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| **STATE OF WISCONSIN DEPARTMENT OF HEALTH SERVICES**  Division of Medicaid Services  F-02866 (09/2021) | | | |  | | | | | |
| Foodshare Request for Proof **INSTRUCTIONS:** You are getting this form because we need proof from you for each person named next to the checked boxes below. This proof will be used to decide if you can get FoodShare benefits. Look at the last page of this form for a list of items used for proof. If you need more time to get the proof, contact your agency ([www.dhs.wisconsin.gov/forwardhealth/imagency/index.htm](http://www.dhs.wisconsin.gov/forwardhealth/imagency/index.htm)).  To get or keep FoodShare benefits, **provide** **proof by:**  Include this form, or a copy of this form, with any proof you submit. If you do not provide the proof by the due date listed above, benefits will be denied, decreased, or ended.  **Form and Proof Submission**  You can submit your completed form and the proof asked for 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](https://access.wisconsin.gov/).  **Note:** You can only scan forms to ACCESS at certain times. If you are unable to scan the form to ACCESS, 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 (DHS) website at [www.dhs.wisconsin.gov/​forwardhealth/imagency/index.htm](http://www.dhs.wisconsin.gov/​forwardhealth/imagency/index.htm) | | | | |
| SECTION 1 | | Information About the Proof Needed | | | | | |  | |
|  | | | | | | | | | |
| Agency | | | | | | Agency Phone Number | | | |
|  | | | | | |  | | | |
| Primary Person Name – First, Last, Middle Initial | | | | | | Case Number | Date | | |
|  | | | | | |  |  | | |
| **Program**: FoodShare | | | **Name of Person(s) That Proof Is Needed For** | | | | | | |
| **Social Security Number** or proof that an application for a Social Security Card has been filled out | | |  | | | | | | |
| **Medical Expenses** | | |  | | | | | | |
| **Earned Income** for months listed: | | |  | | | | | | |
| **Unearned Income** for months listed: | | |  | | | | | | |
| **Other** | | |  | | | | | | |
|  | | | | | | | | | |
| SECTION 2 | | Statements of Understanding and Signature | | | | | | |  |
|  | | | | | | | | | |
| By signing below, I understand that it is my responsibility to provide the proof that was asked for. **If I cannot provide proof, I must call my agency**; someone may be able to assist me. If I do not give the agency the proof I was asked for, I understand that I may not get benefits. I have read and understand this request for proof. | | | | | | | | | |
|  | **SIGNATURE** – Person Applying for or Getting Benefits | | | | | | Date Signed | | |
| Print First and Last Name | | | | | | | | | |

This institution is an equal opportunity provider.

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| **SUGGESTED ITEMS TO USE FOR PROOF**  This is a list of things you can use as proof for the different items this form asks about. If you cannot provide any of the things listed or are having trouble getting the needed proof, contact your agency [(www.dhs.wisconsin.gov/​forwardhealth/imagency/index.htm)](http://(www.dhs.wisconsin.gov/​forwardhealth/imagency/index.htm)). | |
| **Social Security Number (SSN) or Proof of Application**   * Copy of your Social Security card * Any document from the Social Security Administration showing your SSN * Tax document showing your SSN * Copy of an Application for a Social Security Card (Form SS-5) * **For newborns only**: Hospital discharge letter that references SSN application   **Medical Expenses**   * Billing statement * Itemized receipts * Medicare card showing Part B coverage * Health insurance policy showing premium, coinsurance, co-payment, or deductible * Medicine or pill bottle with price on label * Statement from pharmacy | **Earned Income**   * Pay stubs from the last 30 days * Employer Verification of Earnings ([www.dhs.wisconsin.gov/library/F-10146.htm](http://www.dhs.wisconsin.gov/library/F-10146.htm)) form filled out and signed by your employer * A statement from your employer with pay frequency, hourly pay, and average hours per pay period * For self-employment, the Self-Employment Income Report forms or tax forms   **Unearned Income**   * Current statement or document with source type and amount * Check stubs * Tax forms   **Other**  If you do not understand what other verification you need to provide or cannot obtain the items asked for, please contact your agency. |