WISCONSIN DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-02193 (08/2017)

EI

VERIFYING TAX-EXEMPT INCOME FOR LIVE-IN CARE PROVIDERS

INSTRUCTIONS FOR BADGERCARE PLUS APPLICANTS AND MEMBERS: Complete this form to certify that the income you earn as a live-in care provider meets all of the rules for being tax exempt. If income is tax exempt, it is not counted for BadgerCare Plus eligibility.

Mail or fax the completed form to:

If you live in Milwaukee County:
MDPU
PO Box 05676
Milwaukee WI 53205
Fax: 1-888-409-1979

If you **do not** live in Milwaukee County:
CDPU
PO Box 5234
Janesville, WI 53547-5234
Fax: 1-855-293-1822

SECTION 1 – YOUR INFORMATION

Name – Applicant or Member (Last, First, Middle Initial)

Mailing Address

City	State	Zip Code

Phone Number (including area code)	Email Address

SECTION 2 – INFORMATION ABOUT THE CARE YOU PROVIDE

Name(s) of the Person or People to Whom You Provide Care (Last, First, Middle Initial)

Do you provide live-in care as part of a written plan of care for this person? ☐ Yes ☐ No

Is this person enrolled in a Medicaid Home and Community-Based Waivers program? ☐ Yes ☐ No

If yes, check the box below if you know which Home and Community-Based Waivers program the person is enrolled in.

☐ IRIS (Include, Respect, I Self-Direct)
☐ Family Care
☐ Family Care Partnership
☐ Children's Long-Term Support Waiver Program (CLTS)
☐ Community Integration Program 1A/1B (CIP 1A/1B)
☐ Community Integration Program II (CIP II)
☐ Community Options Program Waiver (COP-W)
☐ Program of All-Inclusive Care for the Elderly (PACE)

Do you live full time in the same home as this person? ☐ Yes ☐ No

Do you provide care to more than 10 people under age 19? ☐ Yes ☐ No

Do you provide care to more than 5 people age 19 or older? ☐ Yes ☐ No

Are you a nurse or other health professional providing skilled services that only a health professional may perform? ☐ Yes ☐ No

I certify that the information I have given on this form is accurate to the best of my knowledge. I understand that I may be required to provide documents to prove the answers given above.

SIGNATURE – BadgerCare Plus Applicant or Member	Date Signed

RESET FORM