WISCONSIN DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-00356 (06/2019)

REP

FAMILY PLANNING ONLY SERVICES
AUTHORIZATION FOR ELECTRONIC DATA TRANSFER OF APPLICATION

Complete this form if you want a Medicaid/BadgerCare Plus certified provider to submit a Family Planning Only Services (FPOS) application for you. By signing below, you are authorizing the certified provider to copy information provided by you to an electronic medium and submit an online application for Family Planning Only Services.

By signing below, you agree to and understand **all** of the conditions listed below:

- I understand that I do not have to allow the provider to submit an application on my behalf and that I can apply for FPOS online anytime at access.wi.gov or by calling the Enrollment Services Center at 800-291-2002.
- I understand that by signing this authorization, I am authorizing the provider to submit a FPOS application for me and that I am still responsible for all of the information provided on that application, even if the provider enters any information incorrectly. If I get benefits that I should not have because incorrect information was provided on the application, I am legally responsible to repay the FPOS program for the cost of those benefits.
- I understand that I am still responsible for any follow-up with the Enrollment Services Center for items needed for my application, such as any proof that may be needed, or if the Enrollment Services Center has any questions about the information provided.
- I understand that regardless of when I give the provider the information needed to apply for FPOS, the date my enrollment begins depends on when the provider actually submits my application to the Enrollment Services Center.

PART A – TO BE COMPLETED BY THE APPLICANT

Name – Applicant (Last, First, MI)		Phone Number (Include Area Code)	
Address – Applicant	City	State	Zip Code

I _____ (name of applicant) authorize the following agency:

(Agency Name and Address)

Note: This authorization can only be used once and is only valid within 14 days from the date of the applicant's signature.

to submit an application for me using the online application tool, ACCESS.

Any personal and financial information that I provided about myself and/or family will be copied into ACCESS by _____ (agency name) and will serve as an application for Family Planning Only Services.

I also understand that I am legally responsible for any incorrect information supplied by_____ (agency name) on my application and that I would be required to repay the costs of any benefits I should not have gotten due to the incorrect information.

I will provide information for my application that will be true and correct to the best of my knowledge. My family planning clinic, _____ (agency name), and I understand that penalties for providing fraudulent/false information could be a fine of up to $10,000 and not more than one year in the county jail.

I, and _____ (agency name), will sign and date this authorization form, and I will be given a copy for my records.

SIGNATURE – Applicant	Date Signed

PART B – TO BE COMPLETED BY THE AGENCY REPRESENTATIVE

If you are transcribing the Family Planning Only Services request from the BadgerCare Plus Application (F-10182) for another person, then you and the applicant must complete the information on this form. Also, both you and the applicant must sign and date this form in order for your submission of an ACCESS application to be accepted. Incomplete forms may delay enrollment determination.

The provider must provide a copy of the ACCESS Application Summary to the applicant.

This form and the BadgerCare Plus Application (F-10182) must be retained by the transcribing provider for a minimum of five years from the date of the applicant's signature.

Name – Employee (Please Print)	Name – Agency
Agency Phone Number (Include Area Code)	Medicaid Provider Number
National Provider Identification (NPI) Number	Taxonomy Number
SIGNATURE – Agency Employee Representative	Zip Code + Four (4)