

JOHN SMITH
465 WASHINGTON
MADISON, WI 53703-2703

DANE COUNTY HUMAN SERVICES
1619 ABERG AVENUE
MADISON, WI 53703

Mailing Date: April 15, 2010



<Translated> DHS is an equal opportunity service provider. If you need an interpreter or this letter explained to you in your own language, or if you need help accessing our programs or need this material in a different format because of a disability, please call 1-800-362-3002. These services are free. <Translated>

Dear John Smith:

You asked to complete your

- BadgerCare Plus for Families (Standard or Benchmark Plans) (BC+)
- Family Planning Waiver (FPW)
- Medicaid for Elderly, Blind, or Disabled (EBD)
- Caretaker Supplement (CTS)

renewal by mail. Before we can process your renewal, we need to know if anything has changed or if there is new information about your household. Enclosed with this letter are the:

- Application Summary that tells you what information we have on file about you and your household and
- Signature Page

Complete the mail in renewal steps below no later than May 31, 2010.

1. Review the information on the Application Summary.
2. If something on the Summary has changed, draw a line through the old information and print the new information on the Summary. Include the date the change happened.
3. It is important for us to have information about anyone who has moved into or out of your household. If anyone has moved in or out, tell us who on the Summary or on the back of the Signature page.
4. We also need the correct information about everyone's income. Be sure to check this information closely. If someone in your household has income that is not on the Summary, tell us that information. Write the information about the employer and income on the Summary or on the back of the Signature page. Please include paystubs or other proof of your earned income.
5. If your renewal is for Caretaker Supplement or Medicaid for the Elderly, Blind or Disabled, we also need information about assets. If someone in your household has assets that are not on the Summary, tell us that information on the Summary or on the back of the Signature page.
6. On the Signature page, tell us if you had changes to the Summary or not by checking one of the boxes.
7. Sign the Signature page.
8. Return the Signature Page (and the Summary if you made changes on it) to the address on your letter.

We may need to contact you for more information. Also, if we need you to send us proof of any of the information you give us, you will get a letter telling you what we need.

JOHN SMITH, your summary was generated on May 15, 2010 at 04:30 PM.

Application Summary

Here is the summary of what you told us.

Basic Information

Person	Gender	Language	County or Tribe
JOHN SMITH	MALE	ENGLISH	DANE COUNTY
Where You Live		Mailing Address	
465 WASHINGTON MADISON, WI, 537032703			
Homeless?		No	
Contact Information			
Home Phone		(608) 280-1111	
Work Phone		(608) 280-2222 ext. 234	
Cell Phone		(608) 280-4444	
Message Phone		(608) 280-3333 ext.	
Email Address		HENRY@WISCONSIN.GOV	
Best way to get in touch with you		WORK PHONE	
Phone Type			
Best time to get in touch with you		Any Time	

People In Your Home

Person	Gender	Marital Status	Language	
JOHN SMITH Age: 38	MALE	MARRIED	ENGLISH	
Programs Requested				
FoodShare Health Care				
SSN Application Date			US Citizen	
			Yes	
Resident of WI?		Intends to reside in WI?	Migrant Farm Worker	Where does he/she live?
Yes		Yes	No	INDEPENDENT (HOME/APT/TRLR)
Race and Ethnicity			Out of Home?	
White			No	

Person	Gender	Marital Status	Language	
JANE SMITH Age 33	FEMALE	MARRIED	ENGLISH	
Programs Requested				
FoodShare Health Care				
SSN Application Date			US Citizen	
			Yes	
Resident of WI?	Intends to reside in WI?	Migrant Farm Worker	Where does he/she live?	
Yes	Yes	No	INDEPENDENT (HOME/APT/TRLR)	
Race and Ethnicity			Out of Home?	
White			No	

Person	Gender	Marital Status	Language	
JULIE SMITH Age 8	FEMALE	SINGLE-NEVER MARRIED	ENGLISH	
Programs Requested				
FoodShare Health Care				
SSN Application Date			US Citizen	
			Yes	
Resident of WI?	Intends to reside in WI?	Migrant Farm Worker	Where does he/she live?	
Yes	Yes	No	INDEPENDENT (HOME/APT/TRLR)	
Race and Ethnicity			Out of Home?	
White			No	

Relationship Information

Person	Relationships	Do they buy food and eat meals together?
JOHN Age: 38	Is the husband of Stephanie	Yes
	Is the legal/adj father of Brooke	Yes

Questions About the People in Your Home

Person	Blind or Disabled?	Medicare Part A or Part B?	Convicted of a Drug Felony?	In a Recent Accident?	Getting FS from Another State?	In Drug or Alcohol treatment?	Youth Exiting out of Care?
JOHN Age: 38					No	No	
JANE Age: 33					No	No	
JULIE Age: 8					No	No	

Other Benefits Questions

Person	Previous SSI Benefits?	Has SSI Approval Letter?	Getting SSI 1619(b)	Getting Tribal Commodities	Tribal Member	Son or Daughter of Tribal member?	Kinship Care Court Order?	Foster Care Court Order?
JOHN Age: 38	No	No	No	No	No	No		
JANE Age: 33	No	No	No	No	No	No		
JULIE Age: 8	No	No	No	No	No	No		

School Enrollment Information

Person	Graduation Status	Date of Graduation	Enrollment Status	Type of School
JOHN Age: 38		12/31/9999	NOT ENROLLED	
JANE Age: 33		12/31/9999	NOT ENROLLED	
JULIE Age: 8		12/31/9999	FULL TIME	ELEMENTARY

Cash Information

Person	Set aside for burial?	Value
JOHN Age: 38	No	\$1000.00

Checking Account Information

Person	Set aside for burial?	Value	Account Number
JOHN Age: 38	No	\$1000.00	1234567890
	Bank Name		Bank Address
	BANK OF MADISON		777 W WASHINGTON AVE MADISON WI 53703
	Other Owners		

Job Income Information

Person	Name of Employer	Address of Employer		
JOHN Age: 38	SYSTEMS INC.	W194N1148 MCCORMICK DRIVE		
	Job Start Date	Job End Date	Date of Final Paycheck	How often paid
	01/01/2008	12/31/2009	12/31/2009	MONTHLY
	Is this a temporary job?		Position Type	
	No			
	Type of Pay		Rate of Pay	Hours Per week
	REGULAR PAY		\$20.00	40.0
	On Strike		Strike Begin Date	Strike End Date
No				

Person	Name of Employer	Address of Employer		
JANE Age: 33	SYSTEMS INC.	770 W. WASHINGTON AVE		
	Job Start Date	Job End Date	Date of Final Paycheck	How often paid
	01/01/2008	12/31/2009	12/31/2009	MONTHLY
	Is this a temporary job?		Position Type	
	No			
	Type of Pay		Rate of Pay	Hours Per week
	REGULAR PAY		\$20.00	20.0
	On Strike		Strike Begin Date	Strike End Date
No				

By signing this application, I certify that I understand and acknowledge the following statements:

- The county or tribal local agency and the Wisconsin Department of Health Services are authorized to request any information that is appropriate and necessary for the proper administration of assistance programs authorized under Wisconsin law (Medicaid, BadgerCare Plus, FoodShare, and the Caretaker Supplement programs).
- I may need to provide proof of my answers. Also, by signing this application I am authorizing any other person or organization, including any financial or educational institutions, to provide the agency information or proof needed to determine if I can receive benefits and the level of those benefits.
- This agency cannot discriminate on the basis of race, color, national origin, sex, age, disability, or religious or political beliefs.
- If I have a disability, I may request information about my benefits in an alternate format.
- I assign and give up rights to any payments from a liable third party to the Wisconsin Department of Health Services up to the payment amount that was made for my medical care. These payments may include payments from hospital and health insurance policies or payments received as a settlement from an accident.
- There are penalties for giving false information or breaking the rules. I will have to repay any benefits that are issued incorrectly due to a failure to report changes or to provide complete and correct information.
- I am not required to report a reduction or loss of income, but I may be able to get a higher FoodShare benefit if I do. If I do not report a reduction or loss of income, my FoodShare benefit may not increase.
- If I do not report or verify any listed expenses, I may not receive a deduction for the unreported or unverified expenses.
- By signing this application, I am meeting the FoodShare Program work registration requirement.
- Any member of the household who violates FoodShare rules, such as hiding or giving false information or misusing benefits, may lose benefits for a certain period of time or even permanently. Other criminal penalties may be imposed.

RENEWAL SIGNATURE

JOHN SMITH

1234567890

May 31, 2010

By signing this Renewal Signature page, I certify that I understand and acknowledge the following statements:

- All the information on the Summary sent to me is correct and I have no changes or other information to report, or
- The information on the Summary was not complete or correct. I have made changes on the Summary or the back of this Signature page.

I am authorizing any other person or organization, including any financial or educational institutions, to provide the agency information or proof needed to determine if I can receive benefits and the level of those benefits.

I certify under penalty of perjury and false swearing, that I understand the questions and statements on the Summary and my answers are correct and complete to the best of my knowledge.

SIGNATURE _____
Primary Person

Date Signed

Other Adult

Date Signed

SIGNATURE _____
Authorized Representative

Date Signed

Other Adult

Date Signed

NOTES *Use the space below and the other side of this page if you need more space to write changes.*

NOTES

Use this page if you need more space to write changes.
