CARETAKER SUPPLEMENT
INSTRUCTIONS FOR APPLICATION

Wisconsin's Caretaker Supplement (CTS) is a cash benefit available to parents who receive Supplemental Security Income (SSI) payments. It pays cash only to parents who are living with and caring for their minor children, and who have limited income and assets. Caretaker Supplement is not a Medicaid benefit; this is **not** an application for FoodShare, Medicaid, or child care or W-2 assistance programs. Find more information about applying for those programs on the Department of Health Services website at www.dhs.wisconsin.gov/forwardhealth/apply.htm.

If you need help filling out this application or want to answer the questions in person or over the telephone, contact your local county or tribal agency. Find your local agency at www.dhs.wisconsin.gov/forwardhealth/imagency/index.htm.

If you have a disability and need the instructions and application in an alternate format, or need it translated to another language, contact Member Services at 800-362-3002. All translation services are free.

HOW TO USE THIS FORM

1. Read the instructions completely before completing the application.

2. Type into the form or print and use blue or black ink.

3. Fill out the application completely. There may be a delay in CTS benefits if the application is not complete. If your application is not complete or you requested retroactive eligibility, your local county or tribal agency will contact you for more information.

4. Enter information about all the people who live in your household. If you need more space add a second sheet.

5. If anyone in the household is pregnant, include with your application a signed and dated note from the doctor or another health care professional confirming the pregnancy and stating the expected due date.

6. You may authorize a representative to apply for you. Complete and send the Authorized Representative form (F-10126) with your application. You can get this form by calling Member Services at 800-362-3002. This form authorizes a representative to complete and sign the application for you. A legal guardian, conservator, or power of attorney/durable power of attorney authorized to act on these types of matters may apply for an individual without separate authorization by the individual.

7. Write all dates using the MM/DD/YYYY format. Example: 08/31/2022.

8. Attach an additional sheet of paper if you need more space to provide the required information.

IMPORTANT INFORMATION

The following is important information regarding Caretaker Supplement eligibility.

- Your application date is the date your application is received by your local county or tribal agency. The application must include at least your name, address, and signature. A decision regarding your eligibility for CTS will be mailed to you within 30 days of the application date. Unsigned forms will not be processed and will be returned.

- Your rights and responsibilities are provided in Section 10. If you have any questions about your rights and responsibilities contact your local county or tribal agency.

- If you are found eligible for CTS you will need to complete a review every 12 months to determine eligibility. Changes in your income or household must be reported to your local county or tribal agency within 10 days of the change.

- To receive Caretaker Supplement payments for any child in your care, you must give the State the right to collect

court-ordered child support or family support for that child. The State has the right to use part of the support to pay back the federal cost of Caretaker Supplement payments you receive. Support payments kept by the State cannot be more than 25% of the total amount of support paid. The State will send you 75% of the total amount of support paid.

You will be notified of any changes that would affect your child support. The State's right to collect court-ordered support ends when you no longer receive Caretaker Supplement payments.

By signing the application for Caretaker Supplement, you are giving the State the right to collect court-ordered child support.

SECTION 1 - CLIENT INFORMATION

Name of Person Applying for Caretaker Supplement
Enter your last name, first name, and middle initial.

Telephone Number
Enter your 10-digit telephone number (include area code, for example (608) 292-4021).

Address
Enter your street address, city, state, and zip code.

Mailing Address
Enter the mailing address where you would like information sent regarding your CTS. This may be your current address or the current address of your authorized representative.

SECTION 2 - GENERAL INFORMATION

Eligibility for Caretaker Supplement is based on family members living in your household. Complete this section of the application for all family members living in your household.

Name
Enter the last name, first name, and middle initial of all family members living in your household. This may include yourself, your spouse, father, mother, children or stepchildren, etc.

Social Security Number
Enter a Social Security Number (SSN) for all members of your household who are applying for CTS. If someone in your household is not applying for CTS you do not need to provide SSN information for that person.

Providing or applying for an SSN is voluntary; however, any person who wants CTS but does not want to provide their SSN or apply for one will not be eligible for benefits.

Social Security Number information will be used for the direct administration of the CTS program. Your SSN permits a computer check of your information with government agencies such as the Internal Revenue Service (IRS), Social Security Administration (SSA) and the Department of Workforce Development.

Your SSN will **not** be shared with the U.S. Citizenship and Immigration Service (USCIS).

Date of Birth
Enter the birth date of all members of your household.

Gender
Check “M” for each male member of your household. Check “F” for each female member of your household.

Marital Status
Enter the code in the space provided that best describes each household member’s marital status.

A	=	Annulled
D	=	Divorced
LS	=	Legally Separated
M	=	Married
S	=	Separated
N	=	Never Married
W	=	Widowed

Are you a U.S. Citizen?
Check “Yes” for each member of your household who is a U.S. citizen. Check “No” for each member of your household who is not a U.S. citizen. If you checked “No” for any household member applying for CTS, submit a copy of both sides of the immigration documentation with this application. Information may be submitted to the USCIS for verification for those applying for these programs.

If someone in your household is not applying for CTS, you do not need to provide proof of immigration status for that person.

What is your race or ethnic background? (Optional)
Enter the code or codes that best describe the race or ethnic background of each member of your household. You don't have to answer the ethnicity and race questions if you don't want to. We're asking these questions to help improve our programs and make sure they do not discriminate based on ethnicity or race. Your answers will not be used to make a decision about your benefits.

Ethnicity
H = Hispanic or Latino

Race
A = Asian
B = Black/African American
I = American Indian / Alaska Native
P = Hawaiian / Other Pacific Islander
W = White

Relationship to Applicant
Enter the relationship to the applicant of each person listed.

SECTION 3 - ABSENT PARENT INFORMATION

A CTS eligibility requirement is cooperation with identifying parents who are absent from the home. Complete this section as accurately as you can for each parent absent from the home. If there is a reason you do not want to provide information for an absent parent, leave this section blank.

If this section is left blank, you will be contacted by your local county or tribal agency for additional information.

Do any children have a biological or adoptive parent who is not living at home?
Check "Yes" if any of the children living in your household have either a biological or adoptive parent who is not living in the home. If you checked "Yes," complete all of Section 3.

Check "No" if the children living in the home have both biological or adoptive parents living in the home. If you checked "No," skip to Section 4.

Name
Enter the last name, first name, and middle initial of any parent who is absent from the home.

Social Security Number
Enter the Social Security Number (SSN) of the absent parent if you know it. If this field is left blank, you may be contacted by your local county or tribal agency for additional information.

Date of Birth
Enter the birth date of the absent parent, if known. When entering the birth date, use the number for the month, day and year.

Name(s) of Child(ren)
Enter the last name, first name, and middle initial of the child or children of this absent parent.

Relationship to Child
Write "Parent," "Mother," or "Father" to indicate the absent parent's relationship to the children listed.

Reason for Parent's Absence
List the reason why the parent does not live in the household. (For example, divorced, separated, not married, unable to locate.)

Date Parent Left the Household
Enter the date that the absent parent left the household, if known.

Date of Last Contact with Parent
Enter the date of last contact with the absent parent.

Court Order of Divorce or Paternity
If there is a court order of divorce or paternity, enter the case number, county, and state for the order that was issued.

SECTION 4 - EMPLOYMENT

Caretaker Supplement will be based on your total family income (including minor children).
Enter the expected gross monthly earnings for the current month and next month for each member of your household.

Are you or any household member working, other than self-employed?
Check "Yes" if any member of your household is working and not self-employed and complete the rest of the Section 4. Check "No" if no one in your household is working, and skip to Section 5.

Is anyone listed in Section 4 a migrant worker?
Check "Yes" if any member of your household is a migrant worker and complete the rest of Section 4. Check "No" if no one in your household is a migrant worker.

Name Each Working Person
Enter the last and first name of each member of your household that is employed.

Employer's Name, Address and Telephone Number
Enter the employer's name, address and telephone number for each member of your household who is employed.

Date Employment Began
Enter the beginning date of employment for each member of your household who is employed.

Gross Monthly Earnings Expected this Month
Enter the expected monthly gross earnings (before taxes and deductions) for this month for each member in your household who is employed.

Gross Monthly Earnings Expected Next Month
Enter the expected monthly gross earnings (before taxes and deductions) for next month for each member in your household who is employed.

SECTION 5 - SELF-EMPLOYMENT

Are you or any household member self-employed?
Check "Yes" if you or any member of your household is self-employed. If you checked "Yes" complete the rest of Section 5. List amounts you reported to the IRS on your tax forms. If you did not file taxes last year, leave the net annual income and depreciation boxes blank. Your local county or tribal agency will contact you for more information.

If no one in your household is self-employed, check "No" and continue on to Section 6.

Self-Employed Person
Enter the last name, first name and middle initial of each person in the household who is self-employed.

Business Name and Address
Enter the name and address of the business for each person in the household who is self-employed.

Type of Business
Enter the type of business for each person in the household who is self-employed.

Net Annual Income
Enter the net annual income for each person in the household who is self-employed. List the amounts reported to the IRS on your tax forms. If you did not file taxes last year, leave this box blank. Your local county or tribal agency will contact you for more information.

Depreciation Amount Claimed
List the amounts reported to the IRS on your tax forms. If you did not file taxes last year, leave this box blank. Your local county or tribal agency will contact you for more information.

Income you Expect to Earn this Year
Enter the amount of gross annual income (before taxes and deductions) for each person in the household who is self-employed.

SECTION 6 - UNEARNED INCOME

Other Type of Income
Check "Yes" if anyone in your household receives unearned income. Check "No" if those in your household do not receive unearned income. If you answer "Yes" complete Section 6 for each income type.

Name
Enter the name of the person for the income types that were checked "Yes".

Gross Monthly Amount
Enter the gross monthly amount received for each income type for the ones checked "Yes".

SECTION 7 – ASSETS

Name
Enter the name of the person who owns the asset type listed.

Current Value
Enter the current value of the asset.

Description
Give a description of the asset. For example, for a checking account, list the name of the bank or financial institution, the account numbers, etc.

SECTION 8 - VEHICLE INFORMATION

Type of Vehicle
Enter the type of vehicle. Include all vehicles that are owned jointly with another person.

Year, Make and Model of the Vehicle
Enter the year, make, and model of the vehicle.

Name of the Owner
Enter the name of the owner of the vehicle. If the vehicle is jointly owned, list the names of all owners.

How much is still owed on the vehicle?
If you still owe money on this vehicle, list the amount that is still owed.

Is this vehicle used to get to medical appointments?
Check "Yes" if this vehicle is used to get to medical appointments. Check "No" if you do not use the vehicle to get to medical appointments.

Is this vehicle for employment, training, school, or farming?
Check "Yes" if this vehicle is used for employment, training, school, or farming. Check "No" if it is not used for employment, training, school, or farming.

SECTION 9 - PREGNANCY

Are any members of your household pregnant?
Check “Yes” if anyone is pregnant in your household. Check “No” if no one is pregnant in your household.

If you checked “Yes” answer the questions to the right of the YES / NO box. If you checked “No” go to Section 10.

Name of anyone who is pregnant
Enter the first and last name of anyone who is pregnant in your household.

Due Date
Enter the due date(s) of anyone who is pregnant in your household. (For example, if the due date is April 3, 2023 you would enter 04/03/2023 in the space provided.) You will need to provide verification from a medical professional of each pregnancy and due date to your county / tribal social or human services department.

SECTION 10 - RIGHTS AND RESPONSIBILITIES

Read all of your Rights and Responsibilities. Check each box indicating that you have read and understand them.

Your signature on the application means that you understand and acknowledge that the local county or tribal agency, W-2 agency and the state Department of Health Services is authorized to request any information that is appropriate and necessary for the proper administration of the Caretaker Supplement Program authorized under Wisconsin law.

Your signature on the application also means that you are giving the State the right to collect court-ordered child support or family support, as described above in the IMPORTANT INFORMATION section.

YOUR RIGHTS:

You have the right to:

- Be treated with respect.
- Be treated fairly and not be discriminated.
- Have your private information kept private.
- See agency records and files relating to you, except information obtained from a confidential source.
- Get free language services.
- Get a decision about your application within 30 days of the day your agency gets your application.
- Be told in advance if your CTS benefits are going to be reduced or ended and the reason for the change.
- Ask the agency for help in getting needed information and proof that has been asked for.

You have the right to apply for CTS benefits for any month in which you receive SSI and did not receive W-2 benefits.

YOUR RESPONSIBILITIES:

- You must cooperate with the child support agency.
- You are responsible for obtaining a Social Security Number for your child or children.
- You are responsible for reporting to your agency worker, within 10 days, any change in income, assets or other household circumstances that may affect your eligibility. If any children included in your Caretaker Supplement Group are no longer under your care and custody, you must report it within **five (5)** days.

Use the "Change Report" form that you get when you apply, call your worker, or report the change in person.

You must also report:

- Whenever anyone in your household starts receiving SSI or stops receiving SSI.

- When any member of your household turns 18 years old, graduates from high school, obtains a GED, or quits school.

- When the source of your income changes.
- When anyone moves into or out of your household. If a child(ren) included in your Caretaker Supplement Group is (are) no longer under your care and custody, you must report it in **five (5)** days.
- When anyone in your household has a change in earnings from work.
- When your household's unearned income, cash-in-hand, checking or savings accounts, stocks, bonds or other assets change.
- When the total assets of your children exceed $1,000.
- When anyone in your household gets married, divorced, becomes pregnant or gives birth.
- When your child care or dependent care expenses change.
- When your address changes.
- When you or anyone in your household receives a lump sum payment such as a personal injury award, inheritance, windfall payment, retroactive benefits such as Social Security or Unemployment Insurance. You may be ineligible for CTS for a period of time if you receive lump sum payment. Do not spend this money until you have contacted your worker to find out if there will be a period of time for which you must use this money to meet current living expenses.
- Any other change that affects your eligibility or the amount of your benefits.

You have the right to appeal any action taken concerning your Caretaker Supplement application or ongoing benefits that you do not agree with by requesting a Fair Hearing. You may request a Fair Hearing by writing to:

Wisconsin Department of Administration
Division of Hearings and Appeals
P.O. Box 7875
Madison, WI 53707-7875 OR calling: (608) 266-7709

You may also contact your local county or tribal agency and ask for a Fair Hearing verbally or in writing.

The Department of Health Services is an equal opportunity employer and service provider. For civil rights questions, call , 608-267-4955, TTY: 711.

To file a complaint of discrimination contact either the:

- Wisconsin Department of Health Services
  Civil Rights Coordinator
  1 W. Wilson Street, Room 651
  PO Box 7850
  Madison, WI 53707-7850
  Telephone: 608-267-4955, TTY: 711
  Fax: 608-267-1434
  dhscrc@dhs.wisconsin.gov

- 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/smartscreen/main.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
  1-800-368-1019, 800-537-7697 (TDD)

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

CHECKLIST

☐ Is the application complete?

☐ If you are not a U.S. citizen, did you include a copy of both sides of your immigration status documents?

☐ If you are pregnant, did you include a signed and dated note from a doctor or other health care professional saying that you are pregnant and stating the due date?

☐ Did you read the Rights and Responsibilities Section?

☐ Did you sign and date the application form?

☐ Did you include the Authorized Representative form (F-10126) if you are acting on behalf of an applicant?

Send the completed application to your local county or tribal agency. Addresses for local county or tribal agency can be found at: www.dhs.wisconsin.gov/forwardhealth/imagency/index.htm or by contacting Member Services at 800-362-3002.

OTHER PROGRAM INFORMATION

If you are interested in services for veterans, call 1-800-947-8347 (WIS-VETS), or contact your county Veteran Service Officer.

For information about the Women, Infants, and Children (WIC) Nutrition Program, call 1-800-722-2295.

For information about services for women, children and families, contact the Wisconsin Maternal Child Health Hotline at 1-800-722-2295.