RETURN ADDRESS
XXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXX

Mailing Date: MM/DD/YYYY

000001
ANNA MEMBER
123 MAIN ST
ANYTOWN WI 55555

State of Wisconsin

Case#: 1234567890

Tiểu bang Wisconsin (State of Wisconsin) là một nhà cung cấp dịch vụ cơ hội công bằng. Thư này có những thông tin ảnh hưởng đến quyền lợi của quý vị. Nếu quý vị cần tài liệu này bằng một hình thức khác vì quý vị có khuyết tật hoặc nếu quý vị cần thư này chuyển ngữ hay giải thích bằng tiếng Việt, xin quý vị vui lòng gọi số 1-555-555-5555 và bấm số 4. Khi được trả lời, quý vị hãy cho biết ngôn ngữ của quý vị là tiếng Việt và xin chờ thông dịch viên giúp đỡ quý vị. Tất cả những dịch vụ này đều miễn phí.

Notice of Action Needed

To get or keep **BadgerCare Plus** benefits you need to take action by the due date listed below. The next page tells you the action you need to take along with examples and instructions. If you do not take action by the due date, benefits will be denied, decreased, or ended.

Program(s)	Due Date	Contact Information
BadgerCare Plus	Month DD, YYYY	**ABC Agency** Worker: IM A WORKER Phone #: 1-555-555-5555 Fax #: (444) 444-4444 Use fax # to send verifications.

Action Needed

This section lists actions that you need to take by the due date listed below. Contact us right away if you have questions or problems and we will help you.

What?	Who?	What to do?	Program(s)	Due Date
You need to answer a treatment needs question.	ANNA	You can answer the treatment needs question one of the following ways: • Through the MyACCESS mobile app. • Through the ACCESS website at access.wi.gov. • By calling your agency. Your agency's contact information is listed at the top of page one. • By filling out and returning the enclosed Treatment Needs Question form.	BadgerCare Plus	Month DD, YYYY

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/YYY	**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).