DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-10127 (07/2020)

MEDICAID PURCHASE PLAN WORK REQUIREMENT EXEMPTION

INSTRUCTIONS: If you have been enrolled in the Medicaid Purchase Plan (MAPP) for the last six months, you can use this form to ask not to have to meet the MAPP work requirement because you have a health-related hardship. (This could be a serious mental health or physical illness or you are hospitalized.) An exemption lets you stay enrolled in MAPP for up to six months. If you cannot continue to work, including employment, self-employment, or in-kind work (getting goods or services instead of money), completing this form may allow you to stay enrolled in MAPP and not have to meet the requirement to work for a short time. **You will still have to pay your MAPP premium**.

A health-related hardship means that your mental or physical health makes you unable to be in a work activity or participate in the Heath and Employment Counseling program. In order to qualify, you must meet all of the following:

- Expect to return to your work activity or a Health and Employment Counseling program within the next six months.
- Have been enrolled in MAPP for the last six months.
- Currently be enrolled in MAPP and have paid all MAPP premiums owed.
- Not have been exempted from the work requirement for more than 12 months in the last 36 months.
- Provide a doctor's statement as proof that you cannot work or participate in a Health and Employment Counseling program due to a mental or physical health-related hardship.

How to Submit this Form
Submit your completed form 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.

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

SECTION 1 Personal Information

Name – Individual (Last, First, Middle Initial)	Case Number	PIN (optional)
Request Date (mm/dd/yy)	Actual Months Exemption Is Requested	

MAS

SECTION 2 Signature and Date

By signing this form, you are saying that the information you provided is correct and complete to the best of your knowledge. You understand that you may still be required to pay a premium, based on your income, during the period you do not have to meet the work requirement. You understand that you must provide a doctor's statement as proof within 10 days of our asking for it.

SIGNATURE – Person or Representative of Person Requesting Exemption	Date Signed

Agency Use Only: This section must be completed by the income maintenance worker. The worker will provide a copy to the member or authorized person and place one copy in the member's case file.	
Income Maintenance Worker Name – Individual (Last, First, Middle Initial)	Decision ☐ Approved ☐ Not Approved
Exemption Begin Date	Date of Decision
Reason for Non-Approval	

Nondiscrimination Notice: Discrimination is Against the Law – Health Care-Related Programs
The Wisconsin Department of Health Services complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Department of Health Services does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Department of Health Services:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters.
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters.
  - Information written in other languages.

If you need these services, contact the Department of Health Services civil rights coordinator at 844-201-6870.

If you believe that the Department of Health Services has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Department of Health Services, Attn: Civil Rights Coordinator, 1 West Wilson Street, Room 651, PO Box 7850, Madison, WI 53707-7850, 844-201-6870, TTY: 711, fax: 608-267-1434, or email to dhscrc@dhs.wisconsin.gov. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Department of Health Services civil rights coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 844-201-6870 (TTY: 711).	**Deitsch (Pennsylvania Dutch)** Wann du Deitsch (Pennsylvania Dutch) schwetzscht, kannscht du ebber griege as dich helfe kann mit Englisch, unni as es dich ennich eppes koschte zellt. Ruf 844-201-6870 uff (TTY: 711).
Hmoob (Hmong) LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 844-201-6870 (TTY: 711).	**ພາສາລາວ (Laotian)** ເຊີນຊາບ: ຖ້າທ່ານເວົ້າພາສາລາວ ແມ່ນມີບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ໃຫ້ໂທຫາເບີ 844-201-6870 (TTY: 711).
繁體中文 (Traditional Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 844-201-6870 (TTY: 711).	**Français (French)** ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 844-201-6870 (ATS : 711).
Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 844-201-6870 (TTY: 711).	**Polski (Polish)** UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 844-201-6870 (TTY: 711).
العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان اتصل برقم 844-201-6870 (رقم هاتف الصم والبكم: 711).	**हिंदी (Hindi)** ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 844-201-6870 (TTY: 711) पर कॉल करें।
Русский (Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 844-201-6870 (телетайп: 711).	**Shqip (Albanian)** KUJDES: Nëse flisni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 844-201-6870 (TTY: 711).
한국어 (Korean) 알림: 한국어 지원 서비스를 무료로 이용하실 수 있습니다. 844-201-6870 (TTY: 711) 번으로 전화해 주십시오.	**Tagalog (Tagalog – Filipino)** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 844-201-6870 (TTY: 711).
Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 844-201-6870 (TTY: 711).	**Soomaali (Somali)** FIIRO GAAR AH: Haddii aad ku hadashid af Soomaali, adeegyada caawinta luuqada, oo bilaash ah, ayaa laguu heli karaa. Soo wac 844-201-6870 (TTY: 711).