DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-10182 (04/2024)

STATE OF WISCONSIN

BADGERCARE PLUS APPLICATION PACKET

This is an application for BadgerCare Plus and Family Planning Only Services. You can apply:

- Online at access.wi.gov. Click Apply now.
- By mail or fax: Complete this application, mail or fax it to:

  If you live in Milwaukee County:

  MDPU
  6055 N 64th St.
  Milwaukee WI 53218
  Fax: 1-888-409-1979

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

  CDPU
  PO Box 5234
  Janesville, WI 53547-5234
  Fax: 1-855-293-1822

- By phone or in-person: You will need to call your agency to set up an appointment to apply by phone or in-person.

If you need help filling out this application or want to answer the questions in person or by phone, contact your agency. To get the address or phone number of your agency, call 800-362-3002 or go to dhs.wi.gov/im-agency.

If you have a disability or need this information interpreted/translated or in a different format, contact your agency. These services are free.

ACCESS - APPLY ONLINE

ACCESS is an online tool that lets you apply for benefits, check the status of your benefits, or report changes to your worker. To visit ACCESS, go to access.wi.gov.

On ACCESS, you can also apply for FoodShare Wisconsin, which is a program that helps people buy nutritious food. For more information about FoodShare, go to dhs.wisconsin.gov/forwardhealth/resources.htm.

HOW TO USE THIS FORM — CHECK LIST

- ❑ Read the Important Information, the Rights and Responsibilities sections before you apply.
- ❑ Keep pages 1 through 6 and the Information Change Report, F-10183, in this application packet, for future changes.
- ❑ Print clearly, using blue or black ink.
- ❑ Read any instructions, before you answer the question.
- ❑ Complete all sections of the application that apply to you and your family. You may have a delay in getting BadgerCare Plus benefits if the application is not complete.

  If more room is needed, use an additional sheet of paper or the blank sheets at the end of the application.
- ❑ Enter information about all the people living in your home. List all children who live in the home with you at least 40% of the time.
- ❑ You may need to provide proof of some of your answers. See the Verification/Proof Section on page 4, to see what documents you will need to provide. Enclose with your application any proof documents, additional documentation or sheets of paper used to complete the application. Please send copies. Do not send originals.
- ❑ Sign the application and any attachments that require a signature. Applications and/or attachments without a signature will be returned.
- ❑ If you have a legal guardian of the estate, legal guardian of the person and the estate, conservator, activated durable power of attorney for finances, attach the legal documentation authorizing the appointed legal guardian, conservator, or power of attorney for the applicant. If you have an authorized representative, attach the Appoint, Change, or Remove an Authorized Representative form (Person form F-10126A or Organization form F-10126B).
- ❑ If you want to apply for FoodShare, complete the FoodShare Application, F-16019 on the DHS website at dhs.wisconsin.gov/library/collection/F-16019.

IMPORTANT INFORMATION

The following is important information you will need to know about applying for BadgerCare Plus.

- It is important to apply as soon as possible as your application date is the date the agency gets your signed application.
- If insurance has not paid for your medical expenses or family planning expenses from the last three months, you can apply for coverage to pay those expenses. To request this help, fill out Attachment 7: Help Paying for Medical Expenses Request and send it in with your completed application.
- If you are enrolled in BadgerCare Plus, you will need to complete a renewal with your agency every 12 months to stay enrolled.
- Your application for BadgerCare Plus is also an application for help with paying for private health insurance through the federal Health Insurance Marketplace. If you do not meet the rules to enroll in BadgerCare Plus or Medicaid, your information may be sent to the Marketplace. If this happens, the Marketplace will contact you and let you know if you are able to get help with paying for private health insurance. To learn more about the Marketplace, visit HealthCare.gov or call 1-800-318-2596 or 1-855-889-4325 (TTY).

LEGAL GUARDIAN, CONSERVATOR, OR POWER OF ATTORNEY

If you have a legal guardian of the estate, legal guardian of the person and the estate, conservator, or activated durable power of attorney for finances, that person can fill out and submit this form on your behalf. That person would also need to submit documents about their appointment along with this form.

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

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

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

AUTHORIZED REPRESENTATIVE

You may have an authorized representative apply for you. To appoint an authorized representative, fill out either the Appoint, Change, or Remove an Authorized Representative: Person form, F-10126A (dhs.wisconsin.gov/library/collection/F-10126A) , or the Appoint, Change, or Remove an Authorized Representative: Organization form, F-10126B (dhs.wisconsin.gov/library/collection/F-10126B). This will allow your authorized representative to complete and sign the application for you.

To get this form, call 800-362-3002, or go to dhs.wisconsin.gov/forwardhealth/representative-types.htm.

ACCESS TO EMPLOYER GROUP HEALTH INSURANCE

If employer-sponsored health insurance is available, some children and pregnant women might not be able to get BadgerCare Plus.

The Department of Health Services will check this information with your employer before you are enrolled.

BADGERCARE PLUS DEDUCTIBLE

If you are a pregnant woman who is a U.S. citizen or qualifying immigrant and you have income over 300% of the Federal Poverty Level (FPL) or if your child is not able to enroll because they are over the income limit or has access to employer-sponsor health insurance where the employer pays 80% or more of the premium, you may still be able to enroll by meeting a deductible.

For a pregnant woman a deductible is the difference between your family's net income and 300% of the federal poverty level over a six-month period. For children, a deductible is the difference between your family's net income and 150% of the federal poverty level over a six-month period. For example, if your monthly income is $100 over the 150% federal poverty level, you would have to pay a deductible of $600, to be able to get benefits. ($100 X 6 months = $600). For current income guidelines, call 800-362-3002 or go to www.dhs.wisconsin.gov/forwardhealth/resources.htm.

OTHER MEDICAL COVERAGE

As a condition of BadgerCare Plus enrollment, you must report to the agency 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.

PERSONALLY IDENTIFIABLE INFORMATION/ SOCIAL SECURITY NUMBER (SSN)

Personally identifiable information and Social Security Numbers are used only for the direct administration of the BadgerCare Plus programs.

If someone in your household is not applying for BadgerCare Plus, you do not need to provide a Social

Security Number (SSN) or immigration information for that person. Any person who wants BadgerCare Plus, must provide their SSN or apply for one pursuant to Wis. Stat. § 49.82(2).

If you are applying for BadgerCare Plus and do not have an SSN due to religious beliefs or because of your immigration status, leave the SSN field blank.

Your SSN permits a computer check of your information with government agencies such as the Internal Revenue Service (IRS), Social Security Administration, Department of Revenue, Department of Transportation and the Department of Workforce Development. In addition, the Department of Health Services will match your name and SSN with information provided by health insurance carriers to determine if you have other health insurance.

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

CHILD SUPPORT COOPERATION

In some situations, you must cooperate with the Child Support Agency to establish paternity. This means you must help the agency locate an absent parent, legally name the absent parent and/or enforce medical support liability orders. If you do not cooperate with the Child Support Agency and do not have a good reason to not cooperate, your benefits may end if you are an adult and are not pregnant.

RECOVERY OF BADGERCARE PLUS

Wisconsin state law requires the recovery of certain Medicaid benefits from your estate or the estate of your surviving spouse. The Wisconsin Estate Recovery Program Handbook (P-13032) provides you with information on estate recovery. You may get a copy of the publication from your agency, by contacting Member Services at 800-362-3002 or at dhs.wisconsin.gov/publications/p1/p13032.pdf. Certain benefits you get in the community after age 55 and all benefits you get after age 55 while you are participating in a long-term care program, living in a nursing home or while you are an inpatient in a hospital for 30 days or more, are recoverable.

RIGHTS

State and federal laws guarantee rights for anyone applying for or enrolled in BadgerCare Plus. These rights include the right to:

- Be treated with respect by state and county employees.
- Confidentiality of all information given to local agencies to determine enrollment. (This does not prohibit the use of such information for program administration.)
- Have access to agency records and files relating to your case, except information obtained by the local agency under a promise of confidentiality.
- The right to remain enrolled in BadgerCare Plus even if temporarily absent from the state, if you remain a Wisconsin resident.
- Be notified if you can be enrolled in BadgerCare Plus within 30 days from the day the agency gets your application for BadgerCare Plus.
- Be notified in advance of changes in your benefits or enrollment status.
- Ask for 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.
- Appeal any action taken concerning your BadgerCare Plus application or on-going benefits that you do not agree with by asking for a Fair Hearing.

FAIR HEARING

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

- Your application for BadgerCare Plus was denied in error.
- Your application was not processed within 30 days from the date the agency received it.
- You disagree with the agency's decision to discontinue, terminate, suspend, or reduce your benefit.
- Your request for prior authorization was denied.

You may request a fair hearing by writing to:

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

The Request for Fair Hearing form can be found at www.dhs.wisconsin.gov/forwardhealth/resources.htm.

If you choose to write a letter instead of using the form, you must include:

- Your name.
- Your mailing address.
- A brief description of the problem.
- The name of the agency.
- Your CARES case number.
- Your signature.

An appeal must be made no later than 45 days after the date of the action.

You may also contact the agency where you applied and ask for help filing a Fair Hearing request. Refer to the ForwardHealth Enrollment and Benefits Handbook (P-00079) to learn more about the fair hearing process. You will get a handbook when the agency gets your application or you can find the handbook at www.dhs.wisconsin.gov/forwardhealth/resources.htm.

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

RESPONSIBILITIES

Report Public Assistance Fraud — Go to www.reportfraud.wisconsin.gov or call 877-865-3432 (toll-free).

You have the responsibility to provide truthful and complete information on this application, attachments, or any other form(s) needed for BadgerCare Plus and Family Planning Only Services enrollment.

REPORTING CHANGES

BadgerCare Plus

If you are enrolled in BadgerCare Plus, you must report these changes within 10 days:

- You move to a new address or out of state and become a resident of that state (see Note below).
- Anyone moves in or out of your home, or becomes pregnant or gives birth.
- Your living arrangement changes (example: you go into a nursing home or other institution).
- Your monthly income goes over the program limit for your family size.
- You get married or divorced.
- You have a change in health insurance coverage.
- You have a change in expected tax filing status or tax dependents.
- You no longer have a tax-related deduction you told us about.
- You are now in jail or prison or were released from jail or prison.

If you have a change in income and your gross monthly income goes over the program limit for your family size, you must report the change by the 10th day of the next month.

The program income limit for your family size will be on letters titled "About Your Benefits." You should always look at your latest letter for the program income limit for your family size.

Family Planning Only Services

If you are enrolled in Family Planning Only Services, you only need to report these changes, within 10 days:

- You move to a new address or out of state.
- Your living arrangement changes (example: you go into a nursing home or other institution).
- You are now in jail or prison or were released from jail or prison.

HOW TO REPORT CHANGES

Report changes online at access.wi.gov, by calling your agency, or using the Information Change Report, F-10183, in this application packet.

VERIFICATION/PROOF

You may need to provide proof of certain information. The following are examples of proof documents.

PROOF OF CITIZENSHIP/IDENTITY

People applying for BadgerCare Plus or Family Planning Only Services may need to give proof of their identity, citizenship, and/or immigration status. If you have already provided proof of U.S. citizenship and/or identity, you do not need to provide it again.

U.S. CITIZENS

If you are a U.S. citizen, examples of what you can use to prove citizenship and identity are in List 1:

List 1

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

If you do not have one of the items in List 1, you must give one item from List 2 and one from List 3.

List 2

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

List 3

- State driver's license
- ID card issued by federal, state, or local government
- U.S. military dependent ID card
- U.S. military ID card
- School ID card with photo
- For children under age 18, a signed Statement of Identity form, F-10154, in this application packet

If you have these items available on the day you submit your application (paper or online at access.wi.gov), include them with your application. You may be contacted by the agency and be asked to provide proof of missing, conflicting, or vague information if the information would affect the decision about your BadgerCare Plus or Family Planning Only Services enrollment. If you are applying for benefits, you may have at least 95 days from the date of your application to provide proof to the agency if it is asked for.

IMMIGRANTS

If you are an immigrant applying for BadgerCare Plus, you may be asked to send a copy of your USCIS documentation showing your immigration status.

Note: Undocumented immigrants can only get coverage for emergency health care services. Pregnant immigrants may be able to enroll in BadgerCare Plus Prenatal Services.

PROOF OF INCOME

Job Income and Wages

Some applicants who have a job must give proof of their income. This information can be provided on the Employer Verification of Earnings form (EVF-E), or you can use check stubs you have gotten in the last 30 days. If you want to get a form, call your agency. If enrolled, you may be asked to provide proof of this information at your annual renewal and when you change jobs.

Self-Employment

You must provide proof of any self-employment income for any family member who is self-employed. You may use copies of your tax forms to provide this proof.

Other Income

You may need to provide proof of any other income your family gets (example, pensions, disability pay, unemployment from another state, etc.).

OTHER PROOF

Your worker may ask for other proof. Below are some examples of other items for which you may need to provide proof.

- Medical expenses to meet a deductible.
- Documentation for power of attorney and legal guardianship, or conservator.
- Assets. (Only for those applying for the Medicare Savings Program.)

If you need help getting any required proof, contact your agency and ask for help.

OTHER PROGRAMS

Medicare Savings Program

If you or someone in your home is receiving Medicare Parts A and/or B, they may be able to get help paying their Medicare premiums, copays and deductibles.

This is called the Medicare Savings Program. To see if you can enroll in the program, you will need to complete Attachment 8: Assets and provide proof of these assets.

FoodShare Wisconsin

FoodShare helps people with limited money buy the food they need for good health.

To learn more about FoodShare Wisconsin, visit dhs.wisconsin.gov/foodshare/index.htm.

MINIMUM VALUE STANDARD PLANS

Minimum Value Standard means that the plan pays at least 60 percent of the total benefit costs allowed by that plan.

Your employer should be able to tell you if they offer a minimum value standard plan (MVSP).

Some employers are required to give their employees a letter that says whether their plan meets the minimum value standard. Or, you can go to https://marketplace.cms.gov/applications-and-forms/employer-coverage-tool.pdf to get a form you can give to the employer to help you get more information.

If your employer does offer a plan that meets the minimum value standard, the questions in the Minimum Value Standard Plans section on Attachment 5b, have to do with the lowest-cost, employee-only plan that meets the minimum value standard. Employee-only means a plan that only covers the person who is employed. This is not a plan that covers other members of the employee's family.

Even if you are enrolled in a plan that costs more than the lowest-cost employee only plan, you should still tell us about the lowest-cost plan in Attachment 5b.

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).

APP

BADGERCARE PLUS APPLICATION

Instructions

- Use blue or black ink
- Write all dates in the MM/DD/YY format (example 04/02/58)
- Use an additional sheet of paper or the blank pages at the end of this application if more room is needed.
- Try to give us as much information as you can. If you don't give us some information now, we may have to ask for it before we can make a decision about your application.
- Keep pages 1–6 and the Information Change Report, F-10183, for future use.

For Agency Use Only	
Case Number	Date Received

SECTION 1 – APPLICANT INFORMATION

In this section we will ask about you, the applicant.

Name – Applicant (last, first, MI)	Date of Birth (mm/dd/yy)
Name at Birth and/or Previous Names	Social Security Number

Address

City	State	Zip Code

Mailing address, if different from above

City	State	Zip Code

Are you applying for BadgerCare Plus? ☐ Yes ☐ No	Are you applying for Family Planning Only Services? ☐ Yes ☐ No

Do you need help paying for health care in any of the previous three months, for anyone in your home?
☐ Yes ☐ No
If you check yes, complete the Help Paying for Medical Expenses Request (Attachment 7) in this packet.

Sex ☐ Male ☐ Female	What language do you want your letters printed in? ☐ English ☐ Spanish	What language is spoken in your home?

Ethnicity* (optional)
☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race* (optional, choose one or more)
☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American
☐ Hawaiian/Other Pacific Islander ☐ White

**You don't have to answer the ethnicity and race questions if you don't want to. We're asking these questions to help improve our programs and make sure they do not discriminate based on ethnicity or race. Your answers will not be used to make a decision about your benefits.*

Is anyone in your home blind, disabled, or unable to work due to illness or injury?
☐ Yes ☐ No

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

☐ Yes ☐ No

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

What is your marital status?

☐ Annulled ☐ Divorced ☐ Legally Separated ☐ Married ☐ Never Married ☐ Single ☐ Widowed

Are you a member, child, or grandchild of a member of an American Indian Tribe or an Alaska Native?

☐ Yes ☐ No

If yes, complete Attachment 9.

Are you eligible to get services from Indian Health Services, a tribal clinic, or an urban Indian health program?

☐ Yes ☐ No

Have you received services from Indian Health Services, a tribal clinic, or an urban Indian health program?

☐ Yes ☐ No

Answer the following questions only if you are applying for BadgerCare Plus or Family Planning Only Services.

Are you a U.S. citizen?

☐ Yes ☐ No

If no, complete the following questions:

What is your Alien Registration or USCIS number?

When did you come to the U.S. to live?

Do you have a sponsor?

☐ Yes ☐ No

Are you on active duty in the U.S. military or an honorably discharged veteran, married to someone on active duty or an honorably discharged veteran, the surviving spouse of a veteran, or the child of someone on active duty or an honorably discharged veteran?

☐ Yes ☐ No

Tax Filing

Is anyone planning to file taxes jointly with someone outside of your home, or claim any tax dependents who are not living in your home?

☐ Yes ☐ No

If yes, complete Attachments 1 and 6.

SECTION 2 – CONTACT INFORMATION

Tell us how we can contact you.

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

Email Address

What is the best way and time to contact you during weekdays?

SECTION 3 – OTHER FAMILY MEMBERS

Tell us about all other people in the home, even if they are not applying. You don't have to answer the ethnicity and race questions if you don't want to. We're asking these questions to help improve our programs and make sure they do not discriminate based on ethnicity or race. Your answers will not be used to make a decision about your benefits. List all children who live in the home with you at least 40% of the time. Include any child you are responsible for the care of, who is out of the home for six months or less. Also include any child that has been removed from your home and placed in foster care or with a relative. Use an additional sheet of paper if more room is needed.

Name – Spouse or Other Adult (last, first, MI)	Date of Birth (mm/dd/yy)
Name at Birth	Social Security Number

Applying for BadgerCare Plus? ☐ Yes ☐ No	Applying for Family Planning Only Services? ☐ Yes ☐ No
Sex ☐ Male ☐ Female	Relationship to Applicant

Ethnicity (optional): ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (optional, choose one or more)
☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American
☐ Hawaiian/Other Pacific Islander ☐ White

Are you homeless now or have you been homeless in the last 12 months? ☐ Yes ☐ No

What is your marital status?
☐ Annulled ☐ Divorced ☐ Legally Separated ☐ Married ☐ Never Married ☐ Single ☐ Widowed

Are you a member, child or grandchild of a member of an American Indian Tribe or an Alaska Native?
☐ Yes ☐ No
If yes, complete Attachment 9.

Are you eligible to get services from Indian Health Services, a tribal clinic, or an urban Indian health program?
☐ Yes ☐ No

Have you received services from Indian Health Services, a tribal clinic, or an urban Indian health program?
☐ Yes ☐ No

Answer the following questions only if you are applying for BadgerCare Plus or Family Planning Only Services.

Are you a U.S. citizen?
☐ Yes ☐ No
If no, complete the following questions:

What is your Alien Registration or USCIS number?

When did you come to the U.S. to live?

Do you have a sponsor? ☐ Yes ☐ No

Are you on active duty in the U.S. military or an honorably discharged veteran, married to someone on active duty or an honorably discharged veteran, the surviving spouse of a veteran, or the child of someone on active duty or an honorably discharged veteran?
☐ Yes ☐ No

APP

Name – Child 1 (last, first, MI)	Date of Birth (mm/dd/yy)
Name at Birth	Social Security Number

Applying for BadgerCare Plus? ☐ Yes ☐ No	Applying for Family Planning Only Services? ☐ Yes ☐ No
Sex ☐ Male ☐ Female	Relationship to Applicant

Ethnicity (optional)
☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (optional, choose one or more)
☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American
☐ Hawaiian/Other Pacific Islander ☐ White

What is your marital status?
☐ Annulled ☐ Divorced ☐ Legally Separated ☐ Married ☐ Never Married ☐ Single ☐ Widowed

Are you a member, child or grandchild of a member of an American Indian Tribe or an Alaska Native?
☐ Yes ☐ No
If yes, complete Attachment 10.

Are you eligible to get services from Indian Health Services, a tribal clinic, or an urban Indian health program?
☐ Yes ☐ No

Have you received services from Indian Health Services, a tribal clinic, or an urban Indian health program?
☐ Yes ☐ No

Is this child in foster care or living with a relative?
☐ Yes ☐ No

Answer the following questions only if you are applying for BadgerCare Plus or Family Planning Only Services.

Are you a U.S. citizen?
☐ Yes ☐ No
If no, complete the following questions:

What is your Alien Registration or USCIS number?

When did you come to the U.S. to live?

Do you have a sponsor? ☐ Yes ☐ No

Are you on active duty in the U.S. military or an honorably discharged veteran, married to someone on active duty or an honorably discharged veteran, the surviving spouse of a veteran, or the child of someone on active duty or an honorably discharged veteran?
☐ Yes ☐ No

APP

Name – Child 2 (last, first, MI)	Date of Birth (mm/dd/yy)
Name at Birth	Social Security Number

Applying for BadgerCare Plus? ☐ Yes ☐ No	Applying for Family Planning Only Services? ☐ Yes ☐ No
Sex ☐ Male ☐ Female	Relationship to Applicant

Ethnicity (optional)
☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (optional, choose one or more)
☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American
☐ Hawaiian/Other Pacific Islander ☐ White

What is your marital status?
☐ Annulled ☐ Divorced ☐ Legally Separated ☐ Married ☐ Never Married ☐ Single ☐ Widowed

Are you a member, child or grandchild of a member of an American Indian Tribe or an Alaska Native?
☐ Yes ☐ No
If yes, complete Attachment 9.

Are you eligible to get services from Indian Health Services, a tribal clinic, or an urban Indian health program?
☐ Yes ☐ No

Have you received services from Indian Health Services, a tribal clinic, or an urban Indian health program?
☐ Yes ☐ No

Is this child in foster care or living with a relative?
☐ Yes ☐ No

Answer the following questions only if you are applying for BadgerCare Plus or Family Planning Only Services.

Are you a U.S. citizen?
☐ Yes ☐ No
If no, complete the following questions:

What is your Alien Registration or USCIS number?

When did you come to the U.S. to live?

Do you have a sponsor? ☐ Yes ☐ No

Are you on active duty in the U.S. military or an honorably discharged veteran, married to someone on active duty or an honorably discharged veteran, the surviving spouse of a veteran, or the child of someone on active duty or an honorably discharged veteran?
☐ Yes ☐ No

APP

Name – Child 3 (last, first, MI)	Date of Birth (mm/dd/yy)
Name at Birth	Social Security Number

Applying for BadgerCare Plus? ☐ Yes ☐ No	Applying for Family Planning Only Services? ☐ Yes ☐ No
Sex ☐ Male ☐ Female	Relationship to Applicant

Ethnicity (optional)
☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (optional, choose one or more)
☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American
☐ Hawaiian/Other Pacific Islander ☐ White

What is your marital status?
☐ Annulled ☐ Divorced ☐ Legally Separated ☐ Married ☐ Never Married ☐ Single ☐ Widowed

Are you a member, child or grandchild of a member of an American Indian Tribe or an Alaska Native?
☐ Yes ☐ No
If yes, complete Attachment 9.

Are you eligible to get services from Indian Health Services, a tribal clinic, or an urban Indian health program?
☐ Yes ☐ No

Have you received services from Indian Health Services, a tribal clinic, or an urban Indian health program?
☐ Yes ☐ No

Is this child in foster care or living with a relative?
☐ Yes ☐ No

Answer the following questions only if you are applying for BadgerCare Plus or Family Planning Only Services.

Are you a U.S. citizen?
☐ Yes ☐ No
If no, complete the following questions:

What is your Alien Registration or USCIS number?

When did you come to the U.S. to live?

Do you have a sponsor? ☐ Yes ☐ No

Are you on active duty in the U.S. military or an honorably discharged veteran, married to someone on active duty or an honorably discharged veteran, the surviving spouse of a veteran, or the child of someone on active duty or an honorably discharged veteran?
☐ Yes ☐ No

APP

Name – Child 4 (last, first, MI)	Date of Birth (mm/dd/yy)
Name at Birth	Social Security Number

Applying for BadgerCare Plus? ☐ Yes ☐ No	Applying for Family Planning Only Services? ☐ Yes ☐ No
Sex ☐ Male ☐ Female	Relationship to Applicant

Ethnicity (optional)
☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (optional, choose one or more)
☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American
☐ Hawaiian/Other Pacific Islander ☐ White

What is your marital status?
☐ Annulled ☐ Divorced ☐ Legally Separated ☐ Married ☐ Never Married ☐ Single ☐ Widowed

Are you a member, child or grandchild of a member of an American Indian Tribe or an Alaska Native?
☐ Yes ☐ No
If yes, complete Attachment 9.

Are you eligible to get services from Indian Health Services, a tribal clinic, or an urban Indian health program?
☐ Yes ☐ No

Have you received services from Indian Health Services, a tribal clinic, or an urban Indian health program?
☐ Yes ☐ No

Is this child in foster care or living with a relative?
☐ Yes ☐ No

Answer the following questions only if you are applying for BadgerCare Plus or Family Planning Only Services.

Are you a U.S. citizen?
☐ Yes ☐ No
If no, complete the following questions:

What is your Alien Registration or USCIS number?

When did you come to the U.S. to live?

Do you have a sponsor? ☐ Yes ☐ No

Are you on active duty in the U.S. military or an honorably discharged veteran, married to someone on active duty or an honorably discharged veteran, the surviving spouse of a veteran, or the child of someone on active duty or an honorably discharged veteran?
☐ Yes ☐ No

SECTION 4 – OTHER INFORMATION

You must answer yes or no for each question listed below. If you answer yes, you must go to the following Attachments and complete the section indicated.

A. Is anyone in your home planning to file a tax return for income received this year?

☐ Yes ☐ No

If yes, complete Attachment 6, Tax Information. If you are applying only for Family Planning Only Services, you do not need to complete Attachment 6, Tax Information.

B. Does anyone pay alimony, higher education expenses, deductible self-employment tax, student loan interest, etc.?

☐ Yes ☐ No

If yes, complete Attachment 1, Tax Deductions

C. Was anyone in your home in foster care, court-ordered Kinship Care, or a subsidized guardianship on his or her 18th birthday?

☐ Yes ☐ No

If yes, name of person(s) ______________________________

D. Is anyone in your home pregnant?

☐ Yes ☐ No

If yes, complete Attachment 2, Pregnant Women.

E. Do any children under age 18, (including unborn children) have a natural or adoptive mother or father who is not living in the home?

☐ Yes ☐ No

If yes, is there a reason you do not want to provide information about an absent parent?

☐ Yes ☐ No

F. Will anyone in your home get income from a job this month or in the next month?

☐ Yes ☐ No

If yes, complete Attachment 3, Employment.

G. If your child is found to be over the income limit or has access to employer-sponsored health insurance where the employer pays at least 80% of the premium, do you want to enroll your child in a BadgerCare Plus Deductible? (For more information on BadgerCare Plus Deductible, see page 2.)

☐ Yes ☐ No

If yes, what is the child's name(s)? ______________________________

H. Is anyone in your home self-employed?

☐ Yes ☐ No

If yes, complete Attachment 4a, Self-Employment.

I. Does anyone in your home get income from a source other than a job? Examples of this income include Social Security, maintenance/alimony, Unemployment Insurance, disability or sick pay, etc. If yes, complete Attachment 4b, Other Income.

☐ Yes ☐ No

J. Does anyone have medical or health insurance now, or in the previous three months?

☐ Yes ☐ No

If yes, complete Attachment 5a, Health Insurance.

K. Can anyone in your home get health insurance through an employer but has NOT signed up for it?

☐ Yes ☐ No

If yes complete attachment 5b.

L. Does anyone in your home get Medicare Part A and/or Part B?

☐ Yes ☐ No

If yes and this person would like to apply for the Medicare Savings Program, complete Attachment 8, Assets.

M. Does anyone expect their income to change from month to month?

☐ Yes ☐ No

If yes, complete Attachment 10, Yearly Income.

SECTION 5 – SIGNATURE

Please read the following statements before signing. If you don't understand any part of this application, contact your agency.

Under penalties of law and/or perjury, I declare I have read and understand this application and any attachments and to the best of my knowledge, the information I have given is true, correct and complete. I understand the penalties for giving false information or breaking the rules. I understand I will have to provide proof that what I have said is true. I understand I will have to repay any benefits paid on my behalf that are issued incorrectly due to my failure to report changes or provide complete and correct information.

I understand my rights as well as my responsibilities and agree to abide by them.

I know that federal rules state any information I have given must be reviewed and verified by state staff. Also, I understand that I must cooperate fully with state and federal workers if my case is reviewed. No additional permission by me is needed to get any proof or other information.

I know that BadgerCare Plus does not pay medical costs that a third party, such as a private health insurance company or someone who injures me, is supposed to pay. I therefore assign and give my rights to any payments from a liable third party to the Wisconsin Department of Health Services up to the payment amount that BadgerCare Plus has made for my medical care. This assignment applies to any of my minor children. These payments may include payments from hospital and health insurance policies or payments received as a settlement from an accident.

I understand that my signature authorizes the local agency and the Wisconsin Department of Health Services to request any information that is appropriate and necessary for the proper administration of BadgerCare Plus as authorized under Wisconsin law.

I understand that if I do not meet the rules to enroll in BadgerCare Plus and/or Medicaid, the agency may send my information to the federal Health Insurance Marketplace. The Marketplace will use this information to see if I can get help with paying for private health insurance.

SIGNATURE – Applicant or Authorized Representative, Legal Guardian, Power of Attorney, or Conservator	Date Signed

ATTACHMENT 1 – TAX DEDUCTIONS

Check the boxes to tell us which tax deductions you expect to take on your tax return for this year. You can check "Yes" for anyone who has the expense (for example, student loan interest), even if they are not planning to file taxes. You can see some descriptions of the less common Tax Deductions in the Descriptions of Less Common Tax Deductions table.

Type of Tax Deduction	Who gets this deduction?	How much?	How often?
Alimony Paid ☐ Yes ☐ No			
Higher Education Expenses ☐ Yes ☐ No			
Deductible Self-Employment Tax ☐ Yes ☐ No			
Student Loan Interest ☐ Yes ☐ No			

These are less common Tax Deductions:

Type of Tax Deduction	Who gets this deduction?	How much?	How often?
Domestic Production Activities Deduction ☐ Yes ☐ No			
Fee-based Officials' Tax-deductible Expenses ☐ Yes ☐ No			
Individual Retirement Account Contribution ☐ Yes ☐ No			
Loss from Sale of Business Property ☐ Yes ☐ No			
Military Reserve Tax-deductible Expenses ☐ Yes ☐ No			
Net Operating Loss (NOL) ☐ Yes ☐ No			
Out-of-pocket Costs for a Job-related Move ☐ Yes ☐ No			
Penalties for Early Withdrawal of Savings ☐ Yes ☐ No			
Performance Artists' Tax-deductible Expenses ☐ Yes ☐ No			
Self-Employed Health Insurance Plan Contribution ☐ Yes ☐ No			
Self-Employed Retirement Plan Contribution ☐ Yes ☐ No			
Teachers' Tax-Deductible Expenses ☐ Yes ☐ No			
Other Allowable Write-In Deductions ☐ Yes ☐ No Describe deduction: ____________________			

APP

DESCRIPTIONS OF LESS COMMON TAX DEDUCTIONS

Type of Tax Deduction	Description
Domestic Production Activities Deduction	A deduction for self-employed people who produced or invented items in the U.S. Examples of production are: • Property • Natural gas • Potable water Examples of inventions are: • Creating software • Recording • Film
Fee-based Officials' Tax-Deductible Expenses	A deduction for fee-based officials that have out-of-pocket business expenses. This does not include expenses paid for by their employer. Examples of fee-based officials include: • Chaplains • County commissioners • Judges • Justices of the peace • Sheriffs • Constables. • Registrars of deeds • Building inspectors If you are not sure if you qualify, check IRS Form 2106.
Loss from Sale of Business Property	A deduction for self-employed people with a loss from the sale or exchange of property that they owned for their business.
Net Operating Loss (NOL)	If the person has more deductions than income for the year, they may have a net operating loss (NOL). An NOL can be deducted from income from another year or years. If the person has an NOL carryover from a previous year, check this box. The IRS has a number of rules for having an NOL. Generally, an NOL is caused by a loss from operating a sole proprietorship business or rental property. The IRS also has rules that limit what can be deducted when calculating an NOL. For example, you cannot deduct capital losses in excess of capital gains. In addition, the NOL deduction cannot exceed 80% of taxable income for losses in tax years after 2017. For more information about NOL, please see the instructions for completing IRS Form 1040 and IRS Publication 536.
Out-of-Pocket Costs for a Job-Related Move	A deduction for people who paid out-of-pocket to move for a job. The move must be for a job-related reason, such as starting a new job. In addition, the new job must be at least 50 miles farther than their old home was from their old job. It also counts, if they didn't have a job before, and their new job is at least 50 miles from their old home This deduction is not used if their employer paid their moving expenses.
Penalties for Early Withdrawal of Savings	A deduction for penalties paid to a bank for withdrawing funds early from an account where money must stay for a fixed period of time. This includes: • A time savings account • A certificate of deposit • An annuity

APP

<table>
<tr><td>Performance Artists’ Tax-Deductible Expenses</td><td>A deduction for performing artists who have out-of-pocket business expenses for their art. This does not include expenses that paid by their employer. This can only be used if all these are true:
They worked for at least two employers who each paid at least $200.
They did not earn more than $16,000 for their work.
Their out-of-pocket expenses were more than 10% of their earnings.
If you are not sure if you qualify, check IRS Form 2106.</td></tr>
<tr><td>Self-Employed Health Insurance Plan Contribution</td><td>A deduction for self-employed people who contribute to a retirement or savings plan for self-employed people. This includes:
Simplified Employee Pension (SEP) plan
Savings Incentive Match Plan for Employees (SIMPLE)
Qualified plan contributions</td></tr>
<tr><td>Teachers’ Tax-Deductible Expenses</td><td>A deduction for K-12 teachers who have up to $250 in out-of-pocket work expenses. This does not include expenses paid for by their employer.</td></tr>
<tr><td>Other Allowable Write-In Deductions</td><td>Other write-in deductions can include:
Contributions to Archer Medical Savings Accounts
Deductions for rents and royalties
Certain deductions of life tenants or income beneficiaries of property
Jury duty pay given to the employer because the juror was paid a salary during duty
Reforestation expenses
Costs for discrimination suits
Attorney fees for awards to whistleblowers
Contributions to section 501(c)(18)(D) pension plans
Contributions by certain chaplains to section 403(b) plans
If you are not sure if you qualify for any of these, check IRS Form 1040.</td></tr>
</table>

ATTACHMENT 2 – PREGNANT WOMEN

If more room is needed for any section, use an extra sheet of paper.

PREGNANT WOMAN

Name of pregnant woman	Due date (mm/dd/yy)	If multiple births, number of babies expected.
Name of pregnant woman	Due date (mm/dd/yy)	If multiple births, number of babies expected.
Name of pregnant woman	Due date (mm/dd/yy)	If multiple births, number of babies expected.

APP

ATTACHMENT 3 – EMPLOYMENT

EMPLOYMENT

Complete this section for anyone in your home that will get income or in-kind income from a job this month or in the next month. By in-kind income we mean a job that pays only in goods or services instead of money. For example, someone who gets free housing in exchange for work. ***Use an additional sheet of paper if more room is needed.***

Job 1 – Name of employed person (last, first, MI) | Date employment started

Employer name

Employer Address

City | State | Zip Code

Is this person on strike?
☐ Yes ☐ No

How many hours does this person work each week?

Is this person paid hourly or salary?
☐ Hourly ☐ Salary

If hourly, how much each hour?
$

If salary, how much each pay period?
$

Does this person get cash and/or tips?
☐ Yes ☐ No

If yes, how much per pay period?
$

Does this person get bonuses and/or commissions?
☐ Yes ☐ No

If yes, how much per pay period?
$

How often is this person paid?
☐ Weekly ☐ Every 2 weeks ☐ Twice each month ☐ Once a month
☐ Other, explain: ______________________________

Job Type
☐ Permanent ☐ Temporary

Job Title
☐ Manager ☐ Staff

If employment ended, date ended (mm/dd/yy) | Date of last paycheck | Amount of last paycheck $

Is this person a migrant worker?
☐ Yes ☐ No

List all pre-tax deductions this employed person has taken out of his or her paychecks for this job.

Type of Pre-tax Deduction	How much?	How often?
Child Care Savings Account ☐ Yes ☐ No	$	
Group Life Insurance ☐ Yes ☐ No	$	
Health Insurance Premiums ☐ Yes ☐ No	$	
Health Savings Account ☐ Yes ☐ No	$	
Parking and Transit Costs ☐ Yes ☐ No	$	

APP

Retirement Contributions ☐ Yes ☐ No	$	

Job 2 – Name of employed person (last, first, MI)	Date employment started (mm/dd/yy)
Employer name	
Employer Address	

City	State	Zip Code

Is this person on strike? ☐ Yes ☐ No	How many hours does this person work each week?

Is this person paid hourly or salary? ☐ Hourly ☐ Salary	If hourly, how much each hour? $	If salary, how much each pay period? $

Does this person get cash and/or tips? ☐ Yes ☐ No	If yes, how much per pay period? $
Does this person get bonuses and/or commissions? ☐ Yes ☐ No	If yes, how much per pay period? $

How often is this person paid?
☐ Weekly ☐ Every 2 weeks ☐ Twice each month ☐ Once a month
☐ Other, explain: ______________________________

Job Type ☐ Permanent ☐ Temporary	Job Title ☐ Manager ☐ Staff

If employment ended, date ended (mm/dd/yy)	Date of last paycheck	Amount of last paycheck $

Is this person a migrant worker?
☐ Yes ☐ No

List all pre-tax deductions this employed person has taken out of his or her paychecks for this job.

Type of Pre-tax Deduction	How much?	How often?
Child Care Savings Account ☐ Yes ☐ No	$	
Group Life Insurance ☐ Yes ☐ No	$	
Health Insurance Premiums ☐ Yes ☐ No	$	
Health Savings Account ☐ Yes ☐ No	$	
Parking and Transit Costs ☐ Yes ☐ No	$	
Retirement Contributions ☐ Yes ☐ No	$	

APP

Job 3 – Name of employed person (last, first, MI)		Date employment started (mm/dd/yy)	
Employer name			
Employer Address			
City		State	Zip Code
Is this person on strike? ☐ Yes ☐ No		How many hours does this person work each week?	
Is this person paid hourly or salary? ☐ Hourly ☐ Salary	If hourly, how much each hour? $	If salary, how much each pay period? $	
Does this person get cash and/or tips? ☐ Yes ☐ No		If yes, how much per pay period? $	
Does this person get bonuses and/or commissions? ☐ Yes ☐ No		If yes, how much per pay period? $	
How often is this person paid? ☐ Weekly ☐ Every 2 weeks ☐ Twice each month ☐ Once a month ☐ Other, explain: ______			
Job Type ☐ Permanent ☐ Temporary		Job Title ☐ Manager ☐ Staff	
If employment ended, date ended (mm/dd/yy)	Date of last paycheck	Amount of last paycheck $	
Is this person a migrant worker? ☐ Yes ☐ No			

List all pre-tax deductions this employed person has taken out of his or her paychecks for this job.

Type of Pre-tax Deduction	How much?	How often?
Child Care Savings Account ☐ Yes ☐ No	$	
Group Life Insurance ☐ Yes ☐ No	$	
Health Insurance Premiums ☐ Yes ☐ No	$	
Health Savings Account ☐ Yes ☐ No	$	
Parking and Transit Costs ☐ Yes ☐ No	$	
Retirement Contributions ☐ Yes ☐ No	$	

ATTACHMENT 4A – SELF-EMPLOYMENT

SELF-EMPLOYMENT

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

Self-Employment 1

Name of Self-Employed Person	Business Name
Business Address	
Business Ownership Type: ☐ Partnership ☐ S corporation ☐ Sole proprietorship ☐ I don't know	
Business Type (for example, a farm, home day care)	Date Business Started
Has this business filed taxes? ☐ Yes ☐ No If yes, for what tax year did the business last file taxes?	
Has the business had a significant change in income or expenses? ☐ Yes ☐ No ☐ I don't know	
On average, how much does this business make each month? Please give us the income received before expenses are taken out. $	
On average, what are the total expenses this business has each month? $	
On average, how many hours per month does this person work for this business?	

Self-Employment 2

Name of Self-Employed Person	Business Name
Business Address	
Business Ownership Type: ☐ Partnership ☐ S corporation ☐ Sole proprietorship ☐ I don't know	
Business Type (for example, farm, home day care)	Date Business Started
Has this business filed taxes? ☐ Yes ☐ No If yes, for what tax year did the business last file taxes?	
Has the business had a significant change in income or expenses? ☐ Yes ☐ No ☐ I don't know	
On average, how much does this business make each month? Please give us the income received before expenses are taken out. $	
On average, what are the total expenses this business has each month? $	
On average, how many hours per month does this person work for this business?	

ATTACHMENT 4B – OTHER INCOME

OTHER INCOME

Please list below all other income you and/or your family members get each month (except for Child Support, Supplemental Security Income, Workers Compensation, Veterans Benefits and gifts/money from another person).

Type of income	Name of person who gets this income (first, last, MI)	Gross monthly amount
		$
		$
		$
		$
		$
		$
		$
		$
		$
		$
		$
		$
		$

ATTACHMENT 5A – HEALTH INSURANCE

HEALTH INSURANCE

Complete the following if anyone has medical or health insurance now, or in the previous three months.

Name – Policy holder	Policy number	Begin Date

Name of Plan (for example “Silver Plan”)

Name of Insurance Company

Insurance Company Address

City	State	Zip Code

Who is or was covered under this policy (family member’s names)?

Has this coverage ended in the last three months?
☐ Yes ☐ No

If yes, what is the date the coverage ended?	Why did the coverage end?

Does this insurance cover services from a doctor?
☐ Yes ☐ No

Is/was this insurance provided by a current employer?
☐ Yes ☐ No

If no, tell us the source of the insurance:
☐ COBRA Continuation Coverage
☐ Private Insurance Plan
☐ Past Employment
☐ Peace Corps
☐ Retiree Health Plan
☐ TRICARE
☐ Veterans Health Administration Programs

If yes, answer all of the remaining questions on this page.

If the insurance is through a current or past employer, what is the employer’s name?

What is the employer’s address?

What is the employer’s Federal Employer Identification Number (FEIN), if known?

Is this insurance through a state employee benefit plan?	Does this insurance cover services from a doctor?
☐ Yes ☐ No	☐ Yes ☐ No

Minimum Value Standard Plans (For more information about Minimum Value Standard Plans, see page 6.)

Does this employer offer a plan that meets the minimum value standard?
☐ Yes ☐ No ☐ Do not know

APP

What is the name of the lowest-cost employee-only plan offered by this employer?

How much are the monthly premiums? $	How often do these premiums need to be paid? ☐ Weekly ☐ Every Two Weeks ☐ Monthly

Plan Changes (Tell us more about changes that this employer may make to the health insurance if offers next year.)

Will this employer continue to offer health insurance next year?
☐ Yes ☐ No ☐ Do not know

Will there be any change in premiums for the lowest-cost employee-only plan that meets the minimum value standard?
☐ Yes ☐ No ☐ Do not know

How much will this plan's new premiums be? $ ☐ Do not know	How often do these premiums need to be paid? ☐ Weekly ☐ Every Two Weeks ☐ Monthly

Name – Policy holder	Policy number	Begin Date

Name of Plan (for example "Silver Plan")

Name of Insurance Company

Insurance Company Address

City	State	Zip Code

Who is or was covered under this policy (family member's names)?

Has this coverage ended in the last three months?
☐ Yes ☐ No

If yes, what is the date the coverage ended?	Why did the coverage end?

Does this insurance cover services from a doctor?
☐ Yes ☐ No

Is/was this insurance provided by a current employer?
☐ Yes ☐ No

If no, tell us the source of the insurance:
☐ COBRA Continuation Coverage
☐ Private Insurance Plan
☐ Past Employment
☐ Peace Corps
☐ Retiree Health Plan
☐ TRICARE
☐ Veterans Health Administration Programs

If yes, answer all of the remaining questions on this page.

If the insurance is through a current or past employer, what is the employer's name?

What is the employer's address?

What is the employer's Federal Employer Identification Number (FEIN), if known?

Is this insurance through a state employee benefit plan? ☐ Yes ☐ No	Does this insurance cover services from a doctor? ☐ Yes ☐ No

Minimum Value Standard Plans (For more information about Minimum Value Standard Plans, see page 5.)

Does this employer offer a plan that meets the minimum value standard?
☐ Yes ☐ No ☐ Do not know

What is the name of the lowest-cost employee-only plan offered by this employer?

How much are the monthly premiums? $	How often do these premiums need to be paid? ☐ Weekly ☐ Every Two Weeks ☐ Monthly

Plan Changes (Tell us more about changes that this employer may make to the health insurance if offers next year.)

Will this employer continue to offer health insurance next year?
☐ Yes ☐ No ☐ Do not know

Will there be any change in premiums for the lowest-cost employee-only plan that meets the minimum value standard?
☐ Yes ☐ No ☐ Do not know

How much will this plan's new premiums be? $ ☐ Do not know	How often do these premiums need to be paid? ☐ Weekly ☐ Every Two Weeks ☐ Monthly

ATTACHMENT 5B – OTHER HEALTH INSURANCE OPTIONS

OTHER HEALTH INSURANCE OPTIONS

If you do not meet the rules to enroll in BadgerCare Plus, your information may be sent to the Marketplace (also called the Exchange). They will use the answers to these and other questions to make a decision about whether you can get help paying for private health insurance. You do not have to answer these questions now, but it could help you get an answer faster if your information is sent to the Marketplace.

Your answers will not be used for making a decision about your BadgerCare Plus benefits.

List the names of those who could get health insurance from a job right now, but have NOT signed up for that insurance.

Does anyone outside of the home have insurance from a job that would cover anyone in the home but have NOT signed up for that insurance?

☐ Yes ☐ No

If yes, what is that person's name? ____

Answer the following question about the employer who offers health insurance.

Name of Employer	Federal Employer ID Number (FEIN) (if known)
Is this insurance offered through a state employee benefit plan? ☐ Yes ☐ No	Employer Phone (including area code)

Employer Address (Street)

City	State	Zip Code

Name – Contact person at employer who can answer questions about the health insurance offered

Contact Phone Number (including area code)	Contact Email Address

Signing Up for Insurance (Tell us why you have not signed up for this insurance.)

What is the reason you did not sign up for this health insurance?

☐ There is a waiting or probationary period ☐ Other, explain: ___________________________

Will you sign up for this health insurance in the next 3 months? ☐ Yes ☐ No	If yes, what is the date the insurance will start?

Minimum Value Standard Plans (For more information about Minimum Value Standard Plans, see page 5.)

Does this employer offer a plan that meets the minimum value standard?

☐ Yes ☐ No ☐ Do not know

What is the name of the lowest-cost employee-only plan offered by this employer?

How much are the monthly premiums? $	How often do these premiums need to be paid? ☐ Weekly ☐ Every Two Weeks ☐ Monthly

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ATTACHMENT 6 – TAX INFORMATION

TAX FILER

List information for each person in your household who expects to file taxes for income they will get this year. If you are married and file jointly, you only need to complete one section for both filers.

Name Tax Filer 1	Name of Spouse (if married and filing jointly)

Tax Filing Status
☐ Singe or Head of Household ☐ Married Filing Jointly ☐ Married Filing Separately

Will this tax filer be claimed as a dependent by someone outside of the home?
☐ Yes ☐ No

Tax Dependents: List the dependents this tax filer will be claiming on his or her taxes. Use an additional sheet of paper if more room is needed.

Name of Tax Dependent	Date of Birth
Social Security Number	Sex ☐ Male ☐ Female

Is this dependent expected to have more than $12,400 in earned income this year?
☐ Yes ☐ No

Is this dependent expected to have more than $1,100 in unearned income this year? (Do not include Child Support, Social Security, Supplemental Security Income, Worker's Compensation, Veterans Benefits or gifts/money from another person.)
☐ Yes ☐ No

Is this tax dependent living outside of the home? ☐ Yes ☐ No	Is this tax dependent deceased? ☐ Yes ☐ No

Name of Tax Dependent	Date of Birth
Social Security Number	Sex ☐ Male ☐ Female

Is this dependent expected to have more than $12,400 in earned income this year?
☐ Yes ☐ No

Is this dependent expected to have more than $1,100 in unearned income this year? (Do not include Child Support, Social Security, Supplemental Security Income, Worker's Compensation, Veterans Benefits or gifts/money from another person.)
☐ Yes ☐ No

Is this tax dependent living outside of the home? ☐ Yes ☐ No	Is this tax dependent deceased? ☐ Yes ☐ No

Name of Tax Dependent	Date of Birth
Social Security Number	Sex ☐ Male ☐ Female

Is this dependent expected to have more than $12,400 in earned income this year?
☐ Yes ☐ No

Is this dependent expected to have more than $1,100 in unearned income this year? (Do not include Child Support, Social Security, Supplemental Security Income, Worker's Compensation, Veterans Benefits or gifts/money from another person.)
☐ Yes ☐ No

Is this tax dependent living outside of the home? ☐ Yes ☐ No	Is this tax dependent deceased? ☐ Yes ☐ No

Name of Tax Dependent	Date of Birth
Social Security Number	Sex ☐ Male ☐ Female

Is this dependent expected to have more than $12,400 in earned income this year?
☐ Yes ☐ No

Is this dependent expected to have more than $1,100 in unearned income this year? (Do not include Child Support, Social Security, Supplemental Security Income, Worker's Compensation, Veterans Benefits or gifts/money from another person.)
☐ Yes ☐ No

Is this tax dependent living outside of the home? ☐ Yes ☐ No	Is this tax dependent deceased? ☐ Yes ☐ No
Name Tax Filer 2	Name of Spouse (if married and filing jointly)

Tax Filing Status
☐ Singe or Head of Household ☐ Married Filing Jointly ☐ Married Filing Separately

Will this tax filer be claimed as a dependent by someone outside of the home?
☐ Yes ☐ No

Tax Dependents: List the dependents this tax filer will be claiming on his or her taxes. Use an additional sheet of paper if more room is needed.

Name of Tax Dependent	Date of Birth
Social Security Number	Sex ☐ Male ☐ Female

Is this dependent expected to have more than $12,400 in earned income this year?
☐ Yes ☐ No

Is this dependent expected to have more than $1,100 in unearned income this year? (Do not include Child Support, Social Security, Supplemental Security Income, Worker's Compensation, Veterans Benefits or gifts / money from another person.)
☐ Yes ☐ No

Is this tax dependent living outside of the home? ☐ Yes ☐ No	Is this tax dependent deceased? ☐ Yes ☐ No

Name of Tax Dependent	Date of Birth
Social Security Number	Sex ☐ Male ☐ Female

Is this dependent expected to have more than $12,400 in earned income this year?
☐ Yes ☐ No

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Is this dependent expected to have more than $1,100 in unearned income this year? (Do not include Child Support, Social Security, Supplemental Security Income, Worker's Compensation, Veterans Benefits or gifts / money from another person.)

☐ Yes ☐ No

Is this tax dependent living outside of the home? ☐ Yes ☐ No	Is this tax dependent deceased? ☐ Yes ☐ No

Name of Tax Dependent	Date of Birth
Social Security Number	Sex ☐ Male ☐ Female

Is this dependent expected to have more than $12,400 in earned income this year?

☐ Yes ☐ No

Is this dependent expected to have more than $1,100 in unearned income this year? (Do not include Child Support, Social Security, Supplemental Security Income, Worker's Compensation, Veterans Benefits or gifts/money from another person.)

☐ Yes ☐ No

Is this tax dependent living outside of the home? ☐ Yes ☐ No	Is this tax dependent deceased? ☐ Yes ☐ No

Name of Tax Dependent	Date of Birth
Social Security Number	Sex ☐ Male ☐ Female

Is this dependent expected to have more than $12,400 in earned income this year?

☐ Yes ☐ No

Is this dependent expected to have more than $1,100 in unearned income this year? (Do not include Child Support, Social Security, Supplemental Security Income, Worker's Compensation, Veterans Benefits or gifts/money from another person.)

☐ Yes ☐ No

Is this tax dependent living outside of the home? ☐ Yes ☐ No	Is this tax dependent deceased? ☐ Yes ☐ No

ATTACHMENT 7 – HELP PAYING FOR MEDICAL EXPENSES REQUEST

If insurance has not paid for your medical expenses or family planning services from the last three months, you can apply for Badger Care Plus or Family Planning Only Services coverage to pay those expenses. If you meet all program rules in those months, you can get BadgerCare Plus and Family Planning Only Services starting up to three months before your application month. The application month is the month in which you agency gets your application. Please Note: Requesting this BadgerCare Plus or Family Planning Only Services coverage does not guarantee you will be enrolled for the months requested.

If there are any changes in the three months before your application month, list the changes below for each month. These changes may include: your address, who lives in the household, income, health insurance. You must provide proof of income for any of the three months you are requesting BadgerCare Plus or Family Planning Only Services coverage.

Check the type(s) of coverage you are requesting.

☐ BadgerCare Plus ☐ Family Planning Only Services

What is the date you want coverage to begin? Note: This date cannot be more than three months ago.

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1. **Are you asking for help paying medical and/or family planning only services expenses from the month prior to the month you are applying?**

   ☐ Yes ☐ No

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

If your income was different, what was your total gross family income for this month?

---

2. **Are you asking for help paying medical and/or family planning only services expenses from two months prior to the month you are applying?**

   ☐ Yes ☐ No

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

If your income was different, what was your total gross family income for this month?

---

3. **Are you asking for help paying medical and/or family planning only services expenses from three months prior to the month you are applying?**

   ☐ Yes ☐ No

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

If your income was different, what was your total gross family income for this month?

SIGNATURE – Applicant / Authorized Representative	Date Signed

ATTACHMENT 8 – ASSETS (FOR MEDICARE SAVINGS PROGRAMS ONLY)

This form should be completed only if someone in your home gets Medicare Part A and/or Part B and you want to apply for the Medicare Savings Program (also called Medicare Premium Assistance or Buy-In program). You must list all your family's assets. Include assets owned jointly with any other person. Do not include the value of personal household belongings (televisions, furniture, appliances). Do not list motor vehicle information in this section. Assets include items such as cash, checking or savings accounts, certificates of deposit, prepaid debit cards, trust funds, stocks, bonds, retirement accounts, interest in annuities, U.S. savings bonds, property agreements, contracts for deeds, timeshares, rental property, life estates, livestock, tools, farm machinery, Keogh plans or other tax shelters, personal property being held for investment purposes, etc.

NOTE: You will be required to provide proof of all your assets. Examples of proof include a copy of your bank statement showing the value of your bank account on the date the application is completed, or something that shows the face value and cash value of your life insurance policy. Use an additional sheet of paper if more room is needed.

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

BURIAL ASSETS

List all burial assets.

Type of Burial Asset	Name of Owner(s)	Value
Burial Insurance: ☐ Yes ☐ No		$
Irrevocable Burial Trust (which means it can't be returned or changed): ☐ Yes ☐ No		$
Other:* ☐ Yes ☐ No *Other examples could be a headstone, casket, marker, or opening and closing costs.		$

VEHICLE INFORMATION

List all motor vehicles. Include vehicles owned jointly with another person.

Vehicle 1				**Vehicle 2**			
Type of Vehicle	Year	Make	Model	Type of Vehicle	Year	Make	Model
Amount Owed on Vehicle $		Fair Market Value* $		Amount Owed on Vehicle $		Fair Market Value* $	

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

LIFE INSURANCE

Tell us about any life insurance you and/or your family has.

Do you or any family member have any life insurance policies? ☐ Yes ☐ No

If yes, complete the section below.

Name of Owner(s)	Cash Surrender Value*	Face Value**
	$	$
	$	$
	$	$

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

ATTACHMENT 9 – AMERICAN INDIAN OR ALASKA NATIVE FAMILY MEMBER

FEDERALLY RECOGNIZED TRIBE

Is anyone a member of a federal recognized tribe?

☐ Yes ☐ No

If yes, list them below.

Person's Name	Name of Tribe

NON-GAMING TRIBAL INCOME

Some tribal income types may not be counted for BadgerCare Plus. List any income (amount and how often) reported on your application that includes money from these sources:

- Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties
- Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations)
- Money from selling things that have cultural significance

Tribal per capita payments from gaming activities are counted for BadgerCare Plus, so you should not list them here.

Name of Person Who Gets Income	Amount	Type of Income	How Often Paid
	$		
	$		
	$		
	$		
	$		

ATTACHMENT 10 – YEARLY INCOME

Complete only if someone's income changes from month to month. If you do not know the exact amount, use your best guess, or write "I don't know."

Name of Person	What is the expected income for this year?	What is the expected income for next year?
	$	$
	$	$
	$	$
	$	$

STATE OF WISCONSIN
DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-10154 (07/08)

ID

STATEMENT OF IDENTITY FOR CHILDREN UNDER 18 YEARS OF AGE

This Statement may be used only to meet the new Medicaid/BadgerCare Plus/Family Planning Only Services proof of **identity** rule for children under 18 years of age. This statement may not be used to meet the Medicaid, BadgerCare Plus/ Family Planning Only Services proof of citizenship rule.

Instructions: In the space provided below, list all the children under age 18 in your household for whom you are a parent, guardian or caretaker relative. For each child you list, include the child's date of birth and place of birth (city, state and country). **Complete, sign and return this statement to your agency.**

Child's Full Name (First, MI, Last)	Date of Birth	Place of Birth (City, State, Country)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		

Personally identifiable information will be used only for the direct administration of Family Planning Only Services, Medicaid and BadgerCare Plus programs.

By signing this statement, I certify, under penalty of perjury and false swearing, that the information I have given is correct and complete to the best of my knowledge. I understand that the local agency may contact other persons or organizations, to confirm the accuracy of my statement.

SIGNATURE ______________________________ Date Signed ______________________
(Parent, Guardian or Caretaker Relative)

Print Name ______________________________ Case Number ______________________
(Parent, Guardian or Caretaker Relative)

STATE OF WISCONSIN
DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-10183 (10/2023)

INFORMATION CHANGE REPORT

BadgerCare Plus
If you are enrolled in BadgerCare Plus, you must report the following types of changes no later than 10 days after the change has occurred:

- You move to a new address or out of state.
- Someone moves in or out of your home, becomes pregnant, or gives birth.
- Your living arrangement changes (for example, you are incarcerated or you go into a nursing home or other institution).
- You get married or divorced.
- Someone in your home has a change in health insurance.
- Someone in your home has a change in expected tax filing status or tax dependents or no longer has a tax deduction that he or she previously reported.

If you have a change in income that makes your gross monthly income go over the BadgerCare Plus program limit, you must report that change by the 10th day of the next month.

When you enroll in BadgerCare Plus or if you have a change in benefits, you will get a notice in the mail with the program limits for your family size. You should always look at your latest notice for the most current information.

Family Planning Only Services
If you are enrolled in Family Planning Only Services, you must report only the following types of changes no later than 10 days after the change has occurred:

- You move to a new address or out of state.
- Your living arrangement changes (for example, you are incarcerated or you go into a nursing home or other institution).

You can report the changes noted above using this form, by calling your agency, or online at ACCESS.wi.gov. If you use this form to report your changes, once you have completed and signed the form, you should mail or fax it to:

If you live in Milwaukee County:
MDPU
6055 N 64th St.
Milwaukee WI 53218
Fax: 1-888-409-1979

If you **do not** live in Milwaukee County
CDPU
PO Box 5234
Janesville, WI 53547-5234
Fax: 1-855-293-1822

If this form does not provide enough room to describe a change, attach a sheet of paper with the additional information.

CHG

Name – Member (Last, First MI)	Case Number or Social Security Number

CHANGE IN ADDRESS

Use this section to report a new address if you moved.

New Street Address		
City	State	Zip Code
New Phone Number	Date of Change (mm/dd/yy)	

CHANGE IN HOUSEHOLD

Use this section to report if someone moved in or out of your home, got married, became pregnant, or gave birth. If someone became pregnant, tell us who it is, the due date, and the number of expected babies.

Name (Last, First MI)		Social Security Number
Date of Birth (mm/dd/yy)	Relationship to You	Date of Change (mm/dd/yy)
Describe the Change		

CHANGE IN INCOME

Use section A to report changes in income from a job or self-employment or from sources other than a job, such as Social Security or unemployment insurance. Fill out section B if someone in your home lost a job or section C if someone in your home got a new job.

A. Changes in Income From Any Source

Name (Last First MI)	Source of Income	
What changed?		
Date of Change (mm/dd/yy)	New Income Amount $	How often is it paid?

B. Loss of Job

Name (Last, First MI)		
Name – Employer		
Date Job Ended (mm/dd/yy)	Date of Final Paycheck (mm/dd/yy)	Amount of Final Paycheck $

CHG

C. New Job

Name (Last, First MI)	Date Job Started (mm/dd/yy)
Name – Employer	Phone Number
Street Address – Employer	

City	State	Zip Code

Is this person on strike? ☐ Yes ☐ No		Hours Worked Each Week	
☐ Paid by the hour	Amount Per Hour $	☐ Paid a salary	Amount Per Pay Period $
Does this person get cash and/or tips? ☐ Yes ☐ No		If Yes – Amount Per Pay Period $	
Does this person get bonuses and/or commissions? ☐ Yes ☐ No		If Yes – Amount Per Pay Period $	

How often is this person paid?
☐ Weekly ☐ Every 2 weeks ☐ Twice each month ☐ Once a month ☐ Other – Explain Below

Job Type	Job Title	Is this person a migrant worker?
☐ Permanent ☐ Temporary	☐ Manager ☐ Staff	☐ Yes ☐ No

List all pre-tax deductions this person has taken out of his or her paychecks for this job.

Type of Pretax Deduction	How much?	How often?
☐ Child care savings account	$	
☐ Group life insurance	$	
☐ Health insurance premiums	$	
☐ Health savings accounts	$	
☐ Parking and transit costs	$	
☐ Retirement contributions	$	

CHANGE IN TAX INFORMATION

Use this section to report if someone in your home had a change in expected tax filing status or tax dependents. If the person is married and filing jointly, you only need to complete the information for one of the spouses. If you need more room, attach a sheet of paper with the additional information.

Name (Last, First MI)	Name – Spouse if Filing Jointly (Last, First MI)

Is this person expecting to file taxes for income he or she will get this year?
☐ Yes ☐ No

CHG

If yes, what is his or her tax filing status?

☐ Single ☐ Married filing jointly ☐ Married filing separately

Will this tax filer be claimed as a dependent by someone outside of the home?

☐ Yes ☐ No

List the dependents this person will be claiming on his or her taxes.

Name – Tax Dependent (Last, First MI)

Date of Birth (mm/dd/yy)	Social Security Number	Sex ☐ Male ☐ Female

Is this tax dependent expected to have more than $6,300 in earned income this year?

☐ Yes ☐ No

Is this tax dependent expected to have more than $1,050 in unearned income this year? (Do not include child support, Social Security, Supplemental Security Income, workers compensation, or veterans benefits.)

☐ Yes ☐ No

Is this tax dependent living outside of the home? ☐ Yes ☐ No	Is this tax dependent deceased? ☐ Yes ☐ No

Name – Tax Dependent (Last, First MI)

Date of Birth (mm/dd/yy)	Social Security Number	Sex ☐ Male ☐ Female

Is this tax dependent expected to have more than $6,300 in earned income this year?

☐ Yes ☐ No

Is this tax dependent expected to have more than $1,050 in unearned income this year? (Do not include child support, Social Security, Supplemental Security Income, workers compensation, or veterans benefits.)

☐ Yes ☐ No

Is this tax dependent living outside of the home? ☐ Yes ☐ No	Is this tax dependent deceased? ☐ Yes ☐ No

Name – Tax Dependent (Last, First MI)

Date of Birth (mm/dd/yy)	Social Security Number	Sex ☐ Male ☐ Female

Is this tax dependent expected to have more than $6,300 in earned income this year?

☐ Yes ☐ No

Is this tax dependent expected to have more than $1,050 in unearned income this year? (Do not include child support, Social Security, Supplemental Security Income, workers compensation, or veterans benefits.)

☐ Yes ☐ No

Is this tax dependent living outside of the home? ☐ Yes ☐ No	Is this tax dependent deceased? ☐ Yes ☐ No

OTHER CHANGES

Use this space to report other changes.

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 get 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 – Member	Date Signed (mm/dd/yy)