WISCONSIN DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-10140 (10/12)

APP

WISCONSIN MEDICAID SUPPLEMENT TO FOODSHARE WISCONSIN APPLICATION

Providing or applying for a Social Security Number (SSN) is voluntary; however, any person who wants Wisconsin Medicaid or FoodShare benefits but does not provide an SSN or apply for one will not be able to get benefits. SSNs and personally identifiable information will be used only for the direct administration of Medicaid and FoodShare Wisconsin.

This form is used as a supplement to the FoodShare Wisconsin Application. Complete this form **only** if you are applying for FoodShare Wisconsin and Medicaid. If additional space is needed, use an additional sheet of paper. Write all dates in the MM/DD/YY format (Example 04/02/58).

SECTION 1 – APPLICANT INFORMATION

Applicant Name (Last, First, MI)			
Applicant Address - Street	City	State	ZIP Code

SECTION 2 – VEHICLE INFORMATION

List all motor vehicles owned by you and/or your spouse, if married. Include vehicles owned jointly with another person.

Vehicle 1

Type of vehicle	Year	Make	Model
Amount owed on vehicle $		Fair Market Value* $	

Vehicle 2

Type of vehicle	Year	Make	Model
Amount owed on vehicle $		Fair Market Value* $	

*By fair market value, we mean the amount that you would get if you sold it on the open market.

SECTION 3 – RESOURCE/INCOME TRANSFER

Please tell us about any income or resources you and/or your spouse have given away or sold for less than fair market value in the last five years. Examples of resources include cash and cash gifts, real estate, stocks or bonds, etc. Use an additional sheet of paper if more room is needed.

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SECTION 3 – RESOURCE/INCOME TRANSFER (Continued)

Check all that apply. In the last five years, did you and/or your spouse:

☐ Yes ☐ No Sell any assets for less than fair market value, (By fair market value, we mean the amount that you would get if you sold it on the open market.)
☐ Yes ☐ No Trade assets or income,
☐ Yes ☐ No Transfer or give away assets or income,
☐ Yes ☐ No Establish or fund a trust,
☐ Yes ☐ No Decline or refuse to accept an inheritance, or
☐ Yes ☐ No Purchase an annuity, life estate in another person's home, promissory note, loan or mortgage?

If you answered "Yes", to any of the above fill out the following information. If "No", go to Section 4.

Asset or Income 1

Type of asset or income	Date given away or sold	Value of asset or income $
What did you get in return?		

Asset or Income 2

Type of asset or income	Date given away or sold	Value of asset or income $
What did you get in return?		

SECTION 4 – MEDICAL INSURANCE INFORMATION

You must report any third party that may be liable to pay for medical care for you and/or your spouse, including private health insurance, nursing home/long term care insurance, Medicare or Medi-GAP insurance. You must cooperate by giving information as requested. This also includes any insurance that may be available through an employer group health plan or long-term care policy.

Do you and/or your spouse have Medicare Part A or Part B coverage? ☐ Yes ☐ No

Who has the coverage?	Medicare ID Number	Premium Amount	Part A Start Date	Part B Start Date
		$		
		$		

Do you and/or your spouse have Medicare Part D coverage? ☐ Yes ☐ No

Who has the coverage?	Name of Plan	Start Date	Monthly Premium Amount
			$
			$

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MEDICAL INSURANCE INFORMATION (Continued)

Do you and/or your spouse have private health or long-term care insurance? ☐ Yes ☐ No

Who Is Covered? ☐ You ☐ Your Spouse	Date Coverage Began	Premium Amount $	How Often Paid
Who Pays The Premium? ☐ You ☐ Your Spouse	Name of Policyholder	Policy/Insurance Number	
Name and Address of Insurance Company			

If eligible, would you and/or your spouse like the State of Wisconsin to pay your Medicare premiums?
☐ Yes ☐ No

Have you incurred medical bills as a result of an accident or do you have an accident claim pending?
☐ Yes ☐ No If yes, check all that apply. ☐ Incurred Bills ☐ Claim or Settlement Pending

Has your spouse incurred medical bills as a result of an accident or does your spouse have an accident claim pending? ☐ Yes ☐ No If yes, check all that apply. ☐ Incurred Bills ☐ Claim or Settlement Pending

SECTION 5 – RIGHTS AND RESPONSIBILITIES

If you are enrolled in Medicaid, Wisconsin State law, with limited exceptions, requires the recovery of certain Medicaid benefits from your estate. The "Estate Recovery Program" brochure (P-13032) provides you with information on estate recovery. You may obtain a copy of the brochure from your local agency, or by contacting 1-800-362-3002. Certain benefits you receive in the community after age 55 and all Medicaid benefits you receive while residing in a nursing home or while you are an inpatient in a hospital for 30 days or more, are recoverable. Also, if you reside in a nursing home or are institutionalized in a hospital, and are not expected to return home to live, a lien may be placed on your home. A lien may not be placed on your home if you, your spouse, or certain other family members reside in the home.

You have the right to an appeal by requesting a Fair Hearing if you do not agree with any action taken concerning your application or ongoing benefits. You may request a Fair Hearing, by calling 1-608-266-3096, or writing to:

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

You may also contact the local agency and ask for a fair hearing verbally or in writing. DHS is an equal service provider. To file a complaint of discrimination, contact:

Wisconsin Department of Health Services
Affirmative Action/Civil Rights Compliance Office
1 West Wilson Street, Room 555
Madison, WI 53707-7850
Telephone: 1-608-266-9372 (voice) or
1-888-701-1251 (TTY)
Fax: 1-608-267-2147

OR

U.S. Department of Health and Human Services
Office of Civil Rights – Region V
233 N. Michigan Avenue Suite 240
Chicago, IL 60601
Telephone: 1-312-886-2359 (voice) or
1-312-353-5693 (TTY)

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I understand the questions and statements on this application form. I understand the penalties for giving false information or breaking the rules. I certify, under penalty of perjury and false swearing, that all my answers are correct and complete to the best of my knowledge, including information provided about the citizenship or immigration status of each household member, applying for benefits. I understand and agree to provide documents to prove what I have said. I understand that the local agency may contact other persons or organizations to obtain the necessary proof of my enrollment and level of benefits. (The applicant's signature must be witnessed by two people if signed with an "x".)

SIGNATURE – Applicant / Representative / Guardian / Power of Attorney / Conservator	Date Signed
SIGNATURE – Spouse / Representative / Guardian / Power of Attorney / Conservator	Date Signed
SIGNATURE – Witness (Needed if Application Signed with an "X" above)	Date Signed
SIGNATURE – Witness (Needed if Application Signed with an "X" above)	Date Signed

Reset Form