DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-10119 (02/2024)

STATE OF WISCONSIN
WI Stats. s. 49.45

TEMPORARY ENROLLMENT FOR FAMILY PLANNING ONLY SERVICES

SECTION I — APPLICANT INFORMATION (GENERAL) Are you a resident of Wisconsin? (If no, go to Section III) ☐ Yes ☐ No

1. Name – Applicant (Last, First, MI)	Sex ☐Male ☐Female	Birth Date (MM/DD/YY)	10-Digit Phone Number
2. Address (Street, City, State, Zip Code)			County of Residence

3. Are you currently receiving Wisconsin Medicaid or BadgerCare Plus? (If yes, go to section III.)	☐ Yes ☐ No
4. Have you been temporary enrolled in Family Planning Only Services the last 12 months? (If yes, go to section III)	☐ Yes ☐ No
5. Are you in need of contraceptive services? (If no, go to section III)	☐ Yes ☐ No
6. Are you one of the following (If no, go to Section III): • A U.S. Citizen, • Lawfully residing in the United States for at least 5 years, or • Lawfully residing in the United States and a refugee or is seeking asylum, or • From Cuba or Haiti and is lawfully residing in the United States, or • Under age 19 and lawfully present in the United States, or • Lawfully residing in the United Status under one of the eligible immigration statuses listed in the BadgerCare Plus Eligibility Handbook (refer to instructions for more information)	☐ Yes ☐ No

SECTION II – APPLICANT INCOME INFORMATION

7. Enter ONLY the applicant's total monthly job income and wages.	$
8. Enter ONLY the applicant's total monthly other income (Social Security Income, unemployment compensation, etc.).	$
9. Add lines 7 and 8. Enter the applicant's total monthly income.	$
10. Compare the applicant's total net income (Line 9) with the federal poverty level guideline for a group size of 1. Does the applicant meet the rules for income limits?	☐ Yes ☐ No

SECTION III — NOTICE

11. ☐ I certify that the above-named applicant, based on the information provided above, meets program rules and is able to be temporarily enrolled in Family Planning Only Services. I have informed the applicant of the requirement to apply by mail, phone, online at access.wi.gov or with the local agency by the end of the month following the current month. I have informed the applicant of privacy and service availability issues under Family Planning Only Services.

OR

☐ Based on the information provided above, I have determined that the applicant cannot be enrolled in Family Planning Only Services because the applicant (check all that apply):

☐ Is not in need of contraceptive services
☐ Is not of childbearing age
☐ Is not a U.S. citizen or qualifying immigrant
☐ Has been determined temporarily enrolled in Family Planning Only Services within the past 12 months
☐ Does not qualify under the income guidelines
☐ Is currently enrolled in Wisconsin Medicaid or BadgerCare Plus
☐ Is not a resident of Wisconsin

Name — Provider (Type or Print)	Address — Provider	Medicaid Provider Number
Name — Provider Representative (Type or Print)	**SIGNATURE** — Provider Representative	Date Signed

12. ☐ I certify, under penalty of false swearing, that the information on this application and given in connection with it is a true and complete statement of facts according to my best knowledge and belief. I understand that I need to be determined eligible for Family Planning Only Services to receive benefits beyond the end date of my temporary enrollment for Family Planning Only Services period. I will need to apply for Family Planning Only Services by mail, phone, online at access.wi.gov or in person with the local agency before the end of the month following the month in which I am determined eligible for temporary enrollment and that my temporary enrollment also ends on that date.

OR

☐ I understand that I do not meet the enrollment rules for temporary enrollment in Family Planning Only Services. The provider named above has informed me that I may still apply by mail, phone, online at access.wi.gov or in person.

SIGNATURE — Applicant	Date Signed

SECTION IV TEMPORARY ENROLLMENT FOR FAMILY PLANNING ONLY SERVICES TEMPORARY IDENTIFICATION CARD

Card Effective Dates (MM/DD/YY) From	Through	Medical Status Code	Member ID Number	Agency Code
		PF		

Member Name and Address

To the Patient

This card identifies you as being able to get certain family planning services through Temporary Enrollment for Family Planning Only Services. You may get these services from **any certified Family Planning provider**. You must present this card to your provider **BEFORE** getting medical care, services or supplies. In order to get Family Planning Only Services benefits after the expiration date of this card, you must apply with your agency immediately. If you have any questions call: **1-800-362-3002.**

To the Provider

The individual listed has been determined temporarily enrolled in Family Planning Only Services in accordance with §49.465 Wis. Stats. This card entitles this individual to receive certain family planning related services including certain family planning related pharmacy services through Family Planning providers for the time period specified on this card. (See card effective dates.) For additional information, contact Provider Services at (800) 947-9627 or see the online provider handbook on at https://www.forwardhealth.wi.gov/WIPortal/Default.aspx.

NOTE: The applicant may present this card prior to enrollment information being recorded on the Family Planning Only Services file. Providers should keep a photocopy of this card.

WISCONSIN DEPARTMENT OF HEALTH SERVICES

TEMPORARY IDENTIFICATION CARD FOR TEMPORARY ENROLLMENT FOR FAMILY PLANNING ONLY SERVICES