WISCONSIN DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-10137 (06/2023)

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WISCONSIN MEDICAID CHANGE REPORT

If you are receiving Medicaid, you must report any changes in the make up of your household (if anyone moves in or out of your household, if anyone gets married, becomes pregnant, or gives birth to a child), a change in address, income, assets or employment status **within 10 days.** If this report does not provide enough room to document a change, attach a sheet of paper with the additional information written on it to this report. You may also report changes online at access.wi.gov, by telephone or in person.

If you fail to report any changes or provide false information, you may be fined, have to pay back any Medicaid benefits you received that you should not have (even if you did not use your card), be prosecuted or all three. You may be required to provide proof of any changes you report.

Personally identifiable information will be used only for the direct administration of the Medicaid program.

Your Name	Case Number	Worker Name

SECTION 1 - CHANGE IN ADDRESS

If you have moved, you must report your new address.

Date of Change		New Telephone Number	
New Address - Street	City	State	Zip Code

SECTION 2 - CHANGE IN HOUSEHOLD COMPOSITION

You must report if anyone moves in or out of your household, if anyone gets married, becomes pregnant or gives birth to a baby (include information about the person who gave birth and the newborn.)

Name(s) (Last, First, MI)		Date of Change
Social Security Number (SSN)*	Date of Birth	Relationship to Case Head
Describe the Change		

*Providing or applying for an SSN is voluntary; however, any person who wants Wisconsin Medicaid but does not want to provide their SSN or apply for one will not be eligible for benefits, pursuant to Wisconsin Statutes section 49.82(2).

SECTION 3 - CHANGE IN ASSETS

You must report changes in your household's cash, bank accounts, bonds, stocks or other assets.

Name of Owner (Last, First, MI)		Date of Change
Type of Asset	Describe the Change	New Value or Amount $

Administrative Rule DHS 102.01 (6)

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SECTION 4 – CHANGE IN RESOURCES/INCOME

You must report any income or resources you and/or your spouse have given away or sold for less than fair market value. Examples of resources include cash and cash gifts, real estate, stocks or bonds, an inheritance, etc.

Type of asset or income	Date sold or given away	Value of asset or income $
What did you get in return?		

SECTION 5 – CHANGE IN VEHICLES

You must report if you obtain, sell or give away a car, truck, motorcycle, boat, snowmobile, camper or another type of vehicle.

Name of Owner(s) (last, first, MI)			Date of Change
Type of Vehicle	Make	Model	Year
Describe Change (bought, sold, etc.)	Amount Received $	Fair Market Value* $	Amount Owed $

* By fair market value, we mean the amount that you would get if you sold it on the open market.

SECTION 6 - CHANGE IN INCOME

You must report a change in your gross income amount, a new source of income, changes in your employment status (part-time to full-time or full-time to part-time, loss of employment), changes in salary or rate of pay, changes in the amount of Social Security, Unemployment Insurance, Worker's Compensation, Veterans benefits, or any other change in the amount of money your household gets.

Name (Last, First, MI)	Date Income Changed
Source of Income	Monthly Amount $
How Often Paid ☐ Each Week ☐ Every Other Week ☐ Twice Each Month ☐ Once Each Month	

SECTION 7 - OTHER CHANGES

You must report any other changes that may affect your Medicaid eligibility. Examples of other changes include someone getting or dropping health insurance, someone becoming disabled or recovering from a disability. A change could also be a change in expenses such as an increase or decrease in health insurance premiums, medical costs or shelter costs.

Describe change	
Do you expect that the changes reported on this form will remain the same next month? ☐ Yes ☐ No If no, explain.	Date of Change

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SECTION 8 – SIGNATURE

☐ Yes ☐ No I understand that there are penalties for hiding information or giving false information.	
☐ Yes ☐ No I understand that I may have to pay back any benefits I receive because I do not fully report changes in my circumstances (even if I do not use my Medicaid card).	
☐ Yes ☐ No I agree to provide proof of any changes, if asked to do so.	
☐ Yes ☐ No My answers on this report are correct and complete to the best of my knowledge.	
SIGNATURE – Applicant/Representative/Guardian/Power of Attorney/Conservator	Date Signed
Telephone Number (including area code)	

If this report does not provide enough room to document a change, attach a sheet of paper with the additional information written on it to this report.

Mail or Fax Applications, Forms and/or Proof/Verifications

If you live in Milwaukee County:

MDPU
6055 N. 64th St.
Milwaukee, WI 53218

Fax: 1-888-409-1979

If you **do not** live in Milwaukee County

CDPU
PO Box 5234
Janesville, WI 53547-5234

Fax: 1-855-293-1822

You can also scan and/or upload any proof online at access.wi.gov.

RESET FORM