

**AUTHORIZATION OF REPRESENTATIVE FOR MEDICAID / BADGERCARE PLUS / FOODSHARE**

The person who completed the Medicaid, BadgerCare Plus and/or FoodShare application on behalf of an applicant must complete this form.

Social Security Numbers and Personally Identifiable information will only be used for the direct administration of Medicaid, BadgerCare Plus and FoodShare. Request for a Social Security Number on this form will be used only to correctly identify a member who is already in our system.

Did you complete a Medicaid, BadgerCare Plus or FoodShare Wisconsin application on behalf of another person and are you that person's court appointed guardian, conservator or have durable power of attorney for finances for that person?  Yes  No

If you answered "Yes", stop here. You must submit, to the local agency, the legal documentation authorizing you to be that person's appointed guardian or durable power of attorney for finances.

Are you an authorized representative completing the Medicaid, BadgerCare Plus or FoodShare Wisconsin application for another person?  Yes  No

If you are an Authorized Representative completing the Medicaid, BadgerCare Plus or FoodShare Wisconsin application for another person, then you and the applicant must complete the information below. You must sign the Rights and Responsibilities Section of the Medicaid, BadgerCare Plus and/or FoodShare application. Also, both you and the applicant must sign this form in order for you to be an authorized representative.

Name – Authorized Representative (Last, First, MI)		Telephone Number (Including Area Code)	
Address – Street	City	State	Zip Code
Email Address			

**Medicaid / BadgerCare Plus**

I \_\_\_\_\_ (name of applicant/member) authorize the above named to complete and sign applications and renewal forms, receive copies of notices and other communications from the agency and act on my behalf in all other matters, including to give and receive information that in any way relates to my application, eligibility determination and continuing benefits. I will provide information to my representative that will be true and correct to the best of my knowledge. My representative and I understand that penalties for providing fraudulent information could be a fine of up to \$10,000 and not more than one year in the county jail.

**FoodShare Wisconsin**

I \_\_\_\_\_ (name of applicant/member) authorize the above named to represent me in my application/review for FoodShare Wisconsin. I also authorize my representative to provide information and documents which may be necessary to establish my enrollment for FoodShare Wisconsin. I will provide information to my representative that will be true and correct to the best of my knowledge. My representative and I understand that penalties for providing fraudulent information can be barred from FoodShare Wisconsin for 12 months after the first violation, 24 months after the second violation and permanently for the third violation. Depending upon the value of misused benefits, the individual can also be fined up to \$250,000, imprisoned up to 20 years, or both. A court can also bar an individual from the program for an additional 18 months. An individual will not be able to take part in FoodShare Wisconsin for 10 years if s/he is found to have made a fraudulent statement or representation with respect to identity and residence in order to receive multiple benefits at the same time.

**NOTE:** Someone other than your representative must witness your signature. Two witness signatures are required if you sign with an "X".

<b>SIGNATURE</b> - Applicant	Social Security Number	Date Signed
<b>SIGNATURE</b> – Witness (Required)		Date Signed
<b>SIGNATURE</b> – Witness (Required if signed with an "X".)		Date Signed
<b>SIGNATURE</b> – Authorized Representative		Date Signed

As an authorized representative I understand that I am representing the above named applicant for Medicaid and/or FoodShare Wisconsin enrollment and that information provided is true and correct to the best of my knowledge.