

**WISCONSIN MEDICAID, BADGERCARE PLUS, AND FAMILY PLANNING ONLY SERVICES
REGISTRATION APPLICATION**

Fill out and submit this form to set your application filing date for Wisconsin Medicaid, BadgerCare Plus, or Family Planning Only Services. Your application filing date helps determine when you can start getting benefits if it is decided that you meet program rules. Certain people may be able to get benefits up to three months before the month in which they apply. This is called backdated coverage. You can ask for backdated coverage on the full application.

After you submit this form, you need to fill out a full application to see if you meet program rules and can get benefits. You can do this by applying online at access.wi.gov, filling out a paper application packet, or calling or going in person to your local agency. To get your agency contact information, go to www.dhs.wisconsin.gov/forwardhealth/imagency/index.htm or call Member Services at 800-362-3002.

A decision on whether or not you can get benefits will be made within 30 days of your agency getting this form.

If you have a legal guardian, conservator, or power of attorney, that person can fill out and submit this form on your behalf. That person would also need to submit documents about his or her appointment along with this form.

You can also have an authorized representative fill out and submit this form on your behalf. To appoint an authorized representative, fill out and submit the [Appoint, Change, or Remove an Authorized Representative: Person form, F-10126A](#), or the [Appoint, Change, or Remove an Authorized Representative: Organization form, F-10126B](#), along with this form.

The personally identifiable information provided on this form will only be used for the direct administration of Wisconsin Medicaid, BadgerCare Plus, and Family Planning Only Services. Providing or applying for a Social Security number is voluntary; however, if you want benefits you must provide one or apply for one. Your Social Security number will be used to gather information from other government agencies, such as the Social Security Administration and the Wisconsin Department of Workforce Development. It will also be used to see if you have other health insurance.

If you need help filling out this form or need the form in a different language or format, contact your agency.

If you would like more information about Wisconsin Medicaid, BadgerCare Plus, and Family Planning Only Services, including your rights and responsibilities, see the [ForwardHealth Enrollment and Benefits Handbook, P-00079](#). You will be sent the handbook after you submit this form.

SUBMISSION INSTRUCTIONS

If you live in **Milwaukee County**, do one of the following:

- Fax the form to 888-409-1979.
- Mail the form to:
MDPU
P.O. Box 05676
Milwaukee, WI 53205

If you do **not** live in Milwaukee County, do one of the following:

- Fax the form to 855-293-1822.
- Mail the form to:
CDPU
P.O. Box 5234
Janesville, WI 53547

Name – Applicant (Last, First, Middle Initial)

Social Security Number	Date of Birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Phone Number (include area code)
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Home Address

City	State	Zip Code
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 SIGNATURE – Applicant or Representative	Date Signed
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