TWMP

WISCONSIN DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-02603 (07/2020)

REQUEST TO NOT PAY YOUR MEDICAID PURCHASE PLAN PREMIUM FOR A SHORT TIME BECAUSE OF A DIFFICULT SITUATION

INSTRUCTIONS: If you pay a premium for the Medicaid Purchase Plan (MAPP) and cannot pay that premium because of a difficult situation, use this form to ask to not pay your premium for a short time. Examples of a difficult situation are, unexpected expenses related to work, having an unexpected expense that may take a few months to pay off, or not being able to find child care. The situation must have started three months ago or less and cannot last more than 12 months. The information you provide on this form will only be used to see if you meet the rules to not pay a MAPP premium for a short time. This form must be filled out and signed by the person asking to not pay his or her MAPP premium or his or her representative. Changes in income and proof could also change or lower your premium.

Proof of Difficult Situation
In addition to filling out this form, you need to provide proof of the situation making it difficult for you to pay your MAPP premium for a short time. For example, if you have had unexpected vehicle expenses, you could include a receipt for payment of those expenses. Make sure the proof includes the date your situation should improve. Attach your proof to this form.

If you do not provide proof with this form, your agency will send you a letter asking for proof. If you do not provide proof within 10 calendar days from the date the letter is mailed, your request to not pay your MAPP premium will not be approved.

Submission Options
Submit this form and your proof 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.

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 (DHS) website at www.dhs.wisconsin.gov/forwardhealth/imagency/index.htm

SECTION 1 Member Information

Name – Member (Last, First, Middle Initial)	Phone Number

Case Number (if known)	Date of Birth

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SECTION 2 Information About the Difficult Situation

What month and year did the difficult situation start?	How many months do you expect the situation to last?

Please tell us about your difficult situation and why it is hard to pay your MAPP premium. Provide proof of this information along with this form.

SECTION 3 Signature and Date

By signing this form, you are saying that the information provided above is correct and complete to the best of your knowledge.

SIGNATURE – Person Submitting This Form	Date Signed

Print 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).	**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).