

WISCONSIN FAMILY MEDICAID, BADGERCARE AND FAMILY PLANNING WAIVER PROGRAM

IMPORTANT INFORMATION

This application is to be used by families with children under age 19 and pregnant women who are applying for Wisconsin Medicaid or BadgerCare and for women who are applying for the Family Planning Waiver Program. This is not an application for FoodShare Wisconsin, Child Care or Wisconsin Works (W-2). If you are interested in applying for these assistance programs you must contact your local office or your W-2 agency. These programs provide help with the cost of food, the cost of child care or finding a job as part of W-2.

If you need help filling out this application or wish to answer the questions in person or over the telephone, contact your Medicaid office. For information on Medicaid offices location or other questions regarding Wisconsin Medicaid, BadgerCare or the Family Planning Waiver Program, please call Recipient Services at 1-800-362-3002. Information is also available on the Department of Health and Family Services' web site at dhfs.wisconsin.gov/medicaid/.

If you have a disability and need to access the instructions and application in an alternate format or need it translated to another language, please contact (608) 266-3465 or (888) 701-1251 (TTY). All translation services and translated information are free of charge.

APPLY ONLINE

ACCESS TO ELIGIBILITY SUPPORT SERVICES FOR HEALTH AND NUTRITION (ACCESS)

ACCESS is an online tool that lets you apply for benefits, check the status of your benefits or report a job to your worker. To visit ACCESS go to <https://access.wisconsin.gov>.

The online application will take 30 to 40 minutes to fill out. It can be used to apply for FoodShare, Medicaid, BadgerCare and/or the Family Planning Waiver Program.

You may need to talk with someone from the Medicaid office after you submit an application online. In many cases, this can be done over the telephone. You will usually get a decision on your benefits within 30 days.

HOW TO USE THIS FORM

1. Read these instructions and important information completely before completing the application.
2. Print clearly. Use blue or black ink.
3. Fill out the application completely. Answer all the questions. There may be a delay in Medicaid, BadgerCare or the Family Planning Waiver Program benefits if the application is not complete. If your application is not complete, your local Medicaid office will contact you for more information. Unsigned forms will not be processed and will be returned.
4. Do not write in the shaded sections.
5. Enter information about all the people that live in your household. If you need more space, use an additional sheet of paper.
6. If you are pregnant, please include (with your application) a signed and dated note from your doctor or other health care professional which states that you are pregnant, what your expected due date is and whether you are expecting multiple births.
7. Keep the Important Information (pages 2 through 4) and the Medicaid Change Report form (HCF 10137) at the back of the application packet for future use.
8. You may authorize a representative to apply for you. Contact Recipient Services at (800) 362-3002 to have a form sent to you or visit our web site at dhfs.wisconsin.gov/medicaid1/applications.htm. This form authorizes a representative to complete and sign the application for you. A legal guardian, conservator, power of attorney or durable power of attorney may apply for an individual without separate authorization by the individual.
9. Send the completed application to your local Medicaid office. Addresses for local agencies can be found at dhfs.wisconsin.gov/em/imagencies/ or by contacting Recipient Services at (800) 362-3002.

OTHER PROGRAM INFORMATION

If you are interested in services for veterans, call (800) 947-8347 (WIS-VETS), or contact your county Veteran Service Officer.

For information about the Women, Infants and Children (WIC) Nutrition Program or other services for women, children and families, call 1-800-722-2295.

IMPORTANT INFORMATION

The following is important information regarding Wisconsin Medicaid, BadgerCare and Family Planning Waiver Program eligibility.

- A decision regarding your eligibility for Medicaid, BadgerCare or the Family Planning Waiver Program will be mailed to you within 30 days of the application date, if all the needed information about you and/or your household is collected.
- Even if you are not eligible in the month you apply, you may be able to get Medicaid benefits for up to three months before your application date if all the needed information is collected for the prior months and you are determined to have been eligible in those months. If you want help paying for health care for any of the three months prior to your application date (backdated coverage), make sure you checked the "Yes" box on the application where the backdated coverage question is asked and complete the Request for Medicaid Backdated Coverage form (HCF 10100B) in this packet.

There is no backdated coverage for BadgerCare or the Family Planning Waiver Program. Eligibility for these programs can begin no earlier than the first of the month in which you apply.

- If you are found eligible for Medicaid, BadgerCare or the Family Planning Waiver Program you will need to complete a review every 12 months to determine your continued eligibility.

PERSONAL INFORMATION

Under Wisconsin Statute section 49.45 (4), personally identifiable information is kept confidential and is only used for the direct administration of Wisconsin Medicaid, BadgerCare and the Family Planning Waiver Program.

SOCIAL SECURITY NUMBER

If someone in your household is not applying for Medicaid, BadgerCare or the Family Planning Waiver Program you do not need to provide Social Security Number (SSN) information for that person. Any person who wants Wisconsin Medicaid, BadgerCare or the Family Planning Waiver Program, but does not provide their SSN or apply for one will not be eligible for benefits, pursuant to Wisconsin Statutes section 49.82(2).

If you are applying only for emergency services because of your immigration status, or you are a pregnant woman applying for the BadgerCare Prenatal Program, you do not need to provide SSN information.

SSN information will be used for administration of Wisconsin Medicaid, BadgerCare and the Family Planning Waiver Program. Your SSN permits a computer check of your information with government agencies such as the Internal Revenue Service (IRS), Social Security Administration and the Department of Workforce Development. In addition, the Department 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).

RIGHTS AND RESPONSIBILITIES

Rights

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

- The right to be treated with respect by state and county employees,
- The right to confidentiality of all information given to local Medicaid offices to determine eligibility. (This does not prohibit the use of such records for program administration,)
- The right of access to Medicaid office records and files relating to your case, except information obtained by the Medicaid office 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, and
- The right to appeal any action taken concerning your Medicaid, BadgerCare or Family Planning Waiver Program application or on-going benefits that you do not agree with by requesting a Fair Hearing. You may request a Fair Hearing by writing to:

Wisconsin Department of Administration
Division of Hearings and Appeals
P.O. Box 7875
Madison, WI 53707-7875

Or by calling: Telephone (608) 266-7709

The "[Request for Fair Hearing](http://dha.state.wi.us/home/)" form can also be found on the Division of Hearings and Appeals web site at <http://dha.state.wi.us/home/>.

You may also contact the local Medicaid office where you applied and ask for assistance with filing a Fair Hearing request. Refer to the *Wisconsin Medicaid Program – Eligibility and Benefits* brochure (PHC 10025), or your Notice of Decision for more information on the fair hearing process.

The Department of Health and Family Services (DHFS) is an equal opportunity employer and service provider. For civil rights questions, call (608) 266-9372 (voice) or (888) 701-1251 (TTY).

To file a complaint of discrimination contact either the:

Wisconsin Department of Health and Family Services (DHFS)
Affirmative Action and Civil Rights Compliance Office
1 W. Wilson, Room 555
Madison, WI 53707-7850
Telephone: (608) 266-9372 (voice); (888) 701-1251 (TTY)
Fax: (608) 267-2147

OR

U.S. Department of Health and Human Services
Office for Civil Rights – Region V
233 N. Michigan Avenue, Suite 240
Chicago, IL 60601
Telephone: (312) 886-5077 (voice) or
(312) 353-5693 (TTY)

Responsibilities

Reporting Changes

Report to the Medicaid office **within 10 days**:

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

Example. If you move out of state and you are in a Medicaid HMO and do not report this move you will be responsible to repay Wisconsin Medicaid any payment they made to your HMO. For example, if Wisconsin Medicaid paid your HMO \$175 per month for each family member and your family size is 4, the amount of overpayment you would have to repay Wisconsin Medicaid is \$700 for each month the HMO was paid after you moved out of state.

Note: For the Family Planning Waiver program, only changes in residency need to be reported within 10 days.

Changes in a job can be reported online at <https://access.wisconsin.gov> or you can report all changes using the Medicaid Change Report form (HCF 10137), which can be found in this application packet. Keep this form for future use. Do not send it with your application.

CITIZENSHIP / IDENTITY

Federal law requires that all persons requesting Medicaid or BadgerCare benefits and declaring to be U.S. citizens must show proof of their U.S. citizenship and identity in order to receive or continue to receive these health care benefits. We also verify with the U.S. Department of Homeland Security the alien status of all immigrants who apply for benefits for themselves. Undocumented immigrants are only eligible for coverage of emergency health care services if they would otherwise be eligible for Medicaid or BadgerCare. However, pregnant immigrants may be eligible for the BadgerCare Prenatal Program. 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, BadgerCare or the Family Planning Waiver Program, you do not need to answer this question for that person.

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

- U.S. Passport
- Certificate of U.S. Citizenship
- Certification of U.S. Naturalization

Examples of proof 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
- Life or health insurance record showing U.S. birth
- Nursing home admission papers showing U.S. birth

Examples of proof you can use to prove identity are:

- State driver license
- ID card issued by federal, state or local government
- School ID card with photo
- U.S. Military ID card or draft record showing U.S. birth
- U.S. Military ID card or draft record showing U.S. birth
- U.S. Military dependent ID card
- U.S. Military ID card or draft record showing U.S. birth
- U.S. Military dependent ID card
- For children under age 16, a signed Statement of Identity form, HCF10154

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 document either your citizenship or identity, contact your local Medicaid office for help.

CHILD SUPPORT COOPERATION

In some situations, you must cooperate with the Child Support Agency to establish paternity, by helping to locate absent parents, legally naming the absent parent and/or enforcing child support orders if you are requesting Medicaid, BadgerCare or the Family Planning Waiver Program. Failure to cooperate with the Child Support Agency without good cause may result in termination or a reduction in benefits for adults who are not pregnant.

OTHER MEDICAL COVERAGE

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

RECOVERY OF MEDICAID

Wisconsin state law provides for the recovery of certain Medicaid and BadgerCare benefits you receive in error. The law also provides for the recovery of certain Medicaid benefits you receive after you turn 55 years old and all Medicaid benefits you receive while you are a resident in a nursing home and while you are an inpatient in a hospital for 30 days or more. Under limited circumstances, a lien may be placed on your home for benefits you receive while you are residing in a nursing home if you are unlikely to return home and your spouse (or minor/disabled son or daughter) does not live in the home.

CODE KEYS

The following are the codes that are used in Section II of the application.

Marital Status

Enter the code in the space provided that best describes each household member's marital status.

A = Annulled
D = Divorced
LS = Legally Separated
M = Married
N = Never Married
S = Single
W = Widowed

Race / Ethnic Background (This information is voluntary and will not be used to determine eligibility.)

A = Asian
B = Black
H = Hispanic origin
I = American Indian/Alaskan Native
P = Native Hawaiian or Pacific Islander
S = Southeast Asian
W = White

CHECKLIST

- Is the application complete?
- Did you enclose proof of your citizenship and identity? See **Citizenship/Identity** on page 3 for examples of what can be used as proof.
- If you are not a U.S. citizen, did you include a copy of both sides of your immigration status documents?
- If you are pregnant, did you include a signed and dated note from a doctor or other health care professional stating that you are pregnant and includes your due date? If multiple births are expected, does the note state the number of babies?
- Did you read the Rights and Responsibilities Section?
- Did you sign and date the application form?
- Did you include the Request for Medicaid Backdated Coverage form, if you are requesting that your coverage be backdated?
- Did you keep the Instructions and Important Information (pages 2 through 4) and the Medicaid Change Report (HCF 10137), for future use?

WISCONSIN FAMILY MEDICAID, BADGERCARE AND FAMILY PLANNING WAIVER PROGRAM

APPLICATION

Use blue or black ink. Do not write in the shaded areas. If more space is needed, use an additional sheet of paper. Write all dates in the MM/DD/YY format (Example 04/02/58). Keep the Important Information (pages 2 through 4) and the Medicaid Change Report form for future use.

SECTION I – CLIENT INFORMATION

Do you need backdated coverage to help pay for health care in any of the previous three months, for any member of your household?

Yes No If you checked “Yes”, complete the Request for Medicaid Backdated Coverage form (HCF 10100B) found in this application packet.

Is anyone in your household blind, disabled or incapacitated? Yes No

Check the language in which you want your notices printed. English Spanish

What language is spoken in your home?

Case Number	Date Received
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The following section should be completed with the information for the person that is applying for assistance.

Name of person applying (Last, First, MI)	Telephone Number (including area code)
Address (street, city, state, zip code)	Mailing address only if different from your residence.

SECTION II – GENERAL INFORMATION

List the names and provide information for all people living in your household (example: yourself, spouse, father, mother, children stepchildren, etc.). See page 4 of the application packet, for marital and ethnic/race codes.

Providing or applying for a Social Security Number (SSN) is voluntary; however any person who wants Wisconsin Medicaid, BadgerCare or the Family Planning Waiver Program, must provide their SSN or apply for one to be eligible for benefits [§49.82(2) Wis. Stats.]. For more information about Social Security Numbers, see page 2.

Name – Applicant (Last, First, MI)	Applying for Medicaid or BadgerCare <input type="checkbox"/> Yes <input type="checkbox"/> No	Applying for Family Planning Waiver Program <input type="checkbox"/> Yes <input type="checkbox"/> No		
Social Security Number	Date of Birth	Race or ethnic code (optional)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital status Code
U.S citizen <input type="checkbox"/> Yes <input type="checkbox"/> No If no, list country born in.	Are you the sponsor of an alien? <input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship to applicant	Enrolled in school full-time? <input type="checkbox"/> Yes <input type="checkbox"/> No	*Has paternity been established? <input type="checkbox"/> Yes <input type="checkbox"/> No

Name (Last, First, MI)	Applying for Medicaid or BadgerCare <input type="checkbox"/> Yes <input type="checkbox"/> No	Applying for Family Planning Waiver Program <input type="checkbox"/> Yes <input type="checkbox"/> No		
Social Security Number	Date of Birth	Race or ethnic code (optional)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital status Code
U.S citizen <input type="checkbox"/> Yes <input type="checkbox"/> No If no, list country born in.	Are you the sponsor of an alien? <input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship to applicant	Enrolled in school full-time? <input type="checkbox"/> Yes <input type="checkbox"/> No	*Has paternity been established? <input type="checkbox"/> Yes <input type="checkbox"/> No

*Complete only if the parents of this child were not married at the time of the child’s birth. Check “Yes” if paternity has been established by a court action, or “No”, if it has not.

Name (Last, First, MI)		Applying for Medicaid or BadgerCare <input type="checkbox"/> Yes <input type="checkbox"/> No		Applying for Family Planning Waiver Program <input type="checkbox"/> Yes <input type="checkbox"/> No	
Social Security Number		Date of Birth	Race or ethnic code (optional)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital status Code
U.S citizen <input type="checkbox"/> Yes <input type="checkbox"/> No If no, list country born in.	Are you the sponsor of an alien? <input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship to applicant		Enrolled in school full-time? <input type="checkbox"/> Yes <input type="checkbox"/> No	*Has paternity been established? <input type="checkbox"/> Yes <input type="checkbox"/> No

Name (Last, First, MI)		Applying for Medicaid or BadgerCare <input type="checkbox"/> Yes <input type="checkbox"/> No		Applying for Family Planning Waiver Program <input type="checkbox"/> Yes <input type="checkbox"/> No	
Social Security Number		Date of Birth	Race or ethnic code (optional)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital status Code
U.S citizen <input type="checkbox"/> Yes <input type="checkbox"/> No If no, list country born in.	Are you the sponsor of an alien? <input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship to applicant		Enrolled in school full-time? <input type="checkbox"/> Yes <input type="checkbox"/> No	*Has paternity been established? <input type="checkbox"/> Yes <input type="checkbox"/> No

*Complete only if the parents of this child were not married at the time of the child's birth. Check "Yes" if paternity has been established by a court action, or "No", if it has not.

SECTION III – PREGNANCY

Is any member of your household pregnant? Yes No

If you answered "Yes", complete the rest of this section for the pregnant women in your household. You will need to provide verification from a medical professional of the pregnancy and the due date.

Name of pregnant woman	Due date	Are multiple births expected? <input type="checkbox"/> Yes <input type="checkbox"/> No	Number of babies expected
		<input type="checkbox"/> Yes <input type="checkbox"/> No	

SECTION IV – ABSENT PARENT INFORMATION

If there is a reason that you do not want to provide information for an absent parent, leave this section blank. You will be contacted by your local Medicaid office for additional information. If you are a woman between the ages of 15 and 18 and applying only for the Family Planning Waiver Program for yourself, leave this section blank.

Do any children (including unborn children) have a natural or adoptive mother or father who is not living at home? Yes No

What is the name of the absent parent? (Last, First, MI)	What is the child's name? (Write in "Unborn" if the child has not been born.)

SECTION V – EMPLOYMENT

Are you or any household member working? Yes No

Is anyone listed below a migrant worker? Yes No

Complete the following for each member in your household (including yourself) who is employed.

Name of working person (Last, First, MI)		Employer's name, address and telephone number	
Date employment began (MM/DD/YY)	If employment ended, date ended		
Gross monthly earnings this month (before taxes and deductions)			
Gross monthly earnings next month (before taxes and deductions)		Is this person on strike? <input type="checkbox"/> Yes <input type="checkbox"/> No	

SECTION V – EMPLOYMENT - Continued

Name of working person (Last, First, MI)		Employer's name, address and telephone number
Date employment began (MM/DD/YY)	If employment ended, date ended	
Gross monthly earnings this month (before taxes and deductions)		
Gross monthly earnings next month (before taxes and deductions)		Is this person on strike? <input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION VI – SELF-EMPLOYMENT

Are you or any household members self-employed? Yes No

If you answered "Yes", complete the rest of this section. List the amounts you reported to the IRS on your tax form. If you did not file taxes last year, leave the net annual income and depreciation boxes empty. If you leave these blank, your local Medicaid office will contact you for more information.

Name of self-employed person (Last, First, MI)	Name and address of business
Net annual income \$	
Depreciation amount claimed \$	Type of business
Do you expect any changes in your net annual income this year? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Name of self-employed person (Last, First, MI)	Name and address of business
Net annual income \$	
Depreciation amount claimed \$	Type of business
Do you expect any changes in your net annual income this year? <input type="checkbox"/> Yes <input type="checkbox"/> No	

SECTION VII – UNEARNED INCOME

Types of unearned income includes Social Security, Supplemental Security Income (SSI), Maintenance, Child Support, Worker's Compensation, Unemployment Compensation, Disability or Sick Pay, Interest or Dividends, Veterans Benefits, etc.

Does anyone in your household receive unearned income? Yes No

If you answered "Yes", complete the rest of this section for each person who receives unearned income.

Type of income	Name (Last, First, MI)	Gross monthly amount

SECTION VIII – INSURANCE

In the current month or in the last 18 months, have you or any employed person in your household been eligible to apply for any family coverage under an employer-provided major medical plan for which your employer paid at least 80% of the premium?

Yes No If "Yes", which family member(s) could have been insured under this health plan?

Family Members' Name:

If yes, what is the name of the employer?

SECTION VIII – INSURANCE - Continued

In the next 12 months, will you or any member of your household be able to enroll in an employer-provided major medical plan at your current employer? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", which family member(s) can be insured under this health plan? Family Members' Name:	If yes, what is the name of the employer?
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If "Yes", what is the date you will be able to enroll?	If "Yes", what is the date coverage will begin?
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Does any person have medical / health insurance coverage now, or in the previous three months? Yes No

Name and address of insurance company	Policyholder's name	
	Policy number	
	Date began	Date ended
	Who is covered under this policy?	

SECTION IX – CHILD CARE

Does anyone pay for child or adult care so they can work, look for work, go to school or receive training? Yes No

If you answered "Yes", complete the rest of this section for the person who pays for the care.

Name of person who pays for the care	For whom is this care provided?	
Name of person providing the care	Does this person live in your household? <input type="checkbox"/> Yes <input type="checkbox"/> No	Monthly amount paid \$

SECTION X – CHILD SUPPORT

Does anyone pay child support? Yes No

If you answered "Yes", complete the rest of this section for the person in your household who pays child support.

Who pays child support?	Who receives the child support payments?	Monthly amount paid \$
		\$

SECTION XI – RIGHTS AND RESPONSIBILITIES

I have read my rights and responsibilities and I understand the questions and statements on this application form. I understand the penalties for giving false information or breaking the rules. I certify, under penalty of false swearing, that all my answers are correct and complete to the best of my knowledge, including information provided about the citizenship status of each household member applying for benefits. I understand and agree to provide documents to prove what I have said. I understand that my signature authorized the local Medicaid office and the state Department of Health and Family Services to request any information that is appropriate and necessary for the proper administration of Wisconsin Medicaid, BadgerCare and the Family Planning Waiver Program authorized under Wisconsin law.

SIGNATURE – Applicant or Authorized Representative	Date signed
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REQUEST FOR MEDICAID BACKDATED COVERAGE

If you want help paying for health care for any of the three months before your application date (backdated coverage), make sure you checked the "Yes" box on the application where this question is asked and complete this form.

If the information on the application form is different for any of the three months before your application month, list the differences below for each month that you are requesting backdated coverage. Differences may include: address, make up of your household, income, assets (only if someone in your household is 65 years of age or older, blind or disabled), vehicles, insurance.

Month 1 will be the earliest month that you could be found eligible. Example, if you applied in June, your application month is June. If you have medical bills in March and want backdated coverage to March, then March is month 1, April is month 2, and May is month 3. Complete the following questions for each month that you have medical bills and want backdated coverage.

Month 1

Are you requesting backdated coverage for this month? Yes No

Is any information included in your application different in this month from the application month? Yes No If "Yes", describe the changes.

Month 2

Are you requesting backdated coverage for this month? Yes No

Is any information included in your application different in this month from the application month? Yes No If "Yes", describe the changes.

Month 3

Are you requesting backdated coverage for this month? Yes No

Is any information included in your application different in this month from the application month? Yes No If "Yes", describe the changes.

SIGNATURE – Applicant

Date Signed

MEDICAID / BADGERCARE CHANGE REPORT

If you are receiving Medicaid or BadgerCare, 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), address, income or employment status **within ten days**. People age 65 or older, blind or disabled must also report changes in assets **within 10 days**. If such a change has occurred, fill out this report and mail it or take it to the office shown in the box below, or contact your worker by telephone or in person about any changes. 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.

(Medicaid office address)

Your Name	Case Number	Worker Name
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If you intentionally fail to report any changes or provide false information, you may be fined, have to pay back any Medicaid benefits you wrongfully received, be prosecuted, or all three. You may be required to provide proof of any changes you report.

SECTION I - CHANGE IN ADDRESS

If you move, you must report your new address.

Date of change	New telephone number
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New address (street, city, state, zip code)

SECTION II - 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
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Social Security Number (SSN)*	Date of birth	Relationship to Case Head
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Describe the change

*Providing or applying for an SSN is voluntary; however any person who wants Wisconsin Medicaid but does not provide their SSN or apply for one will not be eligible for benefits [§49.82(2) Wis. Stats.].

SECTION III - 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, Veterans benefits, Unemployment Insurance, Worker's Compensation, or any other change in the amount of money your household receives.

Name (Last, First, MI)	Date income changed
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Source of income	Monthly amount	How often Paid
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SECTION IV - CHANGE IN ASSETS

Those who are age 65 or older, blind or disabled must report changes in their cash, bank accounts, bonds, stocks, vehicles or other assets.

Name of owner (Last, First, MI)		Date of change
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Type of asset	Describe the change	New value or amount \$
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Name of owner (Last, First, MI)		Date of change
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Type of asset	Describe the change	New value or amount \$
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SECTION V - CHANGE IN VEHICLES

Those who are age 65 or older, blind or disabled must report if you obtain, sell or give away a car, truck, motorcycle, boat, snowmobile, camper, or another type of vehicle.

Name of owner (last, first, MI)					Date of change
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Type of vehicle	Make	Model	Year	Amount received \$	Describe change (bought, sold, etc.)
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SECTION VI - OTHER CHANGES

Report any other changes that you believe may affect your Medicaid eligibility. Examples of other changes include someone getting or dropping health insurance or someone becoming disabled or recovering from a disability. Include the date of any other change.

Describe change

Do you expect that the changes reported on this form will remain the same next month? Yes No

If No, explain.

SECTION VII - SIGNATURE

I understand that there are penalties for hiding information or giving false information. I also understand that I may have to pay back any benefits I receive because I do not fully report changes in my circumstances. I agree to provide proof of any changes, if asked to do so. My answers on this form are correct and complete to the best of my knowledge.

SIGNATURE - Participant	Date signed	Telephone number
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RETAIN COMPLETED FORM IN CASE FILE (FOR MEDICAID OFFICE USE ONLY)