WISCONSIN DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-02431 (06/2023)

ID

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
    6055 N. 64th St.
    Milwaukee, WI 53218
  - 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)

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

SECTION 2 U.S. Military Service Information

Name (First, Last, Middle Initial)	Date of Birth

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.

8 U.S.C. §§1612 and 1613

ID

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

RESET FORM

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 German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 844-201-6870 (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)** ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 844-201-6870 (TTY: 711).
繁體中文 (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 flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 844-201-6870 (TTY: 711).
한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 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.

USDA NONDISCRMINATION STATEMENT
Do Not Send Applications Here

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), 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.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, from any USDA office, by calling (833) 620-1071, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to:

1. **mail:**
   Food and Nutrition Service, USDA
   1320 Braddock Place, Room 334
   Alexandria, VA 22314; or
2. **fax:**
   (833) 256-1665 or (202) 690-7442; or
3. **email:**
   FNSCIVILRIGHTSCOMPLAINTS@usda.gov

This institution is an equal opportunity provider.
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