

TEMPORARY ENROLLMENT FOR BADGERCARE PLUS FAMILY PLANNING WAIVER PLAN

Providing or applying for a Social Security Number (SSN) is voluntary; however, any person who wants BadgerCare Plus but does not provide an SSN or apply for one will not be able to enroll in BadgerCare Plus. SSNs and personally identifiable information will be used only for the direct administration of the BadgerCare Plus program. Instructions on how to complete this form can be found online at: <https://www.forwardhealth.wi.gov/WIPortal/Default.aspx>.

SECTION I — APPLICANT INFORMATION (GENERAL) In what language (other than English) would you like to receive information?

| | | |
|------------------------------------------------------------------------------------------------------------------------|-----------------------|----------------------------------------------------------|
| 1. Name – Applicant (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 Plus? (If yes, go to section III.) | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Are you a U.S. Citizen? (If No, go to Section III, number 13) | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Have you been temporary enrolled in the Family Planning Waiver Plan the last 12 months? (If yes, go to section III) | | <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. Do not count the wages of anyone under 18 years of age. Do not count the parents' income for a minor who is applying on her own. See Instructions. | \$ |
| 8. Enter total monthly other income (VA, SSA, contributions, unemployment compensation, allowance, child support, etc.). | \$ |
| 9. Enter the total monthly gross income (add Lines 7 and 8). | \$ |
| 10. Enter total monthly child support expense ordered by the court. | \$ |
| 11. Enter total net monthly income (subtract Line 9 from Line 10). | \$ |
| 12. Compare the total net income (Line 11) 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

13. I certify that the above-named applicant, based on the preliminary information provided above, is able to be temporarily enrolled in the BadgerCare Plus Family Planning Waiver Plan. I have informed her of the requirement to apply by mail, telephone, online at access.wi.gov, or in person at her local county or tribal agency by the end of the second month following the current month. I have informed her of all privacy issues under the BadgerCare Plus Family Planning Waiver Plan.

OR

I have determined that the above-named applicant cannot be temporarily enrolled in the Family Planning Waiver Plan for the following reason(s)

| | |
|------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> She does not qualify under the age guidelines. | <input type="checkbox"/> She does not qualify under the income guidelines. |
| <input type="checkbox"/> She is currently enrolled in BadgerCare Plus or Medicaid. | <input type="checkbox"/> She was determined temporarily enrolled in the Family Planning Waiver Plan in the past 12 months (can only have one temporary enrollment for the Family Planning Waiver Plan in 12-month period) |
| <input type="checkbox"/> She is not a U.S. citizen. | |
| <input type="checkbox"/> She is not a resident of Wisconsin | |

| | | |
|-------------------------------------------|------------------------------|-------------|
| Name — Qualified Provider (Type or Print) | Address — Qualified Provider | |
| SIGNATURE — Qualified Provider | Medicaid Provider Number | Date Signed |

14 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 enrolled in BadgerCare Plus, I must apply online, by mail, telephone, online at access.wi.gov, or in person at my local county or tribal agency. I understand that temporary enrollment for the Family Planning Waiver Plan ends at the end of the second month following the month in which I was determined temporarily enrolled in the Family Planning Waiver Plan.

OR

I understand that I do not meet the enrollment rules for temporary enrollment in the BadgerCare Plus Family Planning Waiver Plan. The qualified provider named above has informed me that I may still apply for BadgerCare Plus online at access.wi.gov, by mail, telephone, or in person at my local county or tribal agency.

| | |
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| SIGNATURE — Applicant | Date Signed |
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SECTION IV – BADGERCARE PLUS TEMPORARY ENROLLMENT FOR THE FAMILY PLANNING WAIVER PLAN TEMPORARY IDENTIFICATION CARD

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

| | |
|-------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Client Name and Address | To the Patient |
| | This card identifies you as being able to get certain family planning services through the BadgerCare Plus Temporary Enrollment for Family Planning Waiver Plan. You may get these services from any certified BadgerCare Plus Provider . You must present this card to your provider BEFORE getting medical care, services or supplies. In order to qualify for BadgerCare Plus benefits after the expiration date of this card, you must apply with your local county or tribal agency (or other application site) immediately. If you have any questions call: 1-800-362-3002 . |

To the Provider

The individual listed has been determined temporarily enrolled in BadgerCare Plus 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 BadgerCare Plus providers for the time period specified on this card. (See card effective dates.) For additional information, contact Provider Services at (800) 947-9627 or see the online provider handbook on at <https://www.forwardhealth.wi.gov/WIPortal/Default.aspx>.

NOTE: The client may present this card prior to enrollment information being recorded on the BadgerCare Plus file. Providers should keep a photocopy of this card.

WISCONSIN DEPARTMENT OF HEALTH SERVICES

**BADGERCARE PLUS TEMPORARY
IDENTIFICATION CARD FOR
TEMPORARY ENROLLMENT FOR THE
FAMILY PLANNING WAIVER PLAN**

