If more room is needed, use a separate sheet of paper.

Name of Person or Organization Who Gives Goods, Services, or Food in Exchange for Work or Services

Street Address		Phone Number

City	State	ZIP Code

What is done in exchange for goods, services, or food?

How many hours each month?	Date Started

Name of Person or Organization

Street Address	Phone Number

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City	State	ZIP Code
How many hours each month do you volunteer?	Date Started	

SECTION 11 – OTHER INCOME

If more room is needed, use a separate sheet of paper.

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

Type of Income	Do you get this?	Name of Person Who Gets This Income	Gross (Before Taxes or Deductions) Monthly Amount
Social Security	☐ Yes ☐ No		$
Supplemental Security Income (SSI)	☐ Yes ☐ No		$
Alimony/Child Support	☐ Yes ☐ No		$
Workers/Unemployment Compensation	☐ Yes ☐ No		$
Disability/Sick Pay	☐ Yes ☐ No		$
Interest/Dividends	☐ Yes ☐ No		$
Veterans' Benefits	☐ Yes ☐ No		$
Foster Care Payments	☐ Yes ☐ No		$
Kinship Care Payments	☐ Yes ☐ No		$
Other: _____	☐ Yes ☐ No		$

SECTION 12 – EXPENSES

Dependent Care: Does anyone in your household pay for child or adult care so they can work, look for work, go to school, or get training?
☐ Yes ☐ No

Name of Person Paying for Child or Adult Care (First, Middle Initial, Last)	Who is being paid to provide this child or adult care? (First, Middle Initial, Last)	Name of the Child or Adult Being Cared For (First, Middle Initial, Last)

Amount $	How often is this paid (select from below)? ☐ Weekly ☐ Biweekly (Every other week) ☐ Once per Month ☐ Semi-Monthly (Two times per month) ☐ Other, please specify:

Child Support: Is anyone in your household court-ordered to pay child support?
☐ Yes ☐ No

Name of Who is Paying the Child Support (First, Middle Initial, Last)	Name of Person Receiving the Money (First, Middle Initial, Last)	Name of the Child the Support is Being Paid For (First, Middle Initial, Last)

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Amount $	How often is this paid (select from below)? ☐ Weekly ☐ Biweekly (Every other week) ☐ Once per Month ☐ Semi-monthly (Two times per month) ☐ Other, please specify:

Medical Expenses: Does any household member who is elderly, blind or has been determined to have a disability have out-of-pocket medical costs? See the Medical Expenses Deductions and How They Impact FoodShare Benefits pamphlet for examples or P-03315B at www.dhs.wisconsin.gov/library/collection/p-03315b.
☐ Yes ☐ No

Name of Person with Medical Expense (First, Middle Initial, Last)	What types of medical expenses?	Amount
	☐ Prescriptions	$
	☐ Medical Bills	$
	☐ Copayment	$
	☐ Insurance Premium	$
	☐ Other	$
	☐ Other	$

How often is this paid (select from below)?
☐ Weekly ☐ Biweekly (Every other week) ☐ Once per Month ☐ Semi-Monthly (Two times per month)
☐ Other, please specify:

Shelter Costs: Does anyone in the household have shelter costs (rent, mortgage, property taxes)?
☐ Yes ☐ No

Name of Person with Shelter Costs (First, Middle Initial, Last)	Monthly Cost $

What is the expense for?
☐ Rent/Lot Rent ☐ Mortgage ☐ Property Tax ☐ Homeowner's Insurance
☐ Mobile home loan payment ☐ Special Assessment or Taxes for Things Like Sidewalk or Street Repair

Utility Costs: Does anyone in the household pay for utilities? ☐ Yes ☐ No	If renting, is heat included in the rent? ☐ Yes ☐ No

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

Do you pay this utility?			Used for heat?	
Gas (Natural)	☐ Yes	☐ No	☐ Yes	☐ No
Electric	☐ Yes	☐ No	☐ Yes	☐ No
Liquid Propane Gas	☐ Yes	☐ No	☐ Yes	☐ No
Fuel Oil/Kerosene	☐ Yes	☐ No	☐ Yes	☐ No
Coal	☐ Yes	☐ No	☐ Yes	☐ No
Wood	☐ Yes	☐ No	☐ Yes	☐ No

Check the box(es) for the utilities your household is required to pay.
☐ Phone ☐ Water ☐ Sewer ☐ Trash removal ☐ Air conditioning surcharge ☐ Other:_____

Do you get housing assistance (Section 8 or other subsidized public housing)?
☐ Yes ☐ No

Do you get energy assistance (WHEAP, LIHEAP, weatherization, or other energy assistance from another state)?
☐ Yes ☐ No

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WISCONSIN FOODSHARE IMPORTANT INFORMATION

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

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

REPORTING REQUIREMENTS

You are required to report if your household's monthly gross income goes over 130% of the federal poverty level for your household size.

You are required to report receiving any substantial lottery or gambling winning won in a single game, bet, or ticket before taxes or other amounts are withheld.

You or someone in your household may need to meet the FoodShare work requirement at some point in your certification period to keep getting FoodShare benefits. To meet the work requirement, you must work or participate in a work program at least 80 hours a month. If your work hours go below 80 hours per month you must report this.

AS A FOODSHARE MEMBER, YOU HAVE RIGHTS AND RESPONSIBILITIES

Your rights include:

- The right to be notified of your enrollment status within 30 days of applying.
- The right to get benefits within seven days if you qualify for immediate help.
- Not be discriminated against because you are elderly or because of race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal/retaliation for prior civil rights activity.

You are responsible for:

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

People who break FoodShare rules may be disqualified from the program, fined, imprisoned, or all three.
For more information about your rights and responsibilities, go to www.dhs.wisconsin.gov/library/collection/f-10150b.

WRITTEN NOTICE

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

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FAIR HEARING

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

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

Your request must be received within 90 days of the agency's effective date for your FoodShare benefits or, if you do not agree with the amount of your FoodShare benefits, at any time while you are getting benefits.
The Request for Fair Hearing form may be downloaded at www.dhs.wisconsin.gov/forwardhealth/resources.htm, or you can call the agency listed on your letter to request a hearing.

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

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

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

LEGAL GUARDIAN, CONSERVATOR, OR POWER OF ATTORNEY

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

COLLECTION OF INFORMATION/USE OF SOCIAL SECURITY NUMBERS/PERSONALLY IDENTIFIABLE INFORMATION

The collection of this information, including the Social Security number of each household member, is authorized under the Food and Nutrition Act of 2008, as amended, 7 U.S.C. 2011-2036. The information will be used to determine whether your household is eligible or continues to be eligible to participate in SNAP.

**The information will be used to determine if your household can get or keep getting benefits.
Information you give will be verified through computer matching programs. This information will also be used to monitor compliance with program rules and for program management.**

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

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

Providing the requested information, including the Social Security numbers of each household member, is voluntary. However, failure to provide a Social Security number will result in the denial of SNAP benefits to everyone who fails to provide a Social Security number without good cause. Any Social Security numbers provided will be used and disclosed in the same manner as Social Security numbers of eligible household members.

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

FoodShare benefits do not count for public charge ground of inadmissibility.

IMMIGRATION STATUS

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

QUALITY CONTROL REVIEW

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

BASIC WORK RULES FOR INDIVIDUALS AGES 16 THROUGH 59

All FoodShare applicants and members ages 16 through 59 must comply with the basic work rules as a condition of FoodShare eligibility unless they are considered exempt. Compliance with the basic work rules includes registering for work at the time of application by providing enough information regarding employment status or availability for work.

You meet an exemption from the basic work rules if any of the following is true:

- You are 16 or 17 years old and are not the primary person in the FoodShare group.
- You are 16 or 17 years old and are the primary person in the FoodShare group but are enrolled in school or in an employment and training program at least half time.
- You are found to be unfit for work. This applies if:
    - You get temporary or permanent disability benefits from the government or a private source.
    - You are found to be mentally or physically unable to work by your agency.
    - You are verified as unable to work by a statement from a health care professional or social worker.
- You are enrolled in W-2 and complying with the W-2 work requirements.
- You are the primary caregiver for a dependent child younger than age 6 (whether the child lives in your home or out of your home). However, if you and another person both have parental control of the child, only one of you can be exempt from the work registration requirements as the primary caregiver of that child.
- You are the primary caregiver for another person who cannot care for himself or herself (whether the person lives in your home or out of your home).
- You have applied for or are receiving unemployment compensation.
- You are regularly taking part in an alcohol or other drug abuse treatment or rehabilitation program.
- You are working 30 or more hours per week or earning weekly wages of $217.50 or more.
- You are enrolled at least half time in a recognized school, training program, or institution of higher education.

You may need to provide proof to your agency if you meet one of these exemptions. Although complying with the basic work rules is required, taking part in a work program is voluntary.

BASIC WORK RULE SANCTION

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

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

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

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

You can end a sanction period early if you become exempt from the work registration requirements.
You will need to reapply for FoodShare if you want to get benefits after the sanction period ends. If you are part of a FoodShare group, you will need to let your worker know to update your case instead of having to reapply.

FOODSHARE WORK REQUIREMENT FOR ABLE-BODIED ADULTS AGES 18 THROUGH 54

Certain adults ages 18 through 54 with no minor children living in the home may only get three months of time-limited FoodShare benefits in a 36-month (three-year) period unless they meet the FoodShare work requirement or are considered exempt. This work requirement is different from the basic work rule requirement.

There are four ways to meet the FoodShare work requirement for ABAWDs:

- Work at least 80 hours each month.
- Take part in an allowable work program at least 80 hours each month, such as:
    - FoodShare Employment and Training (FSET).
    - W-2.
    - Workforce Innovation and Opportunity Act (WIOA).
- Have an in-kind job (paid with goods instead of money) or volunteer at least 80 hours each month.
- Have a combination of work, an in-kind job, volunteer, or take part in an allowable work program for a total of 80 hours each month.

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

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

- You are living with a child under age 18 who is part of the same FoodShare household, even if the child is not eligible for FoodShare benefits.
- You are the primary caregiver for a person who cannot care for themself (whether the person lives in your home or out of your home).
- You are the primary caregiver for a dependent child under age 6 (whether the child lives in your home or out of your home). However, if you and another person both have parental control of the child, only one of you can be exempt from the FoodShare work requirement as the primary caregiver of the child.
- You are physically or mentally unable to work.
- You are experiencing homelessness. This includes people who are in a temporary housing situation, such as transitional living arrangements and shelters, or staying temporarily (up to 90 days) at another person’s residence.
- You are pregnant.
- You are receiving or have applied for unemployment compensation.
- You are taking part in an alcohol or other drug abuse (AODA) treatment or rehabilitation program.
- You are enrolled at least half-time in a recognized school or institution of higher learning.
- You are age 18 or older attending high school at least half-time.
- You are enrolled in W-2 and meeting W-2 requirements.
- You are working 30 or more hours per week or are earning weekly wages of $217.50 or more.
- You are an 18-24 year-old who was in foster care, a subsidized guardianship, or court-ordered kinship care, when you turned 18.
- You are a veteran. A veteran is a person who served in the United States Armed Forces (including Army, Marine Corps, Navy, Air Force, Space Force, Coast Guard, National Guard, and Armed Forces Reserves) and was discharged or released under any conditions.

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

JOB CENTER

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

COMPUTER CHECK

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

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

FOODSHARE PENALTY WARNING

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

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

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

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

PROOF NEEDED

Enrollment in FoodShare cannot be determined until you provide proof to verify certain answers.

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

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

The following items are examples of proof:

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

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

Self-Employment
- Most recent year taxes

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

The following items may be required to get a credit:

- Housing Costs and Utility Bills
- Current rent receipt with landlord's name and phone number on it
- Lease or mortgage papers
- Real estate property tax statement
- Utility bills
- Child Support (received or paid in a state other than Wisconsin)
- Court order papers or other record of payment
- Payment record from other state

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

MEDICAL COSTS AND EXPENSES

Medical costs and expenses include, but are not limited to, the following:

- Hospital, medical, dental, and vision services
- Premiums for health insurance, Medicare premiums, and costs for prescriptions drug plans
- Prescription and over-the-counter medicine
- Nursing home and home health services
- Medical equipment and supplies
- Transportation and lodging costs for medical care
- Related cost for a specially trained service animal
- Lifeline/Medic Alert costs if prescribed by a health care professional
- Billing statement
- Itemized receipts
- Medicine or pill bottle with price on label
- Health insurance policy showing premium, coinsurance, copayments, or deductible
- Statement from pharmacy
- Repayment agreement with provider
- Statement from doctor verifying over-the-counter drug was prescribed
- Bill for services of a visiting nurse, homemaker, or home health aide
- Lodging and/or transportation receipts for obtaining medical treatment or services
- Bill or receipts for animal food, training, or veterinarian services for a specially trained service animal

APP

USDA 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 (866) 632-9992, 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.