

## BADGERCARE+ APPLICATION PACKET

Please read pages 1 through 6 for some important things you'll need to know before you apply.

This is an application for BadgerCare Plus including family planning services. To apply, complete and sign this application, mail or take it to your local county or tribal agency (local agency) or apply online at [access.wi.gov](https://access.wi.gov). For more information about applying online, see below. To get the address or telephone number of your local agency, call 1-800-362-3002 or go to [badgercareplus.org](https://badgercareplus.org).

If you apply using this application or online, you'll need to provide proof of some of your answers. For more information on what you'll need to provide, see the Verification/Proof Section on page 4.

If you need help filling out this application or want to answer the questions in person or by telephone, contact your local agency.

If you have a disability or need this information translated or in a different format, call (608) 266-3356 or 1-888-701-1251 (TTY). 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](https://access.wi.gov). On ACCESS, you can also apply for FoodShare Wisconsin, which is a program that helps people buy nutritious food.

For questions about BadgerCare Plus or this application, contact your local agency, call 1-800-362-3002 or go to [badgercareplus.org](https://badgercareplus.org).

### HOW TO USE THIS FORM

1. Read the Important Information, the Rights and Responsibilities sections before you apply.
2. Print clearly, using blue or black ink.
3. Read any instructions, before you answer the question.
4. Answer all the questions. You may have a delay in BadgerCare Plus benefits if the application isn't complete.
5. Sign the application. Applications without a signature will be returned.
6. Enter information about all the people living in your home.
7. If more room is needed, use an additional sheet of paper.
8. If you're pregnant, include a signed and dated note from your health care provider. (For more information see the Verification/ Proof Section.)
9. Keep the Important Information (pages 2 – 6) and the BadgerCare Plus Change Report (Attachment 5) for future use.
10. If you want someone to apply for you, complete an Authorization of Representative form. To get this form, call 1-800-362-3002 or go to [badgercareplus.org](https://badgercareplus.org).
11. Completed applications must be sent to your local agency. If there isn't an address in the box below, go to [badgercareplus.org](https://badgercareplus.org), or call 1-800-362-3002 (TTY and translation services are available) for the address of your local agency.

### LOCAL COUNTY OR TRIBAL AGENCY

## **IMPORTANT INFORMATION**

The following is important information you'll need to know about BadgerCare Plus enrollment.

- It's important to apply as soon as possible because your application date is the date the local agency gets your signed application.
- Pregnant women and people with income below certain limits who have medical bills in any of the three months before their application date, may be able to get "backdated coverage". If you'd like to request backdated coverage, fill out the BadgerCare Plus Request for Backdated Coverage form (Attachment 4) included in this packet and send it in with your completed application.
- If you're enrolled in BadgerCare Plus, you'll need to complete a review with your local agency every 12 months to stay enrolled.

### **ACCESS TO EMPLOYER GROUP HEALTH INSURANCE**

If employer-sponsored health insurance is available and the employer pays at least 80 percent of the total premium, you might not be able to get BadgerCare Plus.

The Department of Health and Family Services will check this information with your employer before you're enrolled.

For more information, go to [badgercareplus.org](http://badgercareplus.org).

### **OTHER MEDICAL COVERAGE**

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

If someone in your household is not applying for BadgerCare Plus, you do not need to provide Social Security Number (SSN) information for that person. Any person who wants BadgerCare Plus, but doesn't provide their SSN or apply for one can't enroll in BadgerCare Plus, pursuant to Wisconsin Statutes § 49.82(2).

If you're applying for BadgerCare Plus but don't have an SSN due to religious beliefs or because of your immigration status, leave the SSN field on the application 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 and Family Services will match your name and SSN with information provided by health insurance carriers to determine if you have other health insurance.

Your SSN won't 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, by helping to locate an absent parent, legally naming the absent parent and/or enforcing medical support liability orders if you're requesting BadgerCare Plus. Failure to cooperate with the Child Support Agency without good cause may result in termination of benefits for adults who are not pregnant.

### **RECOVERY OF BADGERCARE PLUS**

Wisconsin state law provides for the recovery of certain BadgerCare Plus benefits you get in error. The law also provides for the recovery of certain BadgerCare Plus benefits you get after you turn 55 years old.

## **RIGHTS**

State and Federal laws guarantee rights for anyone applying for or enrolled in BadgerCare Plus, which includes the right to:

- Be treated with respect by state and county employees,
- Confidentiality of all information given to local agencies to determine enrollment, (This doesn't prohibit the use of such information for program administration.)
- Have access to local 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 local agency receives your application for BadgerCare Plus,
- Be notified in advance of changes in your benefits or enrollment status,
- Request reasonable accommodation to participate in the program for a disability-related reason, or the right to request interpreters or translators to participate in the program, and
- Appeal any action taken concerning your BadgerCare Plus application or on-going benefits that you don't agree with by requesting a Fair Hearing.

## **FAIR HEARING**

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

- Your application for BadgerCare Plus was denied in error,
- Your application was not processed within 30 days from the date the local agency received it,
- You disagree with the local agency's decision to discontinue, terminate, suspend or reduce your benefit, or
- 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  
P.O. Box 7875  
Madison, WI 53707-7875

Or by calling: Telephone (608) 266-3096

The "Request for Fair Hearing" form can be found at [dhfs.wisconsin.gov/em/customerhelp](https://dhfs.wisconsin.gov/em/customerhelp).

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 local agency,
- Your Social Security Number, and
- Your signature.

Your appeal should include the important facts of the matter and your BadgerCare Plus case number. An appeal must be made no later than 45 days after the date of the action.

You may also contact the local agency where you applied and ask for help filing a Fair Hearing request. Refer to the BadgerCare Plus Enrollment and Benefits handbook (PHC 10167), or your Notices of Decision to learn more about the fair hearing process. You will get a handbook once a decision has been made on your application or you can find the handbook at [dhfs.wisconsin.gov/em/customerhelp](https://dhfs.wisconsin.gov/em/customerhelp).

## **RESPONSIBILITIES**

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

## **REPORTING CHANGES**

If you're 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 on Page 4),
- 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), and
- Your monthly gross income goes over the program limit for your family size.

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 10<sup>th</sup> day of the next month. The program income limit for your family size will be in your BadgerCare Plus notices. You should always look at your latest notice for the program income limit for your family size.

### **BadgerCare Plus Family Planning Services**

If you're enrolled in BadgerCare Plus family planning services, you only need to report these changes within 10 days:

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

### **How to Report Changes**

Report changes online at [ACCESS.wi.gov](http://ACCESS.wi.gov), by calling your local agency or you can use the BadgerCare Plus Change Report form (Attachment 5).

**Note:** If you move out of state and don't report this move within 10 days, you'll be responsible to repay the BadgerCare Plus program for any payments they made to your HMO. For example, if BadgerCare Plus paid your HMO \$475 each month, the amount of overpayment you would have to repay BadgerCare Plus is \$475 for each month the HMO was paid, even if you didn't use your card.

### **VERIFICATION/PROOF**

You'll need to provide proof of certain information. Below are examples of proof.

#### **PROOF OF CITIZENSHIP / IDENTITY**

People applying for BadgerCare Plus must give proof of their identity, citizenship and/or immigration status. If you have already provided this proof, you don't need to provide it again.

### **U.S. CITIZENS**

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

#### **List 1**

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

If you don't 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,
- Life or health insurance record showing U.S. birth, or
- Nursing home admission papers showing U.S. birth.

#### **List 3**

- State driver license,
- ID card issued by federal, state or local government,
- U.S. Military Dependent ID card,
- U.S. Military ID card or draft record showing U.S. birth,
- School ID card with photo, or
- For children under age 18, a signed Statement of Identity form, HCF10154. (This form can be found in this application packet.)

### **IMMIGRANTS**

If you're an immigrant applying for BadgerCare Plus, you must send a copy of your INS/USCIS documentation showing your immigration status.

**Note:** Undocumented immigrants can only get coverage for emergency health care services. However, pregnant immigrants can be enrolled in BadgerCare Plus Prenatal Services.

### **PROOF OF INCOME**

#### **Job Income and Wages**

Employed adult family members 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 you local agency. If enrolled, you'll be expected to provide proof of this information at your annual review 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 must provide proof of any other income your family gets (example, pensions, Worker's Compensation, 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 Guardianship,
- Pregnancy. (You will need a signed statement from your health care provider that says you are pregnant, what your due date is and if you are having multiple births.)

**DISCRIMINATION**

The Department of Health and Family Services is an equal opportunity employer and service provider. All people applying for or who get benefits are protected against discrimination based on race, color, national origin, disability, age, sex, or religion. State and federal laws require all BadgerCare Plus health care benefits to be provided on a nondiscriminatory basis.

For civil rights questions, call (608) 266-9372 (voice) or 1-888-701-1251 (TTY).

To file a complaint of discrimination, contact either the:

Wisconsin Department of Health and Family Services  
Affirmative Action/Civil Rights Compliance Office  
1 W. Wilson, Room 555  
Madison, WI 53707-7850

Telephone: (608) 266-9372 (voice)  
(888) 701-1251 (TTY)  
(608) 267-2147 (fax)

**OR**

U.S. Department of Health and Human Services  
Office for Civil Rights – Region V  
233 N. Michigan Avenue, Suite 240  
Chicago, IL 60601

Telephone: (312) 886-5077 (voice) or  
(312) 353-5693 (TTY)

**CODE KEYS**

The following Marital Status codes are to be used in Sections 2 and 3 of the application.

**Marital Status Codes**

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

**CODE KEYS**

The following Race/Ethnic Background codes are to be used in Sections 2 and 3 of the application.

**Race / Ethnic Background Code** (This information is voluntary and won't be used to determine eligibility)

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

## **CHECK LIST**

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

- Read the Rights and Responsibilities Sections.
- Complete all sections of the application that apply to you and your family.
- Enclose with your application any proof, additional documentation or sheets of paper used to complete the application.
- Include proof of any income you or your family members have gotten in the last thirty days.
- If you're a U.S. citizen, provide proof of citizenship and identity. If you have provided this proof already, you won't have to provide it again.
- If you're not a U.S. citizen, provide proof of your immigration status.
- If you're acting on behalf of an applicant, include the Authorized Representative form or legal documentation that allows you to be the appointed guardian or durable power of attorney for finance.
- If you're requesting backdated coverage, fill out and enclose the BadgerCare Plus Backdated Coverage Request (Attachment 4).
- Keep pages 1 through 6 and the BadgerCare Plus Change Report (Attachment 5) for future changes.
- Sign and date the application form.

If you have these items available on the day you submit this application, include them with your application. You'll be contacted by the local agency and be asked to provide proof of missing, conflicting or vague information, if the information would affect the decision about your BadgerCare Plus enrollment.

If you're having trouble getting what you need to document your citizenship and/or identity, contact your local agency for help.

Send the completed application to the local county or tribal agency at the address on page 1 or to get the address for the local agency in your area call 1-800-362-3002 or go to [badgercareplus.org](http://badgercareplus.org).

**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 if more room is needed.
- Keep pages 1 – 6 and the BadgerCare Plus Change Report (Attachment 5) for future use.
- Race or Ethnic code is optional. Codes are on page 5.

**For County or Tribal Agency Use Only**

Case Number \_\_\_\_\_

Date Received \_\_\_\_\_

**SECTION 1 – APPLICANT INFORMATION**

Are you, the applicant, applying for BadgerCare Plus?  
 Yes     No

Are you applying for family planning services only?  
 Yes     No

In this section we'll ask about you, the applicant.

Name – Applicant (last, first, MI)		Name at Birth and/or Previous Names		Date of Birth (mm/dd/yy)
Address		City	State	Zip Code
Mailing address, if different from above		City	State	Zip Code
Where were you born? (city/state/country)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security and/or Alien Registration Number		Race or ethnic code (see page 5)
Do you need help paying for health care in any of the previous three months, for anyone in your home? <input type="checkbox"/> Yes <input type="checkbox"/> No If you check yes, complete the BadgerCare Plus Request for Backdated Coverage form (Attachment 4) in this packet.				
Is anyone in your home blind, disabled or unable to work due to illness or injury? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Do you want your notices printed in <input type="checkbox"/> English    or <input type="checkbox"/> Spanish?		What language is spoken in your home?		
What is your marital status code? (See page 5 for codes.)	Are you a U.S. citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you the sponsor of an immigrant? <input type="checkbox"/> Yes <input type="checkbox"/> No		

**SECTION 2 – CONTACT INFORMATION**

Please tell us how we can contact you. Please include the area code for all telephone numbers.

Telephone Number (    )	Type of telephone <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work
Other Telephone Number (    )	Who does this number belong to? <input type="checkbox"/> Self <input type="checkbox"/> Friend <input type="checkbox"/> Neighbor <input type="checkbox"/> Relative
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. See page 5 for marital status codes and race/ethnicity codes. Include any child you are responsible for the care of, who is out of the home for 6 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.

<b>Name – Spouse or Other Adult</b> (last, first, MI)		Name at Birth	
Applying for BadgerCare Plus? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Birth (mm/dd/yy)	Where was s/he born? (city/state/country)	
Social Security and/or Alien Registration Number	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Race or ethnic code (see page 5)	
What is your marital status? (see page 5 for codes.)	Are you a U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No	Sponsor of an immigrant <input type="checkbox"/> Yes <input type="checkbox"/> No	

<b>Name – Child 1</b> (last, first, MI)		Name at Birth		Applying for BadgerCare Plus? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of Birth (mm/dd/yy)	Where was s/he born? (city/state/country)	Social Security and/or Alien Registration Number			
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Race or ethnic code (see page 5)	Marital status code (see page 5)	U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No		
Relationship to applicant	Is this child in foster care or living with a relative? <input type="checkbox"/> Yes <input type="checkbox"/> No	*Has paternity been established? <input type="checkbox"/> Yes <input type="checkbox"/> No			

<b>Name - Child 2</b> (last, first, MI)		Name at Birth		Applying for BadgerCare Plus? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of Birth (mm/dd/yy)	Where was s/he born? (city/state/country)	Social Security and/or Alien Registration Number			
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Race or ethnic code (see page 5)	Marital status code (see page 5)	U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No		
Relationship to applicant	Is this child in foster care or living with a relative? <input type="checkbox"/> Yes <input type="checkbox"/> No	*Has paternity been established? <input type="checkbox"/> Yes <input type="checkbox"/> No			

<b>Name - Child 3</b> (last, first, MI)		Name at Birth		Applying for BadgerCare Plus? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of Birth (mm/dd/yy)	Where was s/he born? (city/state/country)	Social Security and/or Alien Registration Number			
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Race or ethnic code (see page 5)	Marital status code (see page 5)	U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No		
Relationship to applicant	Is this child in foster care or living with a relative? <input type="checkbox"/> Yes <input type="checkbox"/> No	*Has paternity been established? <input type="checkbox"/> Yes <input type="checkbox"/> No			

\*Complete only if this person is a child whose parents weren't married at the time of the child's birth. Check "Yes" if paternity has been established by a court action or by a Voluntary Paternity Acknowledgement. Check "No", if it hasn't.

**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 any one in your home pregnant?  Yes  No If yes complete Attachment 1, Pregnant Women.
- B. 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 complete Attachment 1, Absent Parent. If you are between the ages of 15 and 18 and applying only for BadgerCare Plus family planning service for yourself, you do not need to complete Attachment 1, Absent Parent.
- C. Will anyone in your home get income from a job this month or in the next month?  Yes  No If yes complete Attachment 1, Employment.
- D. Is anyone in your home self-employed?  Yes  No If yes complete Attachment 2, Self-Employment.
- E. Does anyone in your home get income from a source other than a job?  Yes  No Examples of this income include Social Security, Supplemental Security Income (SSI), maintenance, child support, Worker's Compensation, Unemployment Compensation, disability or sick pay, interest or dividends, Veterans Benefits, etc. If yes, complete Attachment 2, Other Income.
- F. Does anyone have medical or health insurance now, or in the previous three months?  Yes  No If yes complete Attachment 3, Health Insurance.
- G. Is anyone in your home court-ordered to pay child support?  Yes  No If yes complete Attachment 3, Child Support Orders.
- H. Was anyone in your home in foster care on his/her 18<sup>th</sup> birthday?  Yes  No If yes, did they turn 18 after January 1, 2008?  Yes  No

**SECTION 5 – SIGNATURE**

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

Under penalties of law and/or perjury, I declare I've 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'll have to provide proof that what I've said is true. I understand I'll 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've 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 doesn't 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 and Family Services up to the payment amount that BadgerCare Plus has made for my medical care. This assignment applies to any of my minor children who may be injured. 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 and Family Services to request any information that's appropriate and necessary for the proper administration of BadgerCare Plus as authorized under Wisconsin law.

**SIGNATURE** – Applicant or Authorized Representative

Date Signed

**ATTACHMENT 1**

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

**PREGNANT WOMEN**

You'll need to provide proof from a health care provider of the pregnancy.

Name of pregnant woman	Due date	If multiple births, number of babies expected.
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**ABSENT PARENT**

Is there's a reason you don't want to provide information for an absent parent?  Yes  No  
 If yes, leave this section blank. You'll be contacted by your local county or tribal agency for more information. If no, complete the section below.

Name of absent parent (last, first, MI)	Name of child (last, first, MI)
Name of absent parent (last, first, MI)	Name of child (last, first, MI)
Name of absent parent (last, first, MI)	Name of child (last, first, MI)

**EMPLOYMENT**

Complete this section for each person in your home who'll get income from a job this month or in the next month.

Name of employed person (last, first, MI)		Employer name, address and telephone number	
Date employment started (mm/dd/yy)			
Is this person on strike? <input type="checkbox"/> Yes <input type="checkbox"/> No		How many hours does this person work each week?	
Is this person paid by the hour or salary? <input type="checkbox"/> Hourly <input type="checkbox"/> Salary	If hourly, much each hour? \$	If salary, how much each pay period? \$	
Does this person get cash and/or tips? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how much per pay period? \$_____		Does this person get bonuses and/or commissions? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how much each pay period? \$_____	
How often are you paid? <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice each month <input type="checkbox"/> Once a month <input type="checkbox"/> Other If other, explain _____			
Job Type <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary	Job Title <input type="checkbox"/> Manager <input type="checkbox"/> Staff		
If employment ended, date ended (mm/dd/yy)	Date of last paycheck	Amount of last paycheck \$	
Is this person a migrant worker? <input type="checkbox"/> Yes <input type="checkbox"/> No			

**EMPLOYMENT (CONTINUED)**

Complete this section for anyone else in your home who'll get income from a job this month or in the next month. Use an additional sheet of paper if more room is needed.

Name of employed person (last, first, MI)		Employer name, address and telephone number	
Date employment started (mm/dd/yy)			
Is this person on strike? <input type="checkbox"/> Yes <input type="checkbox"/> No		How many hours does this person work each week?	
Is this person paid by the hour or salary? <input type="checkbox"/> Hourly <input type="checkbox"/> Salary	If hourly, much each hour? \$	If salary, how much each pay period? \$	
Does this person get cash and/or tips? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how much per pay period? \$ _____		Does this person get bonuses and/or commissions? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how much each pay period? \$ _____	
How often are you paid? <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice each month <input type="checkbox"/> Once a month <input type="checkbox"/> Other If other, explain _____			
Job Type <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary		Job Title <input type="checkbox"/> Manager <input type="checkbox"/> Staff	
If employment ended, date ended (mm/dd/yy)	Date of last paycheck	Amount of last paycheck \$	
Is this person a migrant worker? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Name of employed person (last, first, MI)		Employer name, address and telephone number	
Date employment started (mm/dd/yy)			
Is this person on strike? <input type="checkbox"/> Yes <input type="checkbox"/> No		How many hours does this person work each week?	
Is this person paid by the hour or salary? <input type="checkbox"/> Hourly <input type="checkbox"/> Salary	If hourly, much each hour? \$	If salary, how much each pay period? \$	
Does this person get cash and/or tips? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how much per pay period? \$ _____		Does this person get bonuses and/or commissions? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how much each pay period? \$ _____	
How often are you paid? <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice each month <input type="checkbox"/> Once a month <input type="checkbox"/> Other If other, explain _____			
Job Type <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary		Job Title <input type="checkbox"/> Manager <input type="checkbox"/> Staff	
If employment ended, date ended (mm/dd/yy)	Date of last paycheck	Amount of last paycheck \$	
Is this person a migrant worker? <input type="checkbox"/> Yes <input type="checkbox"/> No			

**ATTACHMENT 2**

**SELF-EMPLOYMENT**

List the amounts you reported to the IRS on your tax form. If you didn't file taxes last year, leave the net annual income and depreciation boxes empty. Your local agency will contact you for more information.

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

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

**OTHER INCOME**

Please list below all other income you and/or your family members get each month.

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

**ATTACHMENT 3**

**HEALTH INSURANCE**

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

Policyholder's name	Name and address of insurance company
Policy number	
Begin date	
Who is or was covered under this policy? Family Member's Name(s):	
Has this coverage ended in the last three months? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is the date the coverage ended? _____ Why did the coverage end?	
Is/was this insurance provided by an employer? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is the employer's name?	
Does this insurance cover services from a doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No	

**CHILD SUPPORT ORDERS**

Complete this section for the person(s) in your household who is court-ordered to pay child support. If you get child support, list the amount you get in Attachment 2, under Other Income.

Who is court-ordered to pay child support?	Monthly court-ordered amount \$
Who is court-ordered to pay child support?	Monthly court-ordered amount \$

**ATTACHMENT 4**

**BADGERCARE PLUS REQUEST FOR BACKDATED COVERAGE**

If you are requesting backdated coverage, complete, sign and return this attachment with your application. Coverage can only be backdated for three months. Please keep in mind, requesting backdated coverage doesn't guarantee you'll be enrolled for the months requested.

If the information on the application form is different for any of the three months before your application month, list the differences below for each month that you're requesting backdated coverage. Differences may include: address, people in your household, income, health insurance.

**What is the date you want coverage to begin?** \_\_\_\_\_

**1. For what month are you requesting backdated coverage?** \_\_\_\_\_

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

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

**2. For what month are you requesting backdated coverage?** \_\_\_\_\_

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

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

**3. For what month are you requesting backdated coverage?** \_\_\_\_\_

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

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

<b>SIGNATURE</b> – Applicant / Authorized Representative	Date Signed
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**ATTACHMENT 5**

**BADGERCARE PLUS CHANGE REPORT**

You must report, within 10 days if:

- You move to a new address or out of state,
- Anyone moves in or out of your home, someone becomes pregnant or gives birth, or
- Your living arrangement changes (example: you go into a nursing home or other institution).

You must report by the 10<sup>th</sup> of the following month if you have a change in income in which your gross monthly income goes over the program limit. If you're enrolled in BadgerCare Plus, you'll get a notice which will have the program limit for your family size listed. You should always look at your latest notice.

**BadgerCare Plus Family Planning Services**

If you're enrolled in BadgerCare Plus family planning services, you only need to report these changes within 10 days:

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

You can report these changes using this form, by calling the county or tribal agency or online at [access.wi.gov](http://access.wi.gov). If you choose to use this form, once you've completed and signed the form, return it to your local agency. To get the telephone number and address of the local agency go to [badgercareplus.org](http://badgercareplus.org) or call 1-800-362-3002.

If this report doesn't provide enough room to describe a change, attach a sheet of paper with the additional information.

Your Name	Case Number/Social Security Number	Worker Name
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**CHANGE IN ADDRESS**

Use this section to report a new address.

New address	City	State	Zip Code
New telephone number	Date of change		

**CHANGE IN HOUSEHOLD**

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

Name(s) (last, first, MI)	Date of change	
Social Security Number	Relationship to you	Date of birth
Describe the change		

**Do not send this form with your application. Keep this form for future use.**

**CHANGE IN INCOME**

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

Name (last, first, MI)		Date income changed
Source of income	Monthly amount	How often paid

**New Job**

If this is a new job change, what is the employer's name, address and telephone number?	
How many hours per week do you work?	Amount paid per hour?

**Loss of Job**

Name (last, first, MI)		Date ended
Name of Employer	Date of last paycheck	Amount of last paycheck? \$

**OTHER CHANGES**

Use this space for any other changes you want to report.
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**SIGNATURE**

I understand that there are penalties for hiding information or giving false information. I also understand that I may have to pay back any benefits I get because I don't 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.	
<b>SIGNATURE</b> - Applicant	Date Signed