RETURN ADDRESS
XXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXX

Mailing Date: MM/DD/YYYY

000002
ANNA MEMBER
123 MAIN ST
ANYTOWN WI 55555

State of Wisconsin

Case #: 1234567890

ABC Agency
Worker: IM A WORKER
Phone #: 1-555-555-5555
Fax #: (444) 444-4444
Use fax # to send verifications.

Staten Wisconsin er en rettferdig tjenesteleverandør. Dette brevet inneholder informasjon som påvirker rettighetene dine. Hvis du har behov for dette i et annet format, eller hjelp til å åpne programmene på grunn av en feil, eller hvis du trenger å få dette brevet oversatt eller forklart på ditt eget språk, kan du ringe 1-555-555-5555 og trykke 4. Når du blir svart, oppgir du språket ditt og venter på en tolk. Denne tjenesten er gratis.

Action Required: Answer a Treatment Needs Question and Review the Information We Have on File

Each year, we must review the information we have on file for you to see if you can keep getting **BadgerCare Plus** benefits. Based on the information we have on file, you can keep getting **BadgerCare Plus** benefits. **However, you need to take two steps first:**

1. **Answer a treatment needs question.** Your answer to the treatment needs question does not affect whether or not you can get BadgerCare Plus benefits.
2. **Review your information to make sure it is correct.**

Step 1: Answer a treatment needs question.
To keep getting BadgerCare Plus benefits, you need to answer a question asking if you have used drugs in the last 12 months in ways that cause problems for you or those around you and if you are open to getting help. This treatment needs question will help us get to know your health care needs better. You are required to answer the treatment needs question by **Month DD, YYYY,** to keep getting BadgerCare Plus benefits.

You can answer the treatment needs question:
- Through the MyACCESS mobile app.
- Through the ACCESS website at access.wi.gov.
- By calling your agency at the phone number listed at the top of this page.
- By filling out and returning the Treatment Needs Question form included with this letter. Follow the instructions on the form to return it to us.
- By going in person to your agency.

You can change your answer to the treatment needs question at any time.

Step 2: Review your information.
You must review the information we have on file for you to make sure it is correct. The information we have on file is included in the summary with this letter. If any information is wrong, you must correct it by **Month DD, YYYY**.

To correct the information we have on file, you can do one of the following:
- Call your agency. Your agency's phone number is at the top of page one.
- Make changes on the summary and mail or fax it back to your agency. Your agency's fax number is at the top of page one. To make changes, draw a line through any wrong information and write the correct information. If information about your household or income is missing, write it on the summary. Include the date of the change.

If you do not correct the information that is wrong and you get benefits that you should not get, you may have to pay back the benefits. If the information on the summary is correct, you do not need to call your agency or return the summary.

WISCONSIN DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-02547 (02/2020)

TNQ

TREATMENT NEEDS QUESTION

INSTRUCTIONS

Answer the following question "Yes" or "No." BadgerCare Plus applicants or members age 19 to 64 with no dependent children living in their home must answer this question to get health care benefits. Whether you answer "Yes" or "No" to this question will **not** impact your eligibility for health care benefits.

If you are an authorized representative, financial power of attorney, legal guardian over the estate, or someone authorized by the applicant or member, you can answer the question on behalf of another adult member, even if they are not in your home.

Your answer to this question may be shared with your BadgerCare Plus health maintenance organization (HMO) or managed care organization (MCO) for care coordination.

Note: You can also answer this question by using the MyACCESS mobile app or the ACCESS website at access.wisconsin.gov or by calling your agency. You can find your agency's phone number at www.dhs.wisconsin.gov/forwardhealth/imagency/index.htm.

SUBMISSION INSTRUCTIONS

If you live in **Milwaukee County**, do one of the following:

- Fax the form to 888-409-1979.
- Mail the form to:

  MDPU
  PO Box 05676
  Milwaukee, WI 53205

If you do **not** live in Milwaukee County, do one of the following:

- Fax the form to 855-293-1822.
- Mail the form to:

  CDPU
  PO Box 5234
  Janesville, WI 53547

During the last 12 months, have you used drugs in ways that cause problems for you or those around you, and are you open to getting help?

Drugs include cannabis (for example, marijuana or hashish), narcotics/opioids (for example, oxycodone or heroin), stimulants (for example, cocaine or methamphetamine), hallucinogens (for example, LSD), solvents (for example, paint thinner), tranquilizers/benzodiazepines (for example, valium), or barbiturates. This includes the use of prescribed or over-the-counter drugs well in excess of the directions. Drugs in this case do not include alcohol, tobacco, or the appropriate medical use of drugs.

☐ Yes ☐ No

First Name, Middle Initial, and Last Name – Applicant or Member
ANNA MEMBER

Date of Birth – Applicant or Member	Case Number (if known) – Applicant or Member
MM/DD/YYYY	**1234567890**

First Name, Middle Initial, and Last Name – Person Who Completed the Form If Not the Applicant or Member

Wis. Stat. § 49.45(23)(b)

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).

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ANNA MEMBER, your summary was generated on Month DD, YYYY at 07:49 PM

This is a summary of the information we used to determine your eligibility.

Basic Information

Person	Gender	Language	County or Tribe
ANNA MEMBER	FEMALE	NORWEGIAN	ABC COUNTY

Where You Live	Mailing Address
123 MAIN ST ANYTOWN WI 55555	
FoodShare Break in Service Requirements Met Date	
Homeless?	No
Contact Information	
Home Phone	
Work Phone	
Cell Phone	
Message Phone	
Best way to get in touch with you	
Phone Type	
Best time to get in touch with you	

Email Information

Person	Email Address	Get Email from Health Care Partners?	Get Letters Online?
ANNA	AXXXXXXXXX7@GMAIL.COM	No	Yes

People In Your Home

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Person	Gender		Marital Status	Language
ANNA MEMBER Age: 43	FEMALE		SINGLE-NEVER MARRIED	NORWEGIAN
	Programs Requested			
	Health Care			
	SSN Application Date	**SSN Cooperation**	**US Citizen**	
		Yes	Yes	
	Resident of WI?	**Intends to reside in WI?**	**Migrant Farm Worker**	
	Yes	Yes	No	
	Homeless in the last 12 months?			
	Special Needs Child		**Where does he/she live?**	
			INDEPENDENT (HOME/APT/TRLR)	
	Ethnicity		**Race**	
	Not Hispanic or Latino		Asian Hawaiian / Other Pacific Islander	

Pregnancy Information

You told us no one in your home is pregnant.

Treatment Needs Information

Below is information about who answered the treatment needs question. Each person will get a separate letter with more information about his or her response.

Person	Response Provided?
ANNA Age: 43	No

Long-term Care Services

You told us no one in your home has requested long-term care services. These are services for people who need help with activities of daily living through in-home care, a nursing home or other medical facility.

Questions About the People In Your Home

Person	Blind or Disabled?	Medicare Part A or Part B?	Convicted of a Drug Felony?	Getting FS From Another State?	In Drug or Alcohol treatment?	Youth Exiting Out of Care?
ANNA Age: 43	No	No	No	No	No	No

You told us no one in your home has current or pending settlements related to being in any type of accident that requires medical care.

Other Benefits Questions

Person	Previous SSI Benefits?	Has SSI Approval Letter?	Receiving SSI Payments?	Getting SSI 1619(b)?	Getting Tribal Commodities?	Kinship Court Order?	Foster Care Court Order?
ANNA Age: 43	No	No	No	No	No	No	No

Tribal Member Information

Person	Tribal Member or Child or Grandchild of Tribal Member?	Member of Federally Recognized Tribe?	Tribe Name	Eligible for Indian Health Services?	Received Indian Health Services?	Receives Non-Gaming Tribal Income?
ANNA Age: 43	No			No		No

Health Care Coverage Information

You told us no one in your home has Health Care coverage from a source other than BadgerCare Plus, Medicaid or Medicare, either now or in the last three months.

Job Income Information

The job(s) listed below are the only job(s) we have on file for the people in your home.

CHG

Person	Name of Employer		Address of Employer	
ANNA Age: 43	ABC EMPLOYER		Phone Number:	
	Job Start Date	**Job End Date**	**Date of Final Paycheck**	**How often paid**
	MM/DD/YYYY			MONTHLY
	Is this a temporary job?		**Position Type**	
	No		Staff	
	Type of Pay		**Rate of Pay**	**Hours Per Pay Period**
	SALARY			XX.0
	Type of Pre-Tax Deduction		**Amount**	**How Often**
	On Strike		**Strike Begin Date**	**Strike End Date**
	No			

Self-Employment Information

You told us no one in your home is self-employed.

Room and Meals Income Information

You told us no one in your home makes money by providing room and/or meals to someone living in your home.

Other Income Information

You told us no one in your home gets money from a source other than a job or self-employment (for example, Social Security, Supplemental Security Income, unemployment insurance, or child support).

Educational Aid Information

You told us no one in your home has grants, scholarship or other aid for education or training.

Other Bills Questions

You told us no one in your home makes payments to someone living in another household, such as child support, maintenance, alimony, guardian fees, or attorney's fees.

You told us no one in your home has had medical bills in the last four months or has unpaid medical bills.

Dependent Care Bills

You told us no one in your home pays someone to provide care for a child or adult who lives in your home.

BC+ Tax Deductions

You told us no one in your home has deductions listed on page one of the IRS Form 1040. The most common types are student loan interest, alimony paid, higher education expenses, or the deduction for self-employment tax.

Tax Filing Information

Tax Year
2018
NO ONE IN THE HOUSEHOLD IS PLANNING TO FILE TAXES