

ATTACHMENT 5: REASONABLE OPPORTUNITY LETTERS

Samples of the following letters are included in this attachment:

ID	CARES Name	Description	Generation
1	Imm ROP: No Action	This letter is sent when immigration documents have been provided but a real-time response was not provided by Federal Data Services Hub (FDSH). After secondary verification has been initiated, the worker must send a manual letter if additional documentation is needed.	System
2	Imm ROP: Doc #s	This letter is sent when immigration document numbers are needed before the Verify button can be used to obtain verification from FDSH. If document numbers are provided but additional information is later needed, the worker must send a manual letter.	System
3	Imm ROP: Military	This letter is sent when an individual appears to be subject to the five-year bar but has indicated that he or she may have qualifying military service. This letter includes a form for declaring that the individual has met the military service requirement.	System and manual
4	Imm ROP: Pres + Date	This letter is sent when an individual appears to be subject to the five-year bar but does not have a verified arrival date. This letter requests verification of arrival date and continuous presence and includes a form for attesting to continuous presence.	System and manual
5	Imm ROP: Cont Pres	This letter is sent when an individual appears to be subject to the five-year bar but has indicated that he or she has an arrival date of before August 22, 1996. This letter includes a form for attesting to continuous presence.	System and manual
6	Imm ROP: Info Needed	The worker should send this manual letter during the reasonable opportunity period if any additional information is needed other than verification of military service, continuous presence, or arrival date. In most cases, this will be sent when additional immigration documentation is needed, such as a SEVIS ID or a letter from the Department of Homeland Security. The worker must specify in the comments exactly which document is needed and for whom.	Manual



Mailing Date:

#1 Imm ROP: No Action

This letter is sent when immigration documents have been provided but a real-time response was not provided by Federal Data Services Hub (FDSH). After secondary verification has been initiated, the worker must send a manual letter if additional documentation is needed.

000001
ANNA MEMBER
123 MAIN ST
ANYTOWN W

t Services
WORKER
654-3210
56-7890
ifications.



The State of Wisconsin is an equal opportunity service provider. This letter contains information that affects your benefits. If you need this material in a different format because of a disability or if you need this letter translated or explained in your own language, please call 1-888-947-6583. These services are free.

Your Immigration Status Is Being Verified

This letter is for **ANNA MEMBER**. You were approved to get Medicaid, BadgerCare Plus, or Family Planning Only Services benefits for a limited time based on the information you gave us on your application or renewal. We sent a separate letter titled "About Your Benefits" with information about this.

We are currently verifying your immigration status with the federal government to see if you can get ongoing benefits. **You do not need to do anything at this time.**

If we cannot verify your immigration status with the federal government, you may need to give us more information. We will contact you by **Month DD, YYYY**, if you need to give us more information. If you are not eligible to get benefits because of your immigration status, we will send another letter letting you know that your benefits will end.

If you have any questions about this letter or your benefits, please call your agency at the phone number listed at the top of page one.



Mailing Date: MM/DD/YYYY

000002
ANNA MEMBER
123 MAIN ST
MILWAUKEE WI

#2 Imm ROP: Doc #s

This letter is sent when immigration document numbers are needed before the Verify button can be used to obtain verification from FDSH. If document numbers are provided but additional information is later needed, the worker must send a manual letter.

Enrollment Services
WORKER
87-654-3210
456-7890
and verifications.



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Action Required: Provide Immigration Information

This letter is for **ANNA MEMBER**. You were approved to get Medicaid, BadgerCare Plus, or Family Planning Only Services benefits for a limited time based on the information you gave us on your application or renewal. We sent a separate letter titled "About Your Benefits" with information about this.

We need more information so we can verify your immigration status with the federal government. Once we verify your immigration status, we will see if you can get ongoing benefits.

Please provide **one** of the items listed below for **ANNA MEMBER** by **Month DD, YYYY**:

- Alien registration number ("A number") or USCIS number
- Certificate of Citizenship number
- Certificate of Naturalization number
- Employment Authorization Document (Form I-766) card number and expiration date
- Form I-94 Arrival/Departure Record number and expiration date
- Passport number and expiration date of an unexpired foreign passport
- Permanent resident or green card (Form I-551) number
- Student and Exchange Visitor Information System (SEVIS) ID

If you do not provide this information by the date given above or if you are not eligible to get benefits based on the information you provide, your benefits will end.

To provide the information, you can do one of the following:

- Call your agency at the phone number listed at the top of page one.
- Fill out and submit the Needed Immigration Information section of this letter.
- Submit a copy of both sides of your immigration document or card.

See the Document Tracking Sheet at the end of this letter to learn how to send us the Needed Immigration Information section of this letter or a copy of your immigration document or card. Make sure you include the Document Tracking Sheet with the information you send. This helps us process your information as quickly as possible.

If you have any questions about this letter or your benefits, please call your agency at the phone number listed at the top of page one.

SAMPLE

NEEDED IMMIGRATION INFORMATION

Instructions: For each person listed, check the box for the immigration document or card number being provided and then write in the number. Once you have filled out this section, submit it using the instructions on the Document Tracking Sheet.

Name ANNA MEMBER	Case Number 1234567890								
Immigration Document or Card Number Being Provided <table border="0"><tr><td><input type="checkbox"/> Alien registration, A, or USCIS</td><td><input type="checkbox"/> Certificate of Citizenship</td></tr><tr><td><input type="checkbox"/> Certificate of Naturalization</td><td><input type="checkbox"/> Employment Authorization Document</td></tr><tr><td><input type="checkbox"/> Form I-94 Arrival/Departure Record</td><td><input type="checkbox"/> Passport</td></tr><tr><td><input type="checkbox"/> Permanent resident or green card</td><td><input type="checkbox"/> SEVIS ID</td></tr></table>		<input type="checkbox"/> Alien registration, A, or USCIS	<input type="checkbox"/> Certificate of Citizenship	<input type="checkbox"/> Certificate of Naturalization	<input type="checkbox"/> Employment Authorization Document	<input type="checkbox"/> Form I-94 Arrival/Departure Record	<input type="checkbox"/> Passport	<input type="checkbox"/> Permanent resident or green card	<input type="checkbox"/> SEVIS ID
<input type="checkbox"/> Alien registration, A, or USCIS	<input type="checkbox"/> Certificate of Citizenship								
<input type="checkbox"/> Certificate of Naturalization	<input type="checkbox"/> Employment Authorization Document								
<input type="checkbox"/> Form I-94 Arrival/Departure Record	<input type="checkbox"/> Passport								
<input type="checkbox"/> Permanent resident or green card	<input type="checkbox"/> SEVIS ID								
Immigration Document or Card Number									
Expiration Date (applies only to Employment Authorization Document, Form I-94 Arrival/Departure Record, or Passport)									



ECF:0200124510

0200124510

*** You must include this document as the coversheet for all options ***

Document Tracking Sheet**FROM:** ANNA MEMBER**PHONE:** _____**Total number of pages:** _____
(including this sheet)**ATTN:** Milwaukee Enrollment Services

INSTRUCTIONS: Include this document tracking sheet when you submit information by **fax or mail or in person**. This helps us process your information as quickly as possible. In the box above, fill in your phone number and the total number of pages you are submitting. Include the document tracking sheet in the total. Do not write anywhere else on this sheet. If you want to include more information, use a separate piece of paper.

Options	Instructions
MOBILE APP	Use the MyACCESS mobile app to take a photo of and submit all the pages of your document.
ONLINE	Scan or upload all the pages of your document to the ACCESS website at access.wisconsin.gov .
FAX	Fax your document and this document tracking sheet to MILWAUKEE ENROLLMENT SERVICES : 1-123-456-7890. Use this document tracking sheet as the first page of your fax. If your document has information on both sides, copy each side before faxing.
MAIL	Mail your document and this document tracking sheet to: MILWAUKEE ENROLLMENT SERVICES PO BOX 01234 MILWAUKEE WI 55555
IN PERSON	Take your document and this document tracking sheet to the agency office where you usually get services or to the following agency: MILWAUKEE ENROLLMENT SERVICES 1234 ANY ST MILWAUKEE WI 55555

Confidentiality: This fax should only be used by the person or agency listed above. It may have information that is private and should not be shared. If you are not the person or agency listed above, it is against the law to review, use, copy, or share the contents with anyone. If you get this fax by mistake, please call the sender right away at the phone number above.



Mailing Date: MM/DD/YYYY

000001
ANNA MEMBER
123 MAIN ST
ANYTOWN WI

#3 Imm ROP: Military

This letter is sent when an individual appears to be subject to the five-year bar but has indicated that he or she may have qualifying military service. This letter includes a form for declaring that the individual has met the military service requirement.

Enrollment Services
WORKER
87-654-3210
456-7890
and verifications.



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Action Required: Provide Military Service Information

This letter is for **ANNA MEMBER**. You were approved to get Medicaid, BadgerCare Plus, or Family Planning Only Services benefits for a limited time based on the information you gave us on your application or renewal. We sent a separate letter titled "About Your Benefits" with information about this.

On your application or renewal, you told us that you, your parent, or your spouse is serving in the military right now or is a veteran. We need more information about this to see if you can get ongoing benefits.

Please fill out the statement on the next page and send it to us by **Month DD, YYYY**. If you do not send the statement by this date or if you are not eligible to get benefits based on the information you provide, your benefits will end.

See the Document Tracking Sheet at the end of this letter to learn how to send us the statement. Make sure you include the Document Tracking Sheet with the statement. This helps us process your information as quickly as possible.

If you have any questions about this letter or your benefits, please call your agency at the phone number listed at the top of page one.

STATEMENT ABOUT U.S. MILITARY SERVICE

If you are not a citizen of the U.S., you must meet the program rules about immigration to be eligible for Wisconsin Medicaid, BadgerCare Plus, Family Planning Only Services, and/or FoodShare benefits. This form will help us see if you meet the program rules. You do not have to fill out and submit this form. However, if you do not, you may not be eligible for benefits.

Instructions

Write in any information that is not already listed. Check the box for the military service information that applies. If you agree to the statements, sign and date this form. Then print your name.

Submission Options

Submit your completed form in one of the following ways:

- **Mobile app.** Take a photo of all the pages of the form and submit them using the MyACCESS mobile app.
- **Online.** Scan all pages of the form to the ACCESS website. You can do this through your ACCESS account, which you can log into at access.wi.gov.

Note: You can only scan forms to the ACCESS website at certain times. If you are unable to scan the form to the ACCESS website, submit the form using one of the other ways.
- **Fax.**
 - If you live in **Milwaukee County**, fax the form to 888-409-1979.
 - If you do **not** live in Milwaukee County, fax the form to 855-293-1822.
- **Mail.**
 - If you live in **Milwaukee County**, mail the form to:
MDPU
PO Box 05676
Milwaukee, WI 53205
 - If you do **not** live in Milwaukee County, mail the form to:
CDPU
PO Box 5234
Janesville, WI 53547
- **In Person.** Take the form to your agency. Your agency contact information is on the Wisconsin Department of Health Services website at www.dhs.wisconsin.gov/forwardhealth/imagency/index.htm.

SECTION 1**Information About the Person Who Applied for Benefits**

Name – Person Who Applied for Benefits (First, Last, Middle Initial)

ANNA MEMBER

Case Number (if you have one)

1234567890

Date of Birth (if you do not have a case number)

Month DD, YYYY

SECTION 2**U.S. Military Service Information**

Name (First, Last, Middle Initial)

ANNA MEMBER

Date of Birth

Month DD, YYYY

This person is:

- ☐ An honorably discharged veteran.
- ☐ On active duty. This does **not** include active duty for training.
- ☐ The spouse of a veteran or a person on active duty.
- ☐ The child of a veteran or a person on active duty. The child must be unmarried and under age 18.
- ☐ The surviving spouse of a veteran.
- ☐ None of the above.

SECTION 3**Statements of Understanding and Signature**

By signing below, I am saying that the information I have given on this form is true and accurate to the best of my knowledge and that I understand the following:

- The Wisconsin Department of Health Services defines a veteran as a person who was honorably discharged from the U.S. military after one of the following:
 - Serving at least 24 months
 - Serving for the period the person was called to active duty
 - Serving less than 24 months but being discharged or released from active duty for a disability received or aggravated in the line of duty
 - Serving less than 24 months but being discharged due to a family hardship
 - Serving in the Philippine Commonwealth Army or as a Philippine scout during World War II
- I am also saying that I understand that the Wisconsin Department of Health Services defines a surviving spouse as a person who has not remarried since the veteran's death and who meets one of the following:
 - Was married to the veteran for at least one year
 - Was married to the veteran within 15 years of the veteran's military service ending
 - Was married to the veteran for any period of time and had a child with the veteran

SIGNATURE – Adult in Your Household

Date Signed

Print First and Last Name

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).	Deutsch (Pennsylvania Dutch) Wann du Deitsch (Pennsylvania Dutch) schwetzscht, kannst 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) HINWEIS: Wenn Sie Deutsch sprechen, steht Ihnen kostenlos ein Sprachen-Service zur Verfügung. Tel.: +1 844-201-6870 (TTY: 711).	Polski (Polish) UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 844-201-6 (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 सेवा उपलब्ध है। 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 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 bay. 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 lagu heli karaa. Soo wac 844-201-6870 (TTY: 711).

USDA Nondiscrimination Statement

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the [USDA Program Discrimination Complaint Form](#), (AD-3027) found online at: [How to File a Complaint](#), and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

- (1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;
- (2) fax: (202) 690-7442; or
- (3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.



ECF:0200124552

0200124552

***** You must include this document as the coversheet for all options *******Document Tracking Sheet****FROM:** ANNA MEMBER**PHONE:** _____**Total number of pages:** _____
(including this sheet)**ATTN:** Milwaukee Enrollment Services

INSTRUCTIONS: Include this document tracking sheet when you submit information by **fax or mail or in person**. This helps us process your information as quickly as possible. In the box above, fill in your phone number and the total number of pages you are submitting. Include the document tracking sheet in the total. Do not write anywhere else on this sheet. If you want to include more information, use a separate piece of paper.

Options	Instructions
MOBILE APP	Use the MyACCESS mobile app to take a photo of and submit all the pages of your document.
ONLINE	Scan or upload all the pages of your document to the ACCESS website at access.wisconsin.gov .
FAX	Fax your document and this document tracking sheet to MILWAUKEE ENROLLMENT SERVICES : 1-123-456-7890. Use this document tracking sheet as the first page of your fax. If your document has information on both sides, copy each side before faxing.
MAIL	Mail your document and this document tracking sheet to: MILWAUKEE ENROLLMENT SERVICES PO BOX 01234 MILWAUKEE WI 53205
IN PERSON	Take your document and this document tracking sheet to the agency office where you usually get services or to the following agency: MILWAUKEE ENROLLMENT SERVICES 1234 ANY ST MILWAUKEE WI 53205

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Mailing Date: MM/DD/YYYY

000001
ANNA MEMBER
123 MAIN ST
ANYTOWN WI

#4 Imm ROP: Pres + Date

This letter is sent when an individual appears to be subject to the five-year bar but does not have a verified arrival date. This letter requests verification of arrival date and continuous presence and includes a form for attesting to continuous presence.

Enrollment Services
WORKER
87-654-3210
456-7890
and verifications.



The State of Wisconsin is an equal opportunity service provider. This letter contains information that affects your benefits. If you need this material in a different format because of a disability or if you need this letter translated or explained in your own language, please call 1-888-947-6583. These services are free.

Action Required: Provide Information About Arriving and Living in the U.S.

This letter is for **ANNA MEMBER**. You were approved to get Medicaid, BadgerCare Plus, or Family Planning Only Services benefits for a limited time based on the information you gave us on your application or renewal. We sent a separate letter titled "About Your Benefits" with information about this.

We need more information so we can verify your immigration status. Once we verify your immigration status, we will see if you can get ongoing benefits.

Please provide the two items listed below for **ANNA MEMBER** by **Month DD, YYYY**:

- A document proving you were in the U.S. before August 22, 1996. An example would be a pay stub, letter from an employer, lease or rent receipt, utility bill in your name, or a written statement saying when you arrived in the U.S. that is signed under penalty of perjury by someone who is not living with you right now.
- Statement about living in the U.S. that is enclosed with this letter.

If you do not provide this information by the date given above or if you are not eligible to get benefits based on the information you provide, your benefits will end.

See the Document Tracking Sheet at the end of this letter to learn how to send us the information. Make sure you include the Document Tracking Sheet with the information. This helps us process your information as quickly as possible.

If you have any questions about this letter or your benefits, please call your agency at the phone number listed at the top of page one.

SAMPLE

STATEMENT ABOUT LIVING IN THE U.S.

Instructions: Fill in the date each person arrived in the U.S. and the date each person got an immigration status. If the statement about living in the U.S. is true, check the Yes box. If it is not true, check the No box. Sign and date the statement. Then print your name. Submit the statement using the instructions on the Document Tracking Sheet.

Name ANNA MEMBER		Case Number 1234567890
What date did you arrive in the U.S.?	What date did you get an immigration status?	
Is the statement below true? <input type="checkbox"/> Yes <input type="checkbox"/> No I lived in the U.S. between the date I arrived in the U.S. and the date I got an immigration status. During that time, I did not leave the U.S. for more than 30 days at one time. During that time, I also did not leave the U.S. for a total of more than 90 days.		

Signature and Date

Signature – Adult in the Household

Date Signed

Print First and Last Name



ECF:0200124561

0200124561

***** You must include this document as the coversheet for all options *******Document Tracking Sheet****FROM:** ANNA MEMBER**PHONE:** _____**Total number of pages:** _____
(including this sheet)**ATTN:** Milwaukee Enrollment Services

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MAIL	Mail your document and this document tracking sheet to: MILWAUKEE ENROLLMENT SERVICES PO BOX 01234 MILWAUKEE WI 55555
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Mailing Date: MM/DD/YYYY

000001
ANNA MEMBER
123 MAIN ST
ANYTOWN WI

#5 Imm ROP: Cont Pres

This letter is sent when an individual appears to be subject to the five-year bar but has indicated that he or she has an arrival date of before August 22, 1996. This letter includes a form for attesting to continuous presence.

Enrollment Services
WORKER
87-654-3210
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Action Required: Provide Information About Living in the U.S.

This letter is for **ANNA MEMBER**. You were approved to get Medicaid, BadgerCare Plus, or Family Planning Only Services benefits for a limited time based on the information you gave us on your application or renewal. We sent a separate letter titled "About Your Benefits" with information about this.

We need more information so we can verify your immigration status. Once we verify your immigration status, we will see if you can get ongoing benefits.

Please fill out the statement on the next page for **ANNA MEMBER**, and send us the statement by **Month DD, YYYY**.

If you do not provide this information by the date given above or if you are not eligible to get benefits based on the information you provide, your benefits will end.

See the Document Tracking Sheet at the end of this letter to learn how to send us the statement. Make sure you include the Document Tracking Sheet with the statement. This helps us process your information as quickly as possible.

If you have any questions about this letter or your benefits, please call your agency at the phone number listed at the top of page one.

STATEMENT ABOUT LIVING IN THE U.S.

Instructions: Fill in the date each person arrived in the U.S. and the date each person got an immigration status. If the statement about living in the U.S. is true, check the Yes box. If it is not true, check the No box. Sign and date the statement. Then print your name. Submit the statement using the instructions on the Document Tracking Sheet.

Name ANNA MEMBER		Case Number 1234567890
What date did you arrive in the U.S.?	What date did you get an immigration status?	
Is the statement below true? <input type="checkbox"/> Yes <input type="checkbox"/> No I lived in the U.S. between the date I arrived in the U.S. and the date I got an immigration status. During that time, I did not leave the U.S. for more than 30 days at one time. During that time, I also did not leave the U.S. for a total of more than 90 days.		

Signature and Date

Signature – Adult in the Household

Date Signed

Print First and Last Name



ECF:0200124579

0200124579

*** You must include this document as the coversheet for all options ***

Document Tracking Sheet**FROM:** ANNA MEMBER**PHONE:** _____**Total number of pages:** _____
(including this sheet)**ATTN:** Milwaukee Enrollment Services

INSTRUCTIONS: Include this document tracking sheet when you submit information by **fax or mail or in person**. This helps us process your information as quickly as possible. In the box above, fill in your phone number and the total number of pages you are submitting. Include the document tracking sheet in the total. Do not write anywhere else on this sheet. If you want to include more information, use a separate piece of paper.

Options	Instructions
MOBILE APP	Use the MyACCESS mobile app to take a photo of and submit all the pages of your document.
ONLINE	Scan or upload all the pages of your document to the ACCESS website at access.wisconsin.gov .
FAX	Fax your document and this document tracking sheet to MILWAUKEE ENROLLMENT SERVICES : 1-123-456-7890. Use this document tracking sheet as the first page of your fax. If your document has information on both sides, copy each side before faxing.
MAIL	Mail your document and this document tracking sheet to: MILWAUKEE ENROLLMENT SERVICES PO BOX 01234 MILWAUKEE WI 55555
IN PERSON	Take your document and this document tracking sheet to the agency office where you usually get services or to the following agency: MILWAUKEE ENROLLMENT SERVICES 1234 ANY ST MILWAUKEE WI 53205

Confidentiality: This fax should only be used by the person or agency listed above. It may have information that is private and should not be shared. If you are not the person or agency listed above, it is against the law to review, use, copy, or share the contents with anyone. If you get this fax by mistake, please call the sender right away at the phone number above.



Mailing Date:

#6 Imm ROP: Info Needed

The worker should send this manual letter during the reasonable opportunity period if any additional information is needed other than verification of military service, continuous presence, or arrival date. In most cases, this will be sent when additional immigration documentation is needed, such as a SEVIS ID or a letter from the Department of Homeland Security. The worker must specify in the comments exactly which document is needed and for whom.

ment Services
WORKER
7-654-3210
456-7890
verifications.

ANNA MEMBER
123 MAIN ST
ANYTOWN WI



Th
tha
if you need this letter translated or explained in your own language, please call 1-888-947-6583.
These services are free.

tains information
of a disability or

Action Required: Provide More Immigration Information

This letter is for **ANNA MEMBER**. You were approved to get Medicaid, BadgerCare Plus, or Family Planning Only Services benefits for a limited time based on the information you gave us on your application or renewal. We sent a separate letter titled "About Your Benefits" with information about this.

We need more information about your immigration status to see if you can get ongoing benefits. Please send us the following by **Month DD, YYYY**:

Immigration document

See the Document Tracking Sheet at the end of this letter to learn how to send us the information. Make sure you include the Document Tracking Sheet with the information you send. This helps us process your information as quickly as possible.

If you do not send us the information by the date given above or if you are not eligible to get benefits based on the information you provide, your benefits will end.

If you have any questions about this letter or your benefits, please call your agency at the phone number listed at the top of page one.

Document Tracking Sheet

Please submit the information in one of the following ways.

Options	Instructions
Mobile App	Use the MyACCESS mobile app to take a photo of and submit your information.
Online	Scan or upload your information to the ACCESS website at access.wisconsin.gov .
Fax	<ul style="list-style-type: none">- If you live in Milwaukee County, fax the information and this document tracking sheet to 888-409-1979.- If you do not live in Milwaukee County, fax the information and this document tracking sheet to 855-293-1822.
Mail	<ul style="list-style-type: none">- If you live in Milwaukee County, mail the information and this document tracking sheet to: MDPU PO Box 05676 Milwaukee, WI 53205- If you do not live in Milwaukee County, mail the information and this document tracking sheet to: CDPU PO Box 5234 Janesville, WI 53547
In Person	Take the information and this document tracking sheet to the agency office where you usually get services.