WISCONSIN DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-10114 (07/2023)

MADR

MEDICAID DISABILITY REDETERMINATION REPORT

Use this report only for a redetermination for continued eligibility. When forwarding this information to the Department of Health Services (DHS), Disability Determination Bureau, please include the medical and social information reports on which the previous determination was based. Include updated medical releases authorizing release of medical records.

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.

You can also have an authorized representative fill out and submit this form on your behalf. 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 (at the end of this report).

Under Wis. Stat. § 49.45 (4), personally identifiable information is only used for the direct administration of the Medicaid program.

Providing or applying for a Social Security number (SSN) is voluntary; however, any person who wants Wisconsin Medicaid but does not want to provide his or her SSN or apply for one will not be eligible for benefits, pursuant to Wis. Stat. § 49.82(2). SSN information will be used for administration of the Medicaid program. A person's SSN permits a computer check of his or her information with government agencies, such as the Internal Revenue Service (IRS), Social Security Administration (SSA), and the Department of Workforce Development (DWD). In addition, DHS will match the person's name and SSN with information provided by health insurance carriers to determine if he or she has other health insurance. The applicant's SSN will not be shared with the United States Citizenship and Immigration Services (USCIS).

SECTION 1 – MEMBER INFORMATION

Name – Member (First, Last, MI)				SSN
Street Address				
City		State	Zip Code	County
Phone Number	Sex	Age	Date of Birth	Name – Spouse

SECTION 2 – DISABILITY INFORMATION (If additional space is needed, go to Section 6.)

Describe the disabling condition(s) for which you are receiving Medicaid disability.

MADR

Has there been any change (better or worse) in your condition(s) since you last reported to Medicaid?

☐ Yes ☐ No

If Yes, describe the change.

Do you have any new injuries or illnesses?

☐ Yes ☐ No

If Yes, describe the new injury or illness.

Has your doctor told you that you are able to return to work?

☐ Yes ☐ No

If Yes, complete the information below. If No, go to Section 3.

List the name and address of the doctor who told you that you could return to work.

Name – Doctor

Street Address

City	State	Zip Code

What date (mm/dd/yy) did your doctor tell you that you could return to work?

Did your doctor restrict you to limited or part-time work?

☐ Yes ☐ No

If Yes, explain the limitation.

SECTION 3 – MEDICAL RECORDS INFORMATION (If additional space is needed, go to Section 6.)

Have you applied for Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI) benefits?

☐ Yes ☐ No

If Yes, complete the information below.

What is the date (mm/dd/yy) of your last application?

MADR

What is the address of the Social Security office where you last applied?

Street Address

City	State	Zip Code

What is the status of your claim?

☐ Allowed ☐ Denied ☐ Pending

If you are receiving SSDI or SSI benefits, have you had a review?	If Yes, what is the date of your last review?
☐ Yes ☐ No	

Have you seen a doctor for your injury or illness?

☐ Yes ☐ No

If Yes, complete the information below.

List the name, address, and phone number of the doctor who has the latest medical records about your disability.

Name – Doctor

Street Address

City	State	Zip Code

How often do you see this doctor?	What is the date (mm/dd/yy) you were last seen by this doctor?

Describe the reason you were or are being seen by this doctor.

Describe the type of treatment, surgery, or medications received.

MADR

If you have seen more than one doctor, list the additional information here.

Name – Doctor

Street Address

City	State	Zip Code

How often do you see this doctor?	What is the date (mm/dd/yy) you were last seen by this doctor?

Describe the reason you were or are being seen by this doctor.

Describe the type of treatment, surgery, or medications you received.

Have you been hospitalized or treated at a clinic for your disability in the last 12 months?

☐ Yes ☐ No

If Yes, complete the information below. If No, go to Section 4.

Name – Hospital or Clinic	Patient Number

Street Address

City	State	Zip Code

Were you an inpatient (staying overnight at least one night)?

☐ Yes ☐ No

If Yes, complete the information below.

MADR

What is the date (mm/dd/yy) you were admitted?	What is the date (mm/dd/yy) you were discharged?

Were you an outpatient? ☐ Yes ☐ No	If Yes, list the dates you were seen.

Describe the reason for your hospitalization or clinic visits.

Describe the type of treatment, surgery, or medications you received.

Have you had any of the following tests in the last 12 months?

Yes	No	Test	Date of Test	Facility Where Test Was Done
☐	☐	Electrocardiogram (EKG)		
☐	☐	Chest X-Ray		
☐	☐	Other X-Ray (Describe below.)		
☐	☐	Breathing test		
☐	☐	Blood test (Describe below.)		
☐	☐	Other Test (Describe below.)		

Describe the types of tests you received.

MADR

Describe the daily activities you do that are listed below. Indicate which activities you do and how often they are done.

Household Maintenance (cooking, cleaning, shopping, and odd jobs around your house and other similar activities)

Recreational Activities and Hobbies (such as hunting, fishing, bowling, hiking, musical activities)

Social Contact (such as visits with friends, relatives, neighbors)

Other Activities (such as driving a car or motorcycle, riding the bus)

Has your doctor limited any of the activities you listed above?

☐ Yes ☐ No

If Yes, describe the limitations.

MADR

Have you been seen by other agencies (such as veterans administration, workers compensation, vocational rehabilitation, and social services) for your disabling condition?

☐ Yes ☐ No

If Yes, complete the information below.

Name – Agency

Claim Number	Dates of Visits

Describe services, treatment, surgery, and/or medication received.

SECTION 4 – WORK HISTORY

Are you currently working?

☐ Yes ☐ No

If Yes, complete the information below. If No, go to Section 5.

Name – Employer

Street Address

City	State	Zip Code

Job Title	Date of Hire	Hours Worked Per Week	Rate of Pay
			$

SECTION 5 – EDUCATIONAL INFORMATION

Have you attended trade, vocational, or academic schooling or had any other type of training since you began receiving Medicaid?

☐ Yes ☐ No

If Yes, complete the information below. If No, go to Section 6.

Describe the type of training.

MADR

Are you attending school now? ☐ Yes ☐ No	What grade are you currently in?

Name – School

Street Address

City	State	Zip Code

SECTION 6 – ADDITIONAL INFORMATION

Use this section for additional information that you think will be helpful in making a decision in your Medicaid disability redetermination or to answer any previous question where additional space was needed. List information, such as other illnesses or injuries, not listed in previous sections, other doctors that you have seen, or hospitalizations that you have not previously described. Please include to the previous section numbers when describing additional information.

(Additional information continued)

SECTION 7 – SIGNATURE OF MEMBER / REPRESENTATIVE

I understand the questions and statements on this report. I understand the penalties for giving false information or breaking rules. I certify, under penalty of false swearing, that all my answers are complete to the best of my knowledge. I understand that the agency may contact other persons or organizations to obtain the necessary proof of my eligibility and level of benefits. (The member's signature must be witnessed by two people if signed with an "X.")

SIGNATURE – Member or Representative	Date Signed
SIGNATURE – Witness	Date Signed
SIGNATURE – Witness	Date Signed

MADR

SECTION 8 – OFFICE USE ONLY

This information is to be completed by the interviewer. The interviewer should be a supportive services planner or social worker.

Does the member need assistance processing this claim?

☐ Yes ☐ No

If Yes, list the name, address, and phone number of the person who will assist the member.

Name – Person Assisting Member	Relationship to Member

Street Address

City	State	Zip Code	Phone Number

Can the member speak English? ☐ Yes ☐ No	If No, what language can the member speak?

If the member cannot speak English, list the name and contact information below of someone who may be contacted who speaks English and will give the member messages.

Name – Person Who Speaks English	Relationship to Member

Street Address

City	State	Zip Code	Daytime Phone Number

Describe the member fully (including general build, height, weight, behavior, grooming, and any problems with the ability to read, write, answer, hear, sit, understand, use hands, breathe, see, or walk).

Name – Interviewer	Title of Interviewer

SIGNATURE – Interviewer	Date Signed

Office Address (Street, City, State, Zip Code)

Phone Number	Fax	Email Address

RESET FORM

STATE OF WISCONSIN
DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-10126A (07/2023)

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, legal guardian in general, 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 a durable power of attorney, you or your power of attorney can 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 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.

REP

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.

Fax

- If you live in **Milwaukee County**, fax the form to 888-409-1979.
- If you do **not** live in Milwaukee County, fax the form to 855-293-1822.

Mail

- If you live in **Milwaukee County**, mail the form to:
  MDPU
  6055 N. 64th St.
  Milwaukee, WI 53218

- If you do **not** live in Milwaukee County, mail the form to:
  CDPU
  P.O. Box 5234
  Janesville, WI 53547

In Person

Take the form to your agency. Your agency contact information is on the Wisconsin Department of Health Services (DHS) website at www.dhs.wisconsin.gov/forwardhealth/imagency/index.htm.

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)

REP

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.

REP

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 (07/2023)

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 www.dhs.wisconsin.gov/forwardhealth/imagency/index.htm.

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, legal guardian in general, 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 a durable power of attorney, you or your power of attorney can 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.

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.

REP

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 www.dhs.wisconsin.gov/forwardhealth/imagency/index.htm.

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 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)

REP

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.
- 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

USDA NONDISCRMINATION STATEMENT
Do Not Send Applications Here

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.
Do Not Send Applications Here

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, 1 West Wilson Street, Room 651, 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).