

## PRESUMPTIVE ELIGIBILITY FOR THE FAMILY PLANNING WAIVER PROGRAM (FPWP)

Providing or applying for a Social Security Number (SSN) is voluntary; however, any person who wants Wisconsin Medicaid but does not provide an SSN or apply for one will not be eligible for benefits. SSNs and personally identifiable information will be used only for the direct administration of the Medicaid Program.

**SECTION I — CLIENT INFORMATION (GENERAL)**      What language (other than English) would you like to receive information?

1. Name – Client (Last, First, MI)	Birth Date (MM/DD/YY)	Telephone Number
2. Residence Address (Street, City, State, Zip Code)		County of Residence
3. Are you currently receiving full benefit Wisconsin Medicaid or BadgerCare? (If yes, stop here.)		<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Are you a U.S. Citizen? (If No, stop here.)		<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you been determined presumptively eligible for the FPWP in the last 12 months? (If yes, stop here.)		<input type="checkbox"/> Yes <input type="checkbox"/> No

**SECTION II – INCOME INFORMATION**

6. How many family members are in the household? (See the instructions to determine who must be included.)	
7. Enter the total monthly gross earned income. This is the amount of money earned monthly before any deductions. Include spouse's income. Do not count the parents' income for a minor who is applying. NOTE: Include any self-employment expenses (use monthly average).	\$
8. Enter total monthly unearned income (VA, SSA, contributions, unemployment compensation, allowance, child support, etc.).	\$
9. Enter the total monthly gross income (add Lines 7 and 8).	\$
10. Enter monthly allowable work-related expense deduction for each employed household member.	\$
11. Enter monthly allowable dependent care expense.	\$
12. Enter any monthly amount of child support actually paid; up to amount ordered by the court.	\$
13. Enter total allowable deductions (add Lines 10, 11 and 12).	\$
14. Enter total net income (subtract Line 13 from Line 9).	\$
15. Compare the total net income (Line 14) with the federal poverty level guideline for the appropriate group size. Does the client meet the eligibility income limits?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**SECTION III — NOTICE**

16.  I certify that the above-named client, based on the preliminary information provided above, is presumptively eligible for the Wisconsin Medicaid FPWP. I have informed her of the requirement to apply by mail, telephone or in person at her county/tribal social or human services department, W-2 agency or Medicaid outstation site by the end of the second month following the current month. I have informed her of all privacy issues under the FPWP.

**OR**

I have determined that the above-named client is not presumptively eligible for the Wisconsin Medicaid FPWP for the following reason(s)

<input type="checkbox"/> She does not qualify under the age guidelines.	<input type="checkbox"/> She was determined PE for the FPWP in the past 12 months
<input type="checkbox"/> She is not a resident of Wisconsin	(can only have one PE certification for FPWP in 12-month period)
<input type="checkbox"/> She is currently eligible for Wisconsin Medicaid.	<input type="checkbox"/> She does not qualify under the income guidelines.
<input type="checkbox"/> She is not a U.S. citizen.	

Name — Qualified Provider (Type or Print)	Address — Qualified Provider	
<b>SIGNATURE</b> — Qualified Provider	Medicaid Provider Number	Date Signed

17.  I certify, under penalty of false swearing, that the information on this application and given in connection with it is a true and complete statement of facts according to my best knowledge and belief. I understand that in order to be determined eligible for Wisconsin Medicaid, I must apply online, by mail, telephone, or in person at a county/tribal social or human services agency or Medicaid outstation site. I understand that presumptive eligibility for the FPWP ends at the end of the second month following the month in which I was determined presumptively eligible for the FPWP.

**OR**

I understand that I do not meet the eligibility requirements for presumptive eligibility for the Wisconsin Medicaid FPWP. The qualified provider named above has informed me that I may still apply for Wisconsin Medicaid online, by mail, telephone, or in person at a county/tribal social or human services agency or Medicaid outstation site.

SIGNATURE — Client	Date Signed
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**SECTION IV - WISCONSIN MEDICAID PRESUMPTIVE ELIGIBILITY FOR THE FAMILY PLANNING WAIVER PROGRAM TEMPORARY IDENTIFICATION CARD**

Card Effective Dates (MM/DD/YY)	Medical Status Code	MA ID Number	Agency Code
From	PF		
Through			

<b>Client Name and Address</b>	<p><b>To the Patient</b></p> <p>This card identifies you as being eligible to receive certain family planning services through the Wisconsin Medicaid Presumptive Eligibility for the Family Planning Waiver Program. You may receive these services from <b>any certified Medicaid Provider</b>. You must present this card to your provider <b>BEFORE</b> receiving medical care, services or supplies. In order to qualify for Wisconsin Medicaid Program benefits after the expiration date of this card, you must apply at your local county/tribal social or human services agency (or other application site) immediately. If you have any questions call: <b>1-800-362-3002</b>.</p>
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**To the Provider**

The individual listed has been determined presumptively eligible for Wisconsin Medicaid in accordance with §49.465 Wis. Stats. This card entitles this individual to receive certain family planning related services including certain family planning related pharmacy services through Wisconsin Medicaid from any certified Medicaid providers for the time period specified on this card. (See card effective dates.) For additional information, see the All Provider Handbook, Recipient Eligibility or call Medicaid Provider Services at (800) 947-9627.

**NOTE:** The client may present this card prior to eligibility information being recorded on the Medicaid file. Providers should keep a photocopy of this card.

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**WISCONSIN DEPARTMENT OF HEALTH AND FAMILY SERVICES**

**WISCONSIN MEDICAID TEMPORARY  
IDENTIFICATION CARD FOR  
PRESUMPTIVE ELIGIBILITY FOR THE  
FAMILY PLANNING WAIVER PROGRAM**

