

**Information
About Your Enrollment
and Benefits**

Reporting Fraud

Report public assistance fraud by calling 877-865-3432 (toll-free) or visiting reportfraud.wisconsin.gov. You may remain anonymous.

Getting This Document Translated or in Another Format

If you have a disability and need this information in a different format, need it translated to another language, or have any questions about your rights and responsibilities, contact your agency or call Member Services at 800-362-3002. All language services are free of charge.

Getting Information About the Agency That Can Help You

To get your agency's address or phone number, go to dhs.wi.gov/im-agency or call 800-362-3002.

This handbook contains information about:

- Health care programs, in accordance with Titles XI, XIX, and XXI of the Social Security Act; Parts 430 through 481 of Title 42 of the Code of Federal Regulations; Chapters 46 and 49 of the Wisconsin Statutes; and Chapters HA 3, DHS 2, 10 and 101 through 109 of the Wisconsin Administrative Code.
- The FoodShare program, pursuant to Chapter 15 of Title 44, United States Code, Federal Register Title 7 Subtitle B Chapter II Subchapter C.
- The FoodShare Employment and Training program, pursuant to Chapter 15 of Title 44, United States Code, Federal Register Title 7 Subtitle B Chapter II Subchapter C; and Chapter 49 of the Wisconsin Statutes.
- The Caretaker Supplement program, in accordance with Section 49.775 of the Wisconsin Statutes and Chapter HA 3 of the Wisconsin Administrative Code.



Enrollment and Benefits Handbook

*Your Connection to Health Care Coverage
and Nutrition Benefits*

August 2026

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Resources and Contact Information

All Applicants and Members

Use the ACCESS website (access.wi.gov) to:

- See what health, nutrition, and other support programs you may be able to get.
- Apply for BadgerCare Plus, Medicaid, Family Planning Only Services, FoodShare, Caretaker Supplement, Wisconsin Shares Child Care, Wisconsin Works (W-2), Job Access Loan, or Emergency Assistance.
- Check your benefits (for example, the health care plan you are enrolled in or the amount of your FoodShare benefits).
- Check the status of your benefits.
- Find out about premiums you may be charged and pay them online.
- Update your contact information, including address, email, or phone number.
- Report changes to your information (for example, a change in job or health care).
- Renew your benefits or see when your renewal is due for health care or FoodShare.
- Submit a FoodShare Six-Month Report form and other documents.
- Replace your lost, stolen, or damaged ForwardHealth card.
- Get an explanation of medical benefits.
- Check to see what health maintenance organization (HMO) you are enrolled in.
- Choose to get your letters online instead of by regular mail.
- Choose communication options for texts and emails.
- View your FoodShare balance and account activity.
- Request replacement FoodShare benefits if food was destroyed.

Use the MyACCESS mobile app to:

- See the programs you have applied for or are enrolled in.
- View your digital ForwardHealth or SeniorCare card.
- Get reminders of actions you need to take or documents you must submit.
- Submit and track documents electronically.
- View your FoodShare balance, scheduled deposits, transactions, and QUEST cardholder information.

- Find out about premiums you may be charged and pay them online.

To download the app, go to the App Store or Google Play Store and search for “MyACCESS Wisconsin.”

NOTE: When experiencing issues while using the ACCESS website or MyACCESS app, contact Member Services at 800-362-3002. The customer service representatives are trained to help with troubleshooting and reporting outages

Contact your local agency to:

- Ask questions about BadgerCare Plus, Medicaid, Caretaker Supplement, or FoodShare enrollment rules.
- Complete your FoodShare interview.
- Find out if your application was approved or why it was denied.
- Find out why your benefits have been reduced or ended.
- Find out about premiums you may be charged and how to pay them.
- Report changes to your information (for example, a change in address, a job, or health care).
- Send documents and verification.

To get your agency’s address and phone number, call 800-362-3002 or visit dhs.wi.gov/im-agency.

Medicaid and BadgerCare Plus Members

Call 800-362-3002 to:

- Ask questions about covered services and copays.
- Ask questions about your coverage or your HMO.
- Find a provider.
- Replace your lost, stolen, or damaged ForwardHealth card.

Katie Beckett Medicaid Members

Call 888-786-3246 to:

- Ask questions about eligibility for Katie Beckett Medicaid.

Resources and Contact Information

You can also contact a Katie Beckett eligibility specialist by:

- Email at DHSKatieBeckett@wisconsin.gov.
- By fax at 608-226-5420.

Call Member Services at 800-362-3002 to:

- Ask questions about billing or covered services for Katie Beckett Medicaid.

SeniorCare Members

Call SeniorCare Customer Service at 800-657-2038 to:

- Ask questions about the use of your SeniorCare card.
- Ask questions about your SeniorCare enrollment or level of enrollment.
- Ask questions about your out-of-pocket costs or copays.
- Ask questions about covered drugs and vaccines.
- Replace your lost, stolen, or damaged SeniorCare card.
- Report that the name on your card is wrong.

Members Needing Non-Emergency Medical Transportation

Contact Medical Transportation Management (MTM), Inc. at 866-907-1493 or 711 (TTY) to schedule or confirm a ride, find out where your ride is, and submit a complaint. You can also book and manage your trips online or through the MTM Link mobile app. Learn more at dhs.wi.gov/nemt/index.htm.

Members Enrolled in an HMO

- If you need help with HMO enrollment, contact an HMO enrollment specialist at 800-291-2002.
- If you have a complaint or problem with your HMO, contact an HMO ombudsperson at 800-760-0001.
- If you need help navigating your plan benefits, services, and requirements, contact your HMO and ask to speak with a member advocate.
- To find out which HMO you are enrolled in, call ForwardHealth Member Services at 800-362-3002.
- To compare HMOs, search for doctors and clinics, or make and update HMO choices, go to access.wi.gov.

FoodShare Members

Call QUEST Card Service at 877-415-5164 to:

- Get general information about your QUEST card.
- Report that you did not get a QUEST card.
- Report a lost, stolen, or damaged QUEST card.
- Allow out-of-state spending.
- Get your current FoodShare account balance.



Other websites or mobile apps may offer to provide your FoodShare balance and account activity. We recommend using the ebtEDGE website and mobile app or ACCESS and MyACCESS to view your FoodShare balance and account activity, as other websites or mobile apps may pose security risks.

Use the ebtEDGE website (ebtedge.com) to:

- Check your current FoodShare balance.
- View FoodShare activity.
- Allow out-of-state spending.
- Enable additional security features like blocking internet transactions.

Use the ebtEDGE mobile app to:

- View your current FoodShare balance.
- View FoodShare activity from the last 60 days, including detailed information about recent purchases.
- Allow out-of-state spending.
- Enable additional security features like blocking internet transactions.
- Find retailers near you that accept the QUEST card.

To download the app, go to the App Store or Google Play Store and search for “ebtEDGE.”

Mail or Fax Applications, Documents, Verifications, or Changes

If you live in **Milwaukee County**:

Milwaukee Document Processing Unit (MDPU)
6055 N. 64th St.
Milwaukee, WI 53218

Fax: 414-438-4580 or 888-409-1979

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

Central Document Processing Unit (CDPU)
PO Box 5234
Janesville, WI 53547-5234

Fax: 855-293-1822

NOTE: If we have your cell phone number or email address on file, DHS may use text or email messages to:

- Send important updates about your benefits
- Remind you of upcoming renewal dates
- Share critical, time-sensitive information

We will never:

- Ask for personal information, like your birthday or Social Security number.
- Ask for financial information, like your bank account or credit card number.
- Offer you a prize or money for responding.

You'll still get notices from us through the mail.
Learn more at dhs.wi.gov/dms/e-comms.htm.

Overpayments, Fraud, and Intentional Program Violations

NOTE: Everyone who is enrolled in any program listed in this handbook is responsible for following **all** program rules.

Fraud means getting benefits or assistance you know you should not get or helping someone else get benefits or assistance you know that person or their household should not get. Anyone who commits fraud to get health care or FoodShare benefits can be prosecuted. If an agency decides that a person or their household got FoodShare benefits by committing fraud, they will require the individual(s) responsible to pay back the state for those benefits, in addition to other penalties.

To report public assistance fraud at the **state** level, call 877-865-3432 (toll-free) or visit reportfraud.wisconsin.gov. You may remain anonymous.

To report fraud at the **federal** level, call 800-424-9121 or visit usda.gov/oig/hotline.htm.

FoodShare Overpayments

Overpayments occur when you receive benefits you should not have. You must repay benefits you received in error, even if it is the agency's fault and not yours. All adults or emancipated minors who applied for FoodShare together or should have been included in the application group when the overpayment occurred are responsible for repaying the overpaid benefits. If responsible members move, they are still responsible for the overpayment. Each person is responsible for 100% of the overpayment until it is fully repaid. If you cannot repay your overpayment, contact your local agency; they may be able to reduce the amount you owe to an amount you can repay in three years. An authorized representative or someone who otherwise causes an overpayment or engages in trafficking may also be held responsible for overpayments.

FoodShare Fraud

If any information you give is incorrect, you may be denied benefits and be subject to criminal prosecution for knowingly providing false information.

You and any other responsible persons must repay any benefits you misused or received in error.

If a FoodShare overpayment claim is filed against your household, the information on your application, including all Social Security numbers, may be referred to federal and state agencies, as well as private claims and collection agencies, for claims collection action. FoodShare overpayments are subject to federal debt collection requirements.

FoodShare Intentional Program Violation

Fraud or intentional program violations by a person in your household or any appointed person connected to the household may result in their disqualification from FoodShare. This means the person will not be able to get FoodShare benefits:

- For one year after the first violation.
- For two years after the second violation.
- Permanently after the third violation.

Any member of the household, or any appointed person connected to the household, who intentionally breaks any of the following rules can be barred from the FoodShare program for the time specified above:

- Trading, selling, buying, or altering FoodShare benefits, including the attempt to trade, sell, buy, or alter FoodShare benefits online and/or in person.
- Allowing another person to use your FoodShare benefits to purchase food that is not for your household.
- Returning items purchased with FoodShare benefits for cash or gift cards.
- Using FoodShare benefits to buy or trade for ineligible FoodShare items, like alcohol, tobacco, or rent.
- Using another person's FoodShare benefits, identification card, or other documentation.
- Providing false information or verification.

Some examples of fraud or an intentional program violation are below:

1. A household of one person is getting FoodShare benefits. This FoodShare member finds out they are

Overpayments, Fraud, and Intentional Program Violations

going to jail for the month, so they give their QUEST card to a friend. The friend will do the grocery shopping while the FoodShare member is in jail.

2. A FoodShare member goes to the store and buys a turkey with their FoodShare benefits. The next day, they return the turkey, say they do not have a receipt, and do not tell the store they purchased it with their QUEST card. The store issues them a gift card, and they buy alcohol with it.
3. A FoodShare member has already spent their benefits for the month. They have a friend who also gets FoodShare benefits. They offer their friend money in exchange for their FoodShare benefits. Both members agree to go grocery shopping with the friend's QUEST card.
4. A person completes an application for FoodShare benefits and must provide proof of their income from their job. The person provides the agency with false information, stating they were earning less money than they actually earned in order to get more FoodShare benefits.

Depending upon the value of misused benefits, the person who committed the fraud or program violation can also be fined up to \$250,000 and/or imprisoned for up to 20 years.

Sometimes, there are bigger penalties, even for a first-time intentional program violation:

- If you are charged criminally, a court can also bar you from the FoodShare program for an additional 18 months.
- If convicted of trafficking benefits of \$500 or more, you will never be allowed to get FoodShare again.
- If you trade FoodShare for a controlled substance like drugs or alcohol, you will not be allowed to get FoodShare for 24 months. If you do this a second time, you will never be allowed to get FoodShare again.
- If you trade FoodShare for guns, ammunition, or explosives, you will never be allowed to get FoodShare again.
- You will not be able to get benefits for 10 years if you make a false statement about your identity or where you live to get multiple benefits at the same time.
- If you are a fleeing felon or are in violation of your probation or parole, you cannot get FoodShare

benefits. You may also be subject to further prosecution under other applicable federal laws.

Health Care Fraud

You may be fined up to \$25,000 for committing fraud if you:

- Intentionally give false or incomplete information on your application for health care benefits.
- Intentionally give false or incomplete information while you are enrolled in health care coverage.
- Use another person's ForwardHealth card to get health care services or prescription drugs for yourself.
- Let someone else use your ForwardHealth card to get health care services or prescription drugs.

General Program Information

Do you have questions?

If you have a question, please read this handbook to see if your question is answered. If you cannot find the answer, contact your agency or call Member Services at 800-362-3002.

You should keep this handbook for one year or until you get a new one. You will get a new handbook once a year. If you are enrolled in more than one program (for example, BadgerCare Plus and FoodShare), you may get a copy of this handbook for each program.

Program Income and Asset Limits

Some income and asset limits are based on federal poverty level guidelines and program rules.

The limits in this handbook are based on the October 1, 2025 (FoodShare) and February 1, 2026 (health care) federal guidelines, which may change each year. For income limits, see Appendix A: Program Income Limits. You can also get the income limits online at dhs.wi.gov/forwardhealth/resources.htm or by calling Member Services at 800-362-3002. For asset limits, see each program section.

ForwardHealth

ForwardHealth is the umbrella term for all health care and nutrition assistance benefit programs offered through the Wisconsin Department of Health Services. The following ForwardHealth programs are available for those who meet the program rules.

Nutrition Assistance

FoodShare Wisconsin

(Also known as the Supplemental Nutrition Assistance Program or SNAP. Formerly food stamps.)

Help buying the food you need for good health.

Health Care

BadgerCare Plus

Health care for children, pregnant people, and adults (with or without dependent children).

BadgerCare Plus Prenatal Plan

Health care for pregnant people who cannot get BadgerCare Plus because of their immigration status or because they are incarcerated in a public institution.

Plans for People Who Are Elderly, Blind, or Disabled

Health care for people who are age 65 or older, blind, or have been determined to be disabled. People qualify for one or more of the following plans depending on their age, income, assets, and the type of care they need:

- Supplemental Security Income (SSI)-Related Medicaid
- Medicaid Purchase Plan
- Wisconsin Well Woman Medicaid
- Katie Beckett Medicaid
- Long-Term Care
 - Children's Long-Term Support Waiver Program
 - Family Care
 - Family Care Partnership
 - PACE (Program of All-Inclusive Care for the Elderly)
 - IRIS (Include, Respect, I Self-Direct)
 - Institutional Medicaid (hospital, nursing home, institutions for mental disease)

Limited Coverage Plans

The following plans provide limited coverage or financial assistance:

- Family Planning Only Services
- Emergency Services
- SeniorCare Prescription Drug Assistance
- Tuberculosis-Related Medicaid
- Medicare Savings Programs

Foster Care Medicaid

Children who are placed in out-of-home care (also known as foster care), court-ordered Kinship Care and Long-Term Kinship Care or are in an active Subsidized Guardianship or Adoption Assistance Agreement are eligible for Foster Care Medicaid. Foster Care Medicaid is a full coverage health care plan. There are no copays, premiums, or deductibles. Household income does not impact eligibility for Foster Care Medicaid.

Who can enroll?

FoodShare Wisconsin

Anyone can apply for FoodShare. You **may** be able to enroll if **all** the following are true:

- Your household income is at or below the gross monthly program limit (see Appendix A: Program Gross Income Limits).
- You live in Wisconsin.
- You are a U.S. citizen or qualifying immigrant.

BadgerCare Plus

You may be able to enroll if **all** the following are true:

- You are one of the following:
 - A child aged 18 or younger with income at or below 306% of the federal poverty level.
 - An adult with income at or below 100% of the federal poverty level.
 - A pregnant person with income at or below 306% of the federal poverty level.
 - A young adult under age 26, and you were in a foster home, court-ordered Kinship Care, or subsidized guardianship when you turned 18 years of age—regardless of your income.
- You are a Wisconsin resident.
- You are a U.S. citizen or qualifying immigrant.

If you are not a U.S. citizen or qualifying immigrant, you may be able to get help through the Emergency Services or BadgerCare Plus Prenatal plan.

BadgerCare Plus Prenatal Plan

Pregnant people who cannot get BadgerCare Plus because of immigration status or because they are incarcerated in a public institution can enroll in the BadgerCare Plus Prenatal Plan. Even though enrollment in this plan is based on pregnancy, you can get all BadgerCare Plus-covered services while enrolled.

Wisconsin Medicaid for the Elderly, Blind, or Disabled

You may be able to enroll if **all** the following are true:

- You are a Wisconsin resident.
- You are age 65 or older, blind, or disabled.
- Your income and assets are at or below the monthly program limit (see Appendix A: Program Income Limits). Some programs look at your household's income and assets, and some look only at your own

income and assets. **Note:** Children are not subject to asset requirements.

- You are a U.S. citizen or qualifying immigrant.

Wisconsin Well Woman Medicaid

Wisconsin Well Woman Medicaid is a full-benefit health care plan. People enrolled in this plan will not be enrolled in an HMO.

Enrollment is limited to people who have been diagnosed with and need treatment for breast or cervical cancer or certain precancerous conditions of the breast or cervix.

You must be enrolled in **one** of these programs before you can initially enroll in Wisconsin Well Woman Medicaid:

- Wisconsin Well Woman Program through Well Woman Program local coordinating agencies
- Family Planning Only Services
- BadgerCare Plus

You may be able to enroll in Wisconsin Well Woman Medicaid if **all** the following apply:

- You are under age 65.
- You are a U.S. citizen or qualifying immigrant.
- You are a Wisconsin resident.
- You have a diagnosis of breast or cervical cancer or a precancerous condition of the breast or cervix.
- You need treatment for breast or cervical cancer or a precancerous condition of the breast or cervix, as identified by the diagnosing provider for the Wisconsin Well Woman Program, Family Planning Only Services, or BadgerCare Plus.
- You are not covered by private or other public health insurance for treatment of your breast or cervical cancer or precancerous condition of the breast or cervix.

NOTE: Refer to the Limited Coverage Health Care Plans section for information on who can enroll in limited benefit plans.

Help From Others

Certain people and organizations can help you with your eligibility and/or benefits for programs you are applying for or are enrolled in. This includes legal guardians,

General Program Information

agents with power of attorney, conservators, patient's representatives, and authorized representatives.

Legal Guardian, Power of Attorney, Conservator, and Patient's Representative

A legal guardian of the estate, legal guardian of the person and the estate, agent with activated power of attorney for finances, conservator, or patient's representative is a person appointed to act on behalf of another person who cannot care for themselves.

A legal guardian of the estate, legal guardian of the person and the estate, agent with activated power of attorney for finances, and conservator can act on your behalf in **all** matters related to your eligibility and benefits. A patient's representative can act on your behalf in matters related to your **health care** eligibility and benefits.

A legal guardian of the person can act on your behalf in all matters related to your eligibility **only** if this power is granted in the court documents appointing the legal guardian of the person.

Your legal guardian, conservator, agent with power of attorney, or patient's representative must send copies of the documents about their appointment to your agency. Your legal guardian, conservator, agent with power of attorney, or patient's representative cannot act on your behalf until your agency has those documents.

Authorized Representative

An authorized representative is a person or an organization familiar with your household's circumstances that you trust to act on your behalf.

An authorized representative may do any or all of the following on your behalf:

- Apply for or renew benefits.
- Report changes to your information.
- Work with your agency on any matters related to your benefits.
- Provide signatures for applications, Six-Month Report forms, or renewals.
- Request a temporary QUEST card.
- File grievances and appeals about your eligibility for programs you are applying for or are enrolled in.

If you are applying for or are enrolled in a **health care program** (for example, Wisconsin Medicaid,

BadgerCare Plus, SeniorCare, or Family Planning Only Services), you can also choose to have your authorized representative do all of the following:

- Get your ForwardHealth card instead of you. (This is not relevant for SeniorCare.)
- Enroll you in an HMO. (This is not relevant for SeniorCare.)
- Talk to Member Services or your HMO about a bill, service, or other medical information, including protected health information (PHI).
- File grievances and appeals about your health care services (for example, treatment and bills).

This is **only** an option if your authorized representative is a **person**, not an organization.

You can appoint an authorized representative for Wisconsin Medicaid, BadgerCare Plus, FoodShare, SeniorCare, Family Planning Only Services, and Caretaker Supplement through:

- ACCESS when you first apply.
- One of the paper forms:
 - Appoint, Change, or Remove an Authorized Representative: Person form, F-10126A, if your authorized representative is a **person**.
 - Appoint, Change, or Remove an Authorized Representative: Organization form, F-10126B, if your authorized representative is an **organization**. You can get the paper forms at dhs.wi.gov/library/F-10126.htm.
- [HealthCare.gov](https://www.healthcare.gov); when you apply and your application is transferred to Medicaid or BadgerCare Plus.

Nutrition Assistance

FoodShare Wisconsin

How to Apply

You can apply online at access.wi.gov, by phone, mail, fax, or in person. You can get the application online at dhs.wi.gov/library/collection/F-16019 or from your agency.

When you apply, you only need to provide your **name, address, signature, and date** to set your filing date (the date your benefits can start). Your application may be approved faster if you submit documents that verify your information with your application (see Appendix D: Examples of Proof).

Send in the signed and completed application and any documents to:

If you live in **Milwaukee County**:

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

Fax: 888-409-1979

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

CDPU
PO Box 5234
Janesville, WI 53547-5234

Fax: 855-293-1822

Everyone who applies for FoodShare must have an interview. The interview will be done by phone unless you want your interview in person at your local agency. To set up an in-person interview, call your local agency and make an appointment.

You will be notified of the status of your application in writing within 30 days from the day your agency gets your application unless you qualify for priority FoodShare services.

Priority FoodShare Services

You may be able to get FoodShare within seven days of completing and submitting your application or late renewal if the agency can confirm:

- Your identity (only required for applications) **and**;
- Your household has \$100 or less available in cash or in the bank and expects to get less than \$150 of income this month, or
- Your household has rent/mortgage or utility costs more than your total gross monthly income (available in cash or in bank accounts for this month), or
- Your household includes a migrant or seasonal farm worker whose income has stopped.

If approved for priority service, you will be offered the opportunity to come into the agency to receive a ready-to-use, temporary QUEST card with your benefits on the same day you are approved or the next business day. Getting this temporary QUEST card means you will not have to wait to start spending your benefits until a permanent card arrives in the mail.

Replacing Food Destroyed in a Disaster or Misfortune

Food that is bought with FoodShare benefits can be replaced if it is destroyed in a household disaster or misfortune. The amount of benefits your agency can replace is the actual amount of food that was destroyed, but not more than the monthly amount of benefits your household got that month.

You can request food benefits replacement in ACCESS, by calling your agency, or by submitting the Request for Replacement FoodShare and/or Summer EBT Benefits form, F-00330. You can get the paper form at dhs.wi.gov/library/collection/f-00330.

You must report your loss of food within 10 days. You have an additional 10 days from the date you reported the food loss to submit a completed form or submit your full request online or by phone.

Work Requirement for Able-Bodied Adults without Dependents Ages 18 Through 64

Some adults aged 18 through 64 with no children age 13 and under living in the home may need to meet a work requirement to get more than three months of FoodShare benefits in a three-year period.

NOTE: Due to recent federal law changes, more FoodShare members must meet the work requirement to get benefits after their next application or renewal. In your interview, your local agency will look at all of your information. If the work requirement applies to you, you will get a letter telling you this and the ways you can meet the requirement.

Adults who have to meet this work requirement must do so each month. You can get FoodShare for three total months within a three-year period without meeting the work requirement or being exempt. This is called the FoodShare time limit, and these three months of FoodShare benefits are known as time-limited benefits. The current three-year period began on January 1, 2025, and will end on December 31, 2027. The FoodShare work requirement is different from the FoodShare basic work rules (see the FoodShare Basic Work Rules for Applicants and Members aged 16 to 59).

There are three ways to meet the work requirement:

1. Work at least 80 hours each month through one of the following:
 - Employment
 - Self-employment
 - Volunteering or community service
 - Getting goods or services in exchange for work
 - A combination of the above
2. Take part in an allowable work program at least 80 hours each month, such as:
 - FoodShare Employment and Training (FSET)
 - Veterans Employment Assistance
 - Certain programs under the Workforce Innovation and Opportunity Act (WIOA)
3. Both work and take part in an allowable work program for a combined total of at least 80 hours each month.

You will get information about the FoodShare Employment and Training (FSET) program if you are enrolled in FoodShare. See the FoodShare Employment and Training (FSET) Program for more information about the benefits of FSET participation.

You may be considered exempt and may not need to meet the work requirement if **any** of the following are true:

- You live with a child under the age of 18 who is part of the same FoodShare household.
- You are physically or mentally unable to work. This includes if you are getting disability benefits or are unable to work because you are experiencing homelessness for more than 30 days.
- You are pregnant.
- You are a Tribal member, Urban Indian, or California Indian.
- You are exempt from the FoodShare basic work rules. This applies if:
 - You are the primary caretaker for a dependent child under the age of 6 (whether the child lives in the home or out of the home).
 - You are the primary caretaker for a person who cannot care for themselves (whether the person lives in the home or out of the home).
 - You are receiving or have applied for unemployment insurance.
 - You are taking part in an alcohol or other drug abuse treatment or rehabilitation program.
 - You are enrolled in a school, training, program, or institution of higher learning at least half-time.
 - You are 18 or older and attend high school at least half-time.
 - You are enrolled in W-2 and complying with W-2 requirements.
 - You are working 30 or more hours per week or are earning wages equal to 30 or more hours per week at the federal minimum wage.

As a reminder, if you need to meet the FoodShare work requirement, you can only get three months of FoodShare benefits in a three-year period unless you meet the work requirement or have an exemption. If you are living on Tribal land or a reservation you don't have to meet the work requirement.

FoodShare Basic Work Rules for Applicants and Members Ages 16 Through 59

All FoodShare applicants and members ages 16 through 59 must follow the FoodShare basic work rules and register for work unless they are considered exempt. You will be registered for work at the time you are determined eligible for FoodShare unless you meet an exemption.

You meet an exemption from the basic work rules if **any** of the following are true:

- You are 16 or 17 years old and are not the primary person in the FoodShare group.
- You are 16 or 17 years old and are the primary person in the FoodShare group but are enrolled in school or an employment and training program at least half-time.
- You are found to be unfit for work. This applies if:
 - You get temporary or permanent disability benefits from the government or a private source.
 - You are found to be mentally or physically unable to work by your agency.
 - You are verified as unable to work by a statement from a health care professional or social worker.
- You are enrolled in W-2 and complying with the W-2 program requirements.
- You are the primary caretaker for a dependent child younger than age 6 (whether the child lives in your home or out of your home). However, if you and another person both have parental control of the child, only one of you can be exempt from the FoodShare basic work rules as the primary caregiver of that child.
- You are the primary caretaker for another person who cannot care for themselves (whether the person lives in your home or out of your home). However, if you and another person care for the same person, only one of you can be exempt from the FoodShare basic work rules as the primary caregiver of that person.
- You have applied for or are getting unemployment compensation.
- You are regularly taking part in an alcohol or other drug abuse (AODA) treatment or rehabilitation program.
- You are working 30 or more hours per week or earning wages equal to 30 or more hours per week at the federal minimum wage.
- You are enrolled at least half-time in a recognized school, training program, or institution of higher education.

You may need to provide proof to your agency if you meet one of these exemptions.

NOTE: Although registration for work as a part of the FoodShare basic work rules is required, taking part in a work program is voluntary.

FoodShare Basic Work Rules Sanction

If you do not comply with the FoodShare basic work rules and you do not meet an exemption, you will not be able to get FoodShare benefits for a specified sanction period. This includes if you voluntarily and without good cause do any of the following:

- Turn down a job offer that is a good fit.
- Quit a job of 30 or more hours per week (or a job with earnings equal to 30 or more hours per week at the federal minimum wage).
- Reduce your work hours to less than 30 hours per week (or your earnings to less than 30 times the federal minimum wage).
- Take part in W-2 but do not meet the W-2 program requirements.
- Apply for or get unemployment benefits but do not meet the unemployment compensation program work requirements.

If, during the sanction period, you move to another FoodShare household, the remainder of your sanction period will transfer with you to that household. The length of a sanction period is:

- First sanction: one month
- Second sanction: three months
- Third or subsequent sanction: six months

You can end a sanction period early if you become exempt from the FoodShare basic work rules.

You will need to reapply for FoodShare if you want to get benefits after the sanction period ends. If you are part of a FoodShare group, you will need to let your worker know to update your case instead of having to reapply.

FoodShare Employment and Training (FSET) Program

FSET offers FoodShare members free services to build job skills and find jobs. If you need help finding a job, need to meet the work requirement, or want to increase your skills, FSET may be able to help you.

FSET can help with:

- Job searches and job referrals
- Job skills assessment
- Career planning

- Job training and education
- Work experience
- Transportation, child care, and other work-related costs
- Referrals to other community services
- Meeting the FoodShare work requirement for able-bodied adults without dependents ages 18 through 54

Ask your agency about the FSET services available in your area. Certain adults may choose to participate in the FSET program to meet the FoodShare work requirement.

How Your FoodShare Benefits Are Calculated

FoodShare benefits are based on a sliding scale. To calculate your benefit amount, your agency will look at the number of people in your home, as well as your household income minus any income credits and other credits you are eligible for.

Household Income

Most types of income are counted. After all your household's countable income is added together to get your gross income, you will be given credit for some of the bills you pay.

Income Credits

Certain credits for shelter, dependent care, and child support are subtracted from your gross monthly income to find your net monthly income. Credits are also referred to as deductions. The FoodShare benefit amount is based on the number of people in your household and your net monthly income (see Appendix A: Program Income Limits).

Other Credits

For FoodShare, if you report and verify certain costs with your agency, you may be able to get up to six credits. Your agency will subtract these credits from your gross monthly income to get your net income. Some households may not get a credit for certain expenses, and not all credits will be the actual amount reported and verified.

Your household may get the following credits:

- **Standard Credit:** All households will get this credit, which is based on household size:

Household Size	Credit
1-3	\$209
4	\$223
5	\$261
6 or more	\$299

The Standard Credit may change by a small amount each year.

- **Employment Credit:** If you are employed, 20% of your job income or wages will be subtracted. For example, if your total gross job income each month was \$1,000, your Employment Credit would be \$200 ($\$1,000 \times 20\% = \200).
- **Medical Expense Credit:** If you are age 60 or older, blind, or disabled, you will get credit for any medical costs you pay out of pocket over \$35. For example, if you reported and verified \$100 each month in out-of-pocket medical costs, you would get credit for \$65 ($\$100 - \$35 = \65).
- **Dependent Care Credit:** If you attend training, school, or work and pay for dependent care, you may get a credit for the amount you pay for dependent care.
- **Child Support Credit:** You will get a credit for any child support you are required by the court to pay as long as you are making the payments.
- **Shelter Credit/Standard Utility Credit:**
 - Homeless Shelter Credit: You may get a homeless credit of \$199 if your household is homeless and has shelter expenses.
 - Shelter Credit: The Shelter Credit is based on your costs for your shelter, such as mortgage, property taxes and property insurance, condo fees, rent, or lot rent.
 - Standard Utility Credit
 - If you pay for heat, you will get a Heating Utility Credit of \$870.
 - If you pay for two or more of the following utilities, you will get a Limited Utility Credit of \$436:
 - Electricity
 - Phone
 - Water
 - Sewer

- Trash
- Cooking fuel
- Air conditioning surcharge
- If you only pay for one utility, you will get the utility credit listed below:

Type of Credit	Amount
Electricity and/or air conditioning surcharge	\$139
Phone	\$106
Water or Sewer	\$112
Trash	\$47
Cooking Fuel	\$34

- Maximum Shelter/Standard Utility Credit:
Group 1: Households that have a member who is age 60 or older, blind, or disabled do not have a maximum Shelter Credit limit.

Group 2: Households that do **not** have a member who is age 60 or older, blind, or disabled can only get the maximum allowed Shelter Credit of \$744.

Example of Group 2 Households: If your (adjusted) net income was \$1,000, 50% would be \$500 ($\$1,000 \times 50\% = \500). If your reported shelter cost was \$700 and you added the Heating Utility Credit (\$870), the total would be \$1,570. Your Standard Shelter Credit would be \$744, the maximum Shelter Credit allowed ($\$1,570 - \$500 = \$1,070$).

Group 3: When all household members are homeless and paying for shelter, the larger of the allowed Shelter Credit or allowed Homeless Credit of \$199 will be used.

Examples of How Income and Credits Are Calculated

The following are examples of how income and credits are calculated for FoodShare.

For the income limits and maximum allotments, see Appendix A: Program Income Limits.

Example 1: A two-person household with a person who is elderly, blind, or disabled applied for FoodShare with a reported and verified gross monthly income of \$828, monthly medical costs of \$41.91, monthly shelter costs

of \$343.78, and monthly utility costs of \$293 for non-heat electric and phone.

The household's gross income is less than the gross income limit for two people (\$3,526), so this household would pass the gross income test.

The next step would be to figure out the household's credits and subtract them from the gross income (\$828) to get the household's adjusted income:

	\$828.00	Gross income
-	\$209.00	Standard Credit
-	\$6.91	Medical costs over \$35
=	\$612.09	Adjusted income

To calculate the Shelter/Standard Utility Credit, the total shelter costs and the \$436 Standard Utility Credit would first be added together. Then, one-half of the adjusted income would be subtracted ($\$612.09 \div 2 = \306.05). The amount left would be the Maximum Shelter/Standard Utility Credit.

	\$343.78	Actual shelter cost
+	\$436.00	Utility Credit
=	\$779.78	Total shelter/utility cost
-	\$306.05	50% of adjusted income
=	\$473.73	Shelter/Utility Credit
	\$612.09	Adjusted income
-	\$473.73	Excess Shelter/Utility Credit
=	\$138.36	Net adjusted income

To calculate the amount of monthly benefits, the maximum monthly benefit amount for two people (\$546) would be compared to 30% of the net adjusted income ($\$138.36 \times 30\% = \41.51).

	\$546.00	Maximum benefits amount
-	\$41.51	30% of net adjusted income
=	\$504.49	Household's monthly benefit

The monthly benefit for this household would be \$504. The amount of benefits will always be rounded down to the nearest dollar.

Example 2: A household of one person applied for FoodShare and reported and verified monthly income of \$2,700, monthly shelter expenses of \$150, and utility expenses of \$300 for heating.

This person's gross income is less than the gross income limit for one person (\$2,610), so they would pass the gross income test.

Nutrition Assistance

The next step would be to figure out the household’s credits and subtract those credits from the gross income (\$2,700) to get the household’s net adjusted income.

	\$2,700	Gross income
-	\$209	Standard Credit
=	\$2,491	Adjusted income

To calculate the Shelter/Standard Utility Credit, the total shelter costs would first be added to the \$870 Heating Standard Utility Credit. Then, one-half of the adjusted income would be subtracted ($\$2,491 \div 2 = \$1,245.50$). The amount left would be the Maximum Shelter/Standard Utility Credit.

	\$150	Shelter costs
+	\$870	Utility costs
=	\$1020	Total shelter/utility costs

Because 50% of the adjusted net income (\$1,245.50) is more than the actual shelter and utility costs (\$1020), the person would not get a shelter credit.

	\$2,491.00	Adjusted income
-	0	Excess Shelter/Utility Credit
=	\$2,491.00	Net adjusted income
x	30%	
=	\$747.30	30% of net adjusted income

To calculate the amount of monthly benefits, the maximum monthly benefit amount for one person (\$298) would be compared to 30% of the net adjusted income.

	\$298.00	Maximum benefits amount
-	\$747.30	30% of net adjusted income
=	\$24.00	Household’s monthly benefit

Because 30% of the net adjusted income (\$747.30) is more than the maximum benefit amount (\$298) and the person passed the gross income test, they would get the minimum amount of benefits for a one- or two-person enrolled household, which is \$24.

Wisconsin QUEST Card

Your FoodShare benefits will be put into your QUEST card account using an electronic benefits transfer (EBT) system. You can spend your benefits by using your QUEST card.

Your QUEST card will be mailed to you. The card will have your name on it. You should keep your QUEST

card until you are sent a new card or your agency tells you to throw it away. You will **not** get a new card each month.



You must have your QUEST card with you every time you go to the store to buy food using your FoodShare benefits.

Your Wisconsin QUEST card is a safe and easy way to use your FoodShare benefits. The following sections will explain how your QUEST card works and when to contact QUEST Card Service.

NOTE: You can also watch an online video that gives you information about your QUEST card and how to use it. To view this video, go to dhs.wi.gov/foodshare/ebt.htm.

When You Get Your Benefits

Each month that you are enrolled in FoodShare, your benefits will automatically be added to your QUEST card. The date you get your benefits is based on the eighth digit of the primary card holder’s Social Security number (see the table).

Eighth Digit of Your Social Security Number	Day of the Month Your FoodShare Benefits Will Be Available
0	2 nd
1	3 rd
2	5 th
3	6 th
4	8 th
5	9 th
6	11 th
7	12 th
8	14 th
9	15 th

Each month, as your benefits are added to your QUEST account, your balance will go up. As you use your

benefits, your balance will go down. Your benefits will be available on the date indicated in the table, even on weekends or holidays.

Spending Your Benefits

Each month, you may use your QUEST card as often as you want to buy food for the people in your household. When you use your QUEST card, there is:

- No minimum dollar amount you need to spend.
- No fee to make a purchase.

You can leave as many benefits in your account as you wish at the end of each month to use in a future month. However, if you do not use your QUEST card for 274 days, any benefits older than 274 days will be removed from your account.

NOTE: You must have your QUEST card with you at the store to buy food with your FoodShare benefits.

You **can** use your benefits to buy foods such as:

- Breads and cereals
- Fruits and vegetables
- Meats, fish, and poultry
- Dairy products
- Snack foods
- Seeds and plants to grow food for your household to eat

You **cannot** use your benefits to buy:

- Nonfood items (pet foods, paper products, soaps, household supplies, grooming items, toothpaste, cosmetics, etc.)
- Beer, wine, liquor, cigarettes, or tobacco
- Hot foods (food purchased and served already hot at the store)
- Food for people who are not part of your household.
- Vitamins and medicines

You also cannot use your benefits to pay for deposit fees on containers, such as glass milk bottles and other returnable soft drink cans or bottles in Wisconsin. Other states may have laws that require you to pay a deposit fee. In those states, your benefits can be used to pay the fee.

If you eat at a group meal site for senior citizens or have your meals delivered to your home, you can use FoodShare benefits to pay for those meals if the site or provider is authorized to accept the QUEST card.

You can also use your benefits at any of the following places if the facility is authorized to accept the QUEST card:

- Drug and alcohol treatment center (special rules apply)
- Domestic violence shelter
- Homeless shelter
- Group home for people with disabilities

Authorized Buyers

A FoodShare authorized buyer is a person who can use your FoodShare benefits to buy food for your household.

Both you and your authorized buyer will get a QUEST card. Your authorized buyer's QUEST card will have their name on it. Your QUEST card will have your name on it.

If you choose an authorized buyer, be sure it is someone you can trust. Any account transactions your authorized buyer makes are considered authorized by the primary cardholder and benefits will not be replaced. If any FoodShare program rules were broken, you, as the primary cardholder, may be held responsible. You can appoint an authorized buyer by filling out and submitting the Add or Remove an Authorized Buyer or Alternate Payee for FoodShare Benefits form, F-16004. You can get this form online at dhs.wi.gov/library/collection/f-16004.

Account Balance

Always check your account balance before you shop. If you do not know your balance, you can do any of the following:

- Call QUEST Card Service at 877-415-5164.
- Look at your last receipt.
- Go to ebtedge.com. Click on Cardholder Login and enter your QUEST card number.
- Use the MyACCESS mobile app.
- Use the ebtEDGE mobile app.

You should get a printed receipt when you buy food with your QUEST card.

①	YOUR FOOD STORE 123 STREET ANYTOWN, WI 53701		
②	TERM ID	12345	
③	MERCH TERM ID	234565ACB	
④	SEQ#	456	
⑤	CLERK	1	
⑥	04/02/16	10:10 AM	
⑦	CARD #	XXXXXXXXXXXX3456	
⑧	POST	04/02/16	
⑨	BEG BAL	TRANS AMT	END
	\$175.00	\$42.50	\$132.50
⑩	FS PURCHASE \$42.50 APPROVED ***DO NOT DISPENSE CASH***		

The receipt will show your account balance. If you do not get a printed receipt, ask for one.

The receipt should have the following information. Some receipts may have more information than listed.

1. **Terminal Location:** This is the store information or where the swipe card machine is located.
2. **Terminal Identification Number:** This identifies the swipe card machine you used.
3. **Merchant Identification Number:** This number tells you who the merchant is or at what store you shopped.
4. **Transaction Sequence Number:** This is the number of sales made on the swipe card machine for that day.
5. **Clerk Number:** This number identifies the salesclerk who helped you at the checkout line.
6. **Transaction Date and Time:** This is the date and time of your grocery purchase.
7. **Card #:** This shows the last four digits of your QUEST card number.
8. **Posting Date:** This is the date your transaction or purchase is posted.
9. **Balance:** This is your FoodShare balance. It shows your balance before you shop, the amount of benefits you are using for this purchase, and the amount of benefits you have left on your QUEST card.
10. **Transaction Amount/Results:** This shows the amount of your transaction or purchase and if your purchase was approved.

If you buy groceries that are more than the amount in your account, tell the clerk what amount you want to subtract from your QUEST card account. You will have to pay for the rest with your own money.

Keep in mind that you cannot get cash from your QUEST card.

You can find out what your last 10 purchases or deposits were online at ebtedge.com, using the ebtEDGE or MyACCESS mobile app, or by calling QUEST Card Service at 877-415-5164. You may also ask for a written history of the purchases and deposits to your account for the past three calendar months by calling QUEST Card Service.

If you find a mistake in your account balance, call QUEST Card Service right away. When you speak with someone, make sure to ask for the name of the person you speak to and ask for a ticket number. The ticket number is a code that will help you prove that you called and reported the mistake.

If a computer problem occurs that takes away or adds benefits to your account in error, a correction may be made to your balance. The correction could affect your current or future month's balance.

You will get a letter in the mail if the correction lowers your balance. If you do not agree that the correction is right, you may ask for a fair hearing. See the Fair Hearings section for more details.

Selecting a Personal Identification Number (PIN)

When you get your QUEST card in the mail, instructions are included that tell you to select a PIN. You will need your PIN to access your benefits when using your QUEST card. The following are step-by-step instructions for selecting a PIN.

1. Select four numbers that are easy for you to remember but hard for someone else to figure out. You can't use common PINs that are easy to guess, like numbers in a row (1234), repeating numbers (2222), or a pattern (1212).
2. Have your QUEST card number, the four digits you have selected for a PIN, your date of birth, and the last four digits of your Social Security number (SSN) ready.
3. Call QUEST Card Service at 877-415-5164. If you are hearing impaired, call 711 and have the TTY operator call 877-415-5164. Then, have the operator make the entries for you.
4. Say or enter your 16-digit QUEST card number.

5. The voice menu will read several options. Pick the option to select a PIN.
6. Then say or enter for:
 - Your date of birth.
 - The last four digits of your SSN.
 - The four-digit PIN you have selected. You will be asked to enter your PIN twice.

Keep Your PIN Safe

Never give your PIN to anyone, including your agency, household members, the grocery clerk, store manager, or other store personnel. Anyone who knows your PIN will have access to your benefits, and you, as the cardholder, will be responsible for any transaction made on the card.

Benefits will not be replaced if your card is used by an authorized buyer, authorized representative, or any other person you give your QUEST card and PIN to.

If You Forget Your PIN

If you do not remember your PIN, call QUEST Card Service and choose a new PIN. If you are in the grocery store and enter the wrong PIN, you have two more chances that day to enter the right PIN. If you do not enter the right PIN by the third try, a lock will be put on your card, and you will not be able to use your card until the next day.

NOTE: Do not write your PIN on your card or on anything you keep in your wallet or purse. You should call QUEST Card Service at 877-415-5164 and select a new PIN if you think someone else knows your PIN.

Problems With Your QUEST Card

If your QUEST card does not work, call QUEST Card Service at 877-415-5164. If you still need help, contact your agency. You can find helpful information about QUEST Card Service at dhs.wi.gov/library/collection/p-03747.

If you notice an error on your account, call QUEST Card Service at 877-415-5164 to report the error. You will get a letter with a decision about the error. If you disagree with the decision, you may file for a fair hearing. Information about filing for a fair hearing will be in your letter.

Error Messages

Call QUEST Card Service if you get an error message when using your QUEST card. These are some examples of error messages and solutions:

- Card not on file.
- Insufficient balance: You have tried to spend more benefits than you have in your account. Put back some of your groceries or pay the remaining amount due with cash or another form of payment.
- Invalid PIN: You have entered the PIN incorrectly. If you enter the wrong PIN three times on the same day, a lock will be put on your card until the next day.
- Inactive card: You did not select a PIN.
- Restricted card: Card is blocked from use in the state that you are in or online. You can call QUEST Card Services at 877-415-5164 or log in to ebtEDGE.com and change your security settings.

Taking Care of Your QUEST Card

Listed below are some helpful tips for using your QUEST card. These tips may help you protect your QUEST card and reduce the need for you to get replacement cards in the future (you may get one free replacement card per calendar year, but additional replacement cards will cost \$2.70 each):

- Keep your QUEST card in a safe place.
- Take care of your QUEST card like you would a credit card.
- Do not use your QUEST card to scrape windshields, open door locks, etc.
- Keep the magnetic strip clean and free from scratches.
- Store your QUEST card in a wallet or purse.
- Keep your QUEST card away from magnets, such as those in money clips and purse clasps.
- Never tell anyone your PIN.
- Do not throw away your QUEST card.

If Your Card Is Lost or Stolen

As soon as you know you have lost your QUEST card or it has been stolen, call QUEST Card Service at 877-415-5164. Your card will be canceled when you call. If someone uses it before you call to cancel your card, your benefits will not be replaced. Once your card is reported lost or stolen, no one will be able to use your

card. A replacement card will be mailed to you on the next business day.

If any QUEST card on your account is lost or stolen, you may have to pay a \$2.70 fee to replace it. The fee will come out of your FoodShare benefits. If your account does not have funds to pay for the fee, it will be paid when benefits are added to your account. A cardholder will get one free replacement QUEST card each calendar year (January 1 to December 31).

Freezing a Card

You can call QUEST Card Service to freeze and unfreeze your card. Freezing your card allows you to stop certain transactions until the card is unfrozen. You can then search for the card if it is lost or stolen without having to worry about losing benefits before replacing the card.

When your QUEST card is frozen you cannot make a food purchase or select or change your PIN.

If Your Card Is Damaged

If your card is damaged or the store must manually key your card number each time you use your card, call QUEST Card Service and request a replacement card.

Monitoring of Excessive Replacement QUEST Cards

Wisconsin is required to monitor the number of replacement QUEST cards each FoodShare group is issued. If you get five or more replacement QUEST cards in a rolling 12-month period, the Office of the Inspector General may review your QUEST card account for possible misuse of your FoodShare benefits.

Refer to the tips in the Taking Care of Your QUEST Card to help you protect your QUEST card and reduce the need for you to get replacement cards in the future.

Using Your Card

Your FoodShare benefits will be put into your FoodShare account using an electronic benefits transfer (EBT) system. Once your benefits are in your account, you can use your QUEST card to buy food at stores and at some farmers markets that accept EBT payments.

At a Store or Farmers Market

To pay for your food, swipe your QUEST card at the swipe card terminal in the checkout line, and enter your personal identification number (PIN).

If the swipe card terminal is not working, the store or farmers market may choose to handle the purchase by using a paper form and calling QUEST Card Service.

If your store or farmers market chooses to complete a paper form, the following steps are required:

1. The clerk must fill out the paper form with the following information:
 - QUEST card number
 - Your name (or FoodShare member's name)
 - Merchant identification number
 - Type of transaction (purchase or refund)
 - Amount of purchase or refund
 - Store name and address
2. The clerk must call the QUEST merchant number for authorization. If the authorization is for a purchase, the clerk will be told if you have enough benefits in your FoodShare account to purchase your groceries.

Once the clerk gets authorization, the clerk will write in the date and time of the call, the amount authorized, and an authorization number.
3. You will be required to approve and sign the paper form. You will get a copy of the form for your records.

A hold for the purchase amount will be placed on your account to make sure the merchant can complete the transaction and get payment.

Some small stores or farmers markets may also use a paper form that you will need to sign.

In Person

Food purchased with FoodShare benefits must be received at the time of purchase. Exception: You may use FoodShare to purchase shares in a Community Supported Agriculture (CSA) up to 14 days in advance of receiving the share of food.

Outside of Wisconsin

By default, you can always use your QUEST card in Wisconsin and its bordering states: Illinois, Iowa, Michigan, and Minnesota. You can still use your FoodShare in additional states; you'll just need to change the security settings on your card to allow out-of-state spending.

There are two ways to change your card settings:

- Call QUEST Card Services at 877-415-5164.
- Log in to the ebtEDGE website (ebtedge.com) or mobile app (fisglobal.com/ebtedgemobile).

For internet purchases, the delivery address determines the state where the spending took place. It's okay if the retailer is based in a different state, but the delivery or pick-up address must be in Wisconsin or a bordering state.

When you allow out-of-state spending, it will only be allowed for the rest of that calendar month. At the end of that month, out-of-state spending will be blocked again.

Online

Many stores offer the option to order food online, choose an EBT card payment option, and swipe your QUEST card when you pick up your food. You can check with your local stores to see if they offer this option.

You can also order and pay for your food online at some stores. Visit dhs.wi.gov/foodshare/ebt.htm to see a list of stores where you can order and pay for food online. The stores will have an EBT card payment option for you to enter your card details.

You will be asked to enter your card PIN each time you check out. In some cases, you may be charged a delivery fee. You will have to use another form of payment to pay for the delivery fee. Your QUEST card can only be used to pay for the cost of your food.

Store Adjustments

A store may need to increase or decrease the amount of your QUEST card purchase to correct an error (for example, a system error). You will get a letter that explains why the adjustment is needed. If you do not agree with the adjustment, you will have 15 calendar

days from the date of the letter to file for a fair hearing. The amount of the adjustment may stay in your account until a fair hearing decision is made.

Returning a Purchase

If you need to return an item to the store, take the item, store receipt, and your QUEST card to the store where you bought the item. The store will put your benefits back into your account. You will be able to use these benefits right away. You will not get cash back.

If You Move

If you move, it is recommended that you contact your agency to report your new address. If a card is mailed to your old address, it will not be forwarded to your new address.

If you move out of state, it is recommended that you report it to your agency. You will still be able to use any benefits you have on your Wisconsin QUEST card in your new state once you change your security settings to allow out-of-state spending. If you cannot find a store in your new state that accepts the Wisconsin QUEST card, contact the Wisconsin agency that issued the FoodShare benefits. To keep getting benefits in your new state, you must apply there.

NOTE: If you get a new card in the mail, you must call QUEST Card Service at 877-415-5164 within 15 days to activate your new card. Your old card will be deactivated or closed 15 days from when your new card is issued.

Keep Your QUEST Card

Even if you stop getting FoodShare benefits, do not throw away your QUEST card. If you get FoodShare benefits again, they will be put on your last active QUEST card. Only throw away your QUEST card if you are told to do so or you are sent a new card.

FoodShare Rules and Responsibilities

If you are getting FoodShare benefits, you must comply with FoodShare program rules to keep getting benefits by:

- Reporting required changes.
 - Report when household gross monthly income goes above 130% of the federal poverty limit.

- Report when an able-bodied adult's work hours drop below 80 per month.
- Report when a household member receives a substantial lottery or gambling winning.
- Completing the Six-Month Report form if required.
- Completing a renewal.
- Providing a signature when applying, completing a Six-Month Report form, and completing a renewal.
- Answering questions completely and honestly.
- Providing the proof you are asked for.

Overpayments

Overpayments are benefits you received but should not have. You must repay benefits you received in error, even if it is the agency's fault and not yours. Authorized representatives or any appointed person connected to the household can be liable for overpayments. If federal and state law requires you to repay benefits and you do not do so, it could result in collection actions, such as:

- Federal or state tax refund interceptions: Tax refund interceptions mean that the State of Wisconsin can take any FoodShare overpayment from any tax refunds you are owed.
- Credit or lien and levy against any real property: If a lien is placed on your home, you cannot sell or trade your home until the overpayment is paid. A levy gives the State of Wisconsin the legal right to keep or sell your property as security for a debt.
- Wage assignment: Wage assignment takes any FoodShare overpayment from your job income or wages before you are paid.

Quality Control Review

The Wisconsin Department of Health Services may randomly select your FoodShare case for a quality control review. These reviews are to make sure that members are getting the right benefits. As a condition of ongoing FoodShare eligibility, members are required to cooperate with state and federal quality control reviews.

You must complete the quality control review to continue to get benefits.

Reporting Changes

If your household income goes over 130% of the gross monthly income limit for the reported household size, you must report it to your agency by the 10th of the following month.

Household Size	Gross Monthly Income Limit
1	\$1,696
2	\$2,292
3	\$2,888
4	\$3,483
5	\$4,079
6	\$4,675
7	\$5,271
8	\$5,867

For households with more than eight members, add \$596 for each additional member.

The income limits listed are based on the October 1, 2025, federal guidelines, which may change each year.

The income limits for your household size will also be listed on your latest enrollment letter.

If the work hours of a household member with time-limited FoodShare benefits drop below 80 hours per month, you must report this change to your agency by the 10th of the month following a month in which the work hours fall below 80 hours per month (see the Work Requirement for Able-Bodied Adults Ages 18 through 54 section).

If a member of your household receives a substantial lottery or gambling winning, you must report this change to your agency by the 10th of the month following the month the winning was received. The substantial winning must have been received while the member was receiving FoodShare.

A substantial winning is a single winning of \$4,500 or more before tax deductions from a single hand, ticket, game, or bet.

The substantial winning asset limit listed above is based on the October 1, 2025, federal guidelines, which may change each year.

Changes can be reported in the following ways:

- Online at access.wi.gov.
- Using the FoodShare Income Change Report, F-16066. You can get this form online at dhs.wisconsin.gov/foodshare/publications.htm or by calling your agency.
- By contacting your agency by phone, in writing, or in person.

You may need to provide proof of the changes you are reporting. If you need help getting the proof, call your agency.

FoodShare Six-Month Reporting

You may be required to complete a FoodShare Six-Month Report form to verify information on file for your household.

There are different ways to submit your FoodShare Six-Month Report form. You will get a letter telling you how. If you need help completing the form, call your agency.

You must let your agency know if any of the following information has changed:

- Address
- Change to shelter and utility costs
- The people living with you
- How much you or another person in your home must pay in court-ordered child support
- A change in employment, including hours, rate of pay, employer name, and if you are starting or have ended the employment
- Starting, stopping, or a major change to self-employment business
- If other types of income, such as unemployment or child support, have changed by more than \$125
- If someone in your home receives a substantial lottery or gambling winning of \$4,500 or more

You may need to send proof of the information you report on the form. You can send proof by mail, fax, the ACCESS website, or through the MyACCESS mobile app. Your agency will use the information on your completed form and the proof you provide to update your information. See Appendix D: Examples of Proof to learn more.

We must receive your Six-Month Report form and all required proof by the end of the month. These are needed to get your full amount of FoodShare benefits for the next month. The due date and suggested forms of proof are listed on the FoodShare Six-Month Report form.

If you don't submit the form and proof by the due date, you will not get FoodShare benefits until we get the

information. The amount of FoodShare benefits for that month will be based on when we get the information.

Your FoodShare will end if your Six-Month Report form and any required proof are more than a month late. You'll need to reapply to start getting benefits again.

NOTE: Elderly, blind, or disabled households without earned income may not need to complete a FoodShare Six-Month Report form.

Homeless and migrant households will not need to complete a Six-Month Report form but will need to complete renewals every six months.

You will get a letter explaining any change to your FoodShare benefits.

Renewals

Once enrolled in FoodShare, most households will need to complete a renewal at least once per year. Certain elderly, blind, or disabled households without earned income will need to complete a renewal once in 36 months. You will receive a letter telling you when your next renewal is due.

The renewal is to make sure you still meet all program rules and that the amount of benefits you get is correct. You will be asked many of the same questions you answered when you applied for FoodShare. If you do not complete your renewal and interview, if one is required, your benefits will end.

You will get a letter in the mail the month before your renewal is due. This letter will also tell you how you can do your renewal.

Example: If your renewal is due in April, your letter would be sent in March. This letter would also give you options on how to do your renewal online at access.wi.gov, by phone, mail, fax, or in person.

You may be asked to send proof of your answers. If you need help getting the proofs, call your agency and ask for help.

You may be required to complete an interview. You will get a letter telling you when a required interview is due by. You may choose to complete an interview even if it

is not required. The interview will be done by phone unless you prefer to have your interview at your agency.

You must complete all renewal requirements by the end of the renewal month to keep getting benefits. Renewal requirements include the renewal form, an interview if required, and all required proof. Your benefits may start from the date you complete the last required renewal requirement.

You may be able to get FoodShare within seven days of completing a late renewal. You must provide a signature when you apply for FoodShare, complete the FoodShare Six-Month Report form, and complete a renewal.

Only an adult member or an authorized representative of your household will be allowed to complete an interview and provide a signature.

Full Coverage Health Care Plans

BadgerCare Plus

How to Apply

You can apply online at access.wi.gov, by phone, mail, fax, or in person with your agency.

If you apply by mail or fax, complete the BadgerCare Plus Application Packet, F-10182. You can get the application in the following ways:

- At dhs.wi.gov/forwardhealth/apply.htm
- By calling 800-362-3002
- From your agency

To get your agency's address and phone number, go to dhs.wi.gov/im-agency or call 800-362-3002.

Your completed and signed application, along with any required proof (see Appendix D: Examples of Proof), should be sent to:

If you live in **Milwaukee County**:

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

Fax: 888-409-1979

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

CDPU
PO Box 5234
Janesville, WI 53547-5234

Fax: 855-293-1822

You will be notified in writing about your enrollment within 30 days from the day the agency gets your application.

Enrollment Date

You cannot get benefits until your agency gets your application and you have met all program rules. Usually, the earliest enrollment start date will be the first day of the month that the application is received by your agency. In most cases, you may request backdated coverage for up to three months before the month you submitted your application.

Income Rules and Limits

NOTE: If your application for BadgerCare Plus is denied, your application may be sent to the federal Health Insurance Marketplace. For more information about the Marketplace, go to HealthCare.gov or call 800-318-2596.

Monthly Income and Annual Income

Most people will have their BadgerCare Plus eligibility determined using their monthly income. This is the amount of money you and the people in your group get in a calendar month. Usually, you will need to provide proof of your group's income for the prior 30 days. If your income varies or you are self-employed, you may be asked to provide proof of several months of income to get an average monthly income amount.

People who are parents or caretakers of children under age 19 or who are adults ages 19 through 64 without dependent children may have their BadgerCare Plus eligibility determined using their annual income if their monthly income is above the monthly income limit. Annual income is the amount of income you and the people in your group expect to get in a calendar year (January 1 through December 31). If you or someone in your group may be eligible for BadgerCare Plus using annual income, your agency may ask for annual income information. Generally, you will be asked about your expected annual income for the current year, so you may have to estimate the total amount since the year is not over. If, later in the year, your income ends up being different than what you estimated, you should report the new amount to your agency at that time.

How Income Is Counted

The income of each person in your group will be reviewed. The size of your group (in other words, who is included in your group) depends on your tax filing status, tax relationships, and family relationships. Each person applying for benefits will have their own group. This means each person in your home may have a different group size, and income may be counted differently for each person in your home. Your family can still apply on the same application.

NOTE: Income limits may change each year. You can get current amounts by contacting your agency or by calling Member Services at 800-362-3002.

Who Is Included in Your Group

For BadgerCare Plus, the following rules will be used to determine who is included in your group:

Relationship Rules: If you are not planning to file taxes and you are not going to be claimed as a tax dependent of someone else this tax year, “relationship rules” will be used to determine who is included in your group. This will include the following people if they live with you:

- You
- Your spouse
- Your children and stepchildren under age 19

If you are under age 19, your group will also include the following people if they live with you:

- Your parents
- Your siblings, half-siblings, and stepsiblings, under age 19

Whenever a pregnant person is included in a group, the group size is increased by the number of babies expected to be born.

Example 1: Billy, age 40, and Sadie, age 39, live together but are not married. They have one daughter together, Courtney, age 16. They are not planning to file taxes.

Billy is not married, so his group includes himself and his daughter, for a group size of two. Sadie’s group includes herself and her daughter, for a group size of two. Courtney is under age 19, so her group includes herself and her parents, for a group size of three.

Tax Rules: If you are planning to file taxes and you are not going to be claimed as a tax dependent of someone else, “tax rules” will be used to determine who is included in your group.

Under tax rules, your group includes you, your spouse, and any tax dependents you are planning to claim, even if they are not living with you. If you have children but

you are not claiming them as tax dependents, they will not be included in your group.

Whenever a pregnant person is included in a group, the group size is increased by the number of babies expected to be born.

Example 2: George, age 42, and Lucy, age 43, are married and planning to file taxes jointly. They live with three children: Toby, age 10; Lindsay, age 8; and Sally, age 16. They plan to claim the two children they have together, Toby and Lindsay, as tax dependents. They will not claim Sally as she is claimed as a tax dependent by her mother, Ellen, who is George’s ex-wife. Even though there are five people in the home, George and Lucy’s group size is four: George and Lucy plus their two tax dependents, Toby and Lindsay.

Example 3: Miles, age 54, and Shauna, age 50, are married and plan to file taxes separately. Miles plans to claim their adult son, Dennis, who is 24 years old, living out of state, and attending college, as a tax dependent. Miles’ group includes himself, his wife, Shauna, and his tax dependent, Dennis, for a group size of three. Shauna’s group will include herself and her husband, Miles, for a group size of two. Because Shauna is filing taxes but not claiming Dennis, she cannot include him in her group.

In many cases, if you are planning to be claimed as a tax dependent of someone else, tax rules will be used to determine who is included in your group. Your group will be the same as your tax filer’s group unless **one** of the following exceptions applies:

- You are being claimed as a tax dependent by someone other than your parent.
- You live with both of your parents, but they are not filing taxes together (for example, unmarried parents or married parents who are filing separately).
- You are being claimed as a tax dependent by a parent who lives outside of your home.

If any of these exceptions apply to you, relationship rules will be used to determine who is included in your group.

Example 4: As described in example 2, George and Lucy are married and planning to file taxes jointly. They live with three children: Toby, Lindsay, and Sally. They plan to claim the two children they have together, Toby

and Lindsay, as tax dependents. They will not claim George's 16-year-old daughter, Sally, because she is claimed as a tax dependent by her mother, Ellen, George's ex-wife.

Toby and Lindsay do not meet any of the three exceptions listed. They are being claimed by their parents who are both living in the home and filing taxes together, and they are not being claimed by a parent outside of the home. Their group is the same as their tax filer's group. George and Lucy's groups have four people (George, Lucy, Toby, and Lindsay), so Toby and Lindsay's groups also have four people.

Sally does meet one of the three exceptions listed; she is being claimed by a parent (her mother, Ellen, George's ex-wife) who lives outside of the home. Relationship rules will be used for Sally. Her group will include herself, her parents (George, her father, and Lucy, her stepmother), and her half-brother and half-sister (Toby and Lindsay), for a group size of five.

NOTE: For Family Planning Only Services, you are considered a group size of one, and only your income is counted.

Once the size of your group is determined, your income is reviewed to see if you meet the rules for BadgerCare Plus and to see whose income is counted in your group.

Exceptions: Income

In most cases, all members in your group will have their income counted unless the member is a child or tax dependent of someone else in your group. A child's or tax dependent's income will not be counted if they expect to have:

- Less than \$16,100* in taxable income from a job in the current tax year **or**
- Less than \$1,350* in taxable income from a source other than a job or self-employment in the current tax year.

*This amount may change each year.

Child support, SSI, Social Security, workers compensation, and veterans benefits are not counted in the \$1,350 amount.

If the child or tax dependent expects to get more than the amounts listed in the current tax year, the child or tax dependent is required to file taxes, and their income will be counted in the group.

Example 5: As described in example 1, Billy and Sadie live together but are not married. They have one daughter together, Courtney, age 16. They are not planning to file taxes. Billy's group includes himself and his daughter, for a group size of two. Billy has \$1,500 each month from a job, and Sadie has \$600 each month in self-employment. In the month they apply for BadgerCare Plus, Courtney has a summer job that pays \$800 each month. Courtney knows she will only be working for three months, so she does not expect to earn more than \$16,100 in the current tax year and will not be required to file taxes.

Courtney is the child or tax dependent of Billy and is in his group, but she does not meet the IRS requirements for being required to file a tax return. Her income will not be counted in Billy's group. Because Sadie and Billy are not married, Sadie is not included in Billy's group, so her income will not be counted in his group. Billy's income will be the \$1,500 each month he has from his job, and his group size is two.

NOTE: If someone is a child or tax dependent but is not the child or tax dependent of a person in the same group, the income exception does not apply.

Example 6: Joanie, age 35, lives with and cares for her niece, Gillian, age 12. Joanie also claims Gillian as a tax dependent. Joanie's group is made up of herself and her tax dependent, Gillian, for a group size of two. Because Gillian meets one of the three tax rule exceptions (her tax filer is not her parent), relationship rules will be used. Gillian does not live with her parents, brothers, or sisters, so Gillian will be a group size of one. Joanie earns \$2,000 each month at her job. Gillian gets a Social Security payment of \$600 each month.

In Joanie's group, her income of \$2,000 each month is counted but not Gillian's Social Security income. This is because Gillian is in Joanie's group and is the child or tax dependent of Joanie. Because Social Security income does not count toward the \$1,350 of income from a source other than a job, Gillian is not expected to

Full Coverage Health Care Plans

be required to file taxes. Joanie's income is \$2,000 each month, for a group size of two.

For Gillian's group, her Social Security income of \$600 each month is counted. This is because she is the only person in her group. Even though she is both a child and a tax dependent, she is not the child or tax dependent of someone else in her group. Joanie's income will not be counted for Gillian because Joanie is not in Gillian's group. Gillian's income is \$600 each month, for a group size of one.

Types of Income That Are Counted

Most taxable income will be counted for BadgerCare Plus. This is true for people who are, and who are not, filing taxes.

Even though Social Security income is not usually taxable, this income type must be counted for BadgerCare Plus.

Common income types that are counted for BadgerCare Plus include the following:

- Income from a job
- Net self-employment income
- Social Security
- Unemployment compensation
- Some types of alimony or spousal support
- The taxable amount of pensions, retirement benefits, and annuities
- Tribal per-capita payments from gaming revenues

If you have self-employment income, your tax return from last year will be used to get your average monthly net income from your business. If your business has had a change in circumstances, your net monthly average will be what your business has made since the change.

The same business expenses that are allowable deductions by the IRS are allowable deductions for BadgerCare Plus. This includes depreciation and depletion. Any losses you have from self-employment will offset your other income (and that of your spouse if you are filing jointly), such as income from a job.

Example 7: Bob and Barbara are both adults over 19 years of age, married, and filing taxes jointly. Barbara earns \$1,200 each month from a job. Bob is self-employed, and this year, he has an average monthly loss of \$200 from his self-employment. Because Bob and

Barbara are filing jointly, the self-employment loss from Bob's business will offset Barbara's income. The monthly net income for Bob and Barbara will be \$1,000 each month.

	\$1,200	Barbara's income
-	\$200	Monthly loss from Bob's business
=	\$1,000	Net income

Some of the income types that are **not** counted for BadgerCare Plus include:

- Child support
- Some types of alimony or spousal support
- Income earned while providing live-in care but only in certain situations (ask your worker for details)
- SSI
- Workers compensation
- Veterans benefits
- Gifts from other people
- Some payments to Native Americans from sources other than gaming revenue

Income Deductions and Disregards

There are two types of deductions for BadgerCare Plus:

1. **Pretax Deductions:** Payments that are taken out of your paycheck before taxes are taken out are pretax deductions. These payments will be subtracted from your gross job income and will lower the amount of income counted from your job.

Allowable pretax deductions include the following:

- Health insurance premiums
- Health savings accounts (including flexible spending accounts)
- Retirement contributions
- Parking and transit costs
- Child care savings accounts
- Group life insurance

2. **Other BadgerCare Plus Tax Deductions:** Some of the following expenses can be deducted from your income for determining your BadgerCare Plus eligibility, even if you are not planning on filing taxes. Allowable tax deductions are listed on Form 1040, Schedule 1.

Most of these deductions are not common, and they do not include itemized tax deductions, such as charitable contributions or mortgage interest. Some deductions have limits. If your expense is more than

the limit, the full amount of the expense will not be deducted from your income.

Deductible expenses include:

Student Loan Interest: Interest on a loan that you took out to pay for school is tax deductible. This could be a loan to pay for school for a spouse or a tax dependent. If all your loans are interest free, such as federal subsidized loans, you cannot get the deduction.

If the loan was used for anything besides paying for education or a relative or employer gave you the loan, you cannot get the deduction.

Example: If your student loan payment is \$200 per month and part of that payment is \$50 in interest, that interest is tax deductible.

Self-Employment Tax Deduction: If you are self-employed and pay self-employment tax, you can deduct a portion of the self-employment tax that you pay.

Alimony: If you pay spousal support, alimony, or maintenance under a separation or divorce agreement completed before January 1, 2019, you may be able to get this deduction. Payments paid under a separation or divorce agreement completed on or after January 1, 2019, cannot be claimed as a deduction.

Teachers' Tax-Deductible Expenses: If you are a K-12 teacher and have up to \$300 in out-of-pocket work expenses (expenses not paid for by your employer), you can get this deduction.

Self-Employed Savings Plans: If you are self-employed and contribute to a retirement or savings plan for self-employed people and/or your employees, you can get this deduction. Examples of these plans include Simplified Employee Pension (SEP) plans, Savings Incentive Match Plan for Employees (SIMPLE), and Qualified Plan Contributions.

Penalties for Early Withdrawal of Funds: If you paid a penalty to a bank or financial institution for withdrawing funds early from a savings account where money must be left in the account for a fixed

period of time, you can get this deduction. Examples include a time savings account, certificate of deposit (CD), or annuity.

Performing Artists' Tax-Deductible Expenses: If you are a performing artist who has out-of-pocket business expenses (expenses not paid by your employer), you can get this deduction.

You can only get this deduction if you worked for at least two employers who each paid at least \$200, did not earn more than \$16,000 for your work in a year, and out-of-pocket expenses were more than 10% of your earnings.

If you are unsure whether this deduction applies to you, see IRS Form 2106 and Instructions for more information.

Military Reserve Members' Tax-Deductible Expenses: If you are a member of the Armed Forces Reserve and travel more than 100 miles away from home to perform work for the Armed Forces Reserve, you can get a deduction for your travel expenses.

If you are unsure whether you qualify, see IRS Form 2106 and Instructions for more information.

Moving Expenses for Military Members: Out-of-pocket moving expenses can be deducted if the person is an active duty member of the military who is ordered to move, and that move is a permanent change of station.

Loss From Sale of Business Property: If you are self-employed and had a loss from the sale or exchange of property that you owned for your business, you can get this deduction.

Individual Retirement Account (IRA)

Contributions: If you had income from a job and made contributions to an IRA, you can get this deduction. An IRA is a savings plan that pays a fixed, regular amount to you after you retire. You can get this deduction if you are self-employed and contribute to an IRA that you set up yourself.

Fee-Based Official Tax-Deductible Expenses: If you are a fee-based official and have out-of-pocket business expenses (expenses not paid by the

employer), you can get a deduction for those expenses.

Examples of fee-based officials include chaplains, county commissioners, judges, justices of the peace, sheriffs, constables, registers of deeds, and building inspectors.

If you are unsure whether you qualify, see IRS Form 2106 and Instructions for more information.

Domestic Production Activities Deduction: If you are self-employed and led the production of things like property, electricity, natural gas, or potable water (as long as these were produced in the United States), or if you were the inventor or creator of software, recordings, or films in the United States, you can get this deduction.

Net Operating Loss (NOL)

If you have more deductions than income for the year, you may have a net operating loss (NOL). An NOL can be deducted from income from another year or years. If you have an NOL carryover from a previous year, you may be able to get this deduction.

The IRS has a number of rules for having an NOL. Generally, an NOL is caused by a loss from operating a sole proprietorship business or rental property. The IRS also has rules that limit what can be deducted when calculating an NOL. For example, you cannot deduct capital losses in excess of capital gains. In addition, the NOL deduction cannot exceed 80% of taxable income for losses in tax years after 2017.

For more information about NOL, see the instructions for completing IRS Form 1040 and IRS Publication 536.

Other Allowable Write-In Expenses: On Form 1040, Schedule 1, there is a place for write-in tax deductions that are very uncommon. They include the following list:

- Contributions to Archer Medical Savings Accounts
- Deductions attributable to rents and royalties
- Certain deductions of life tenants and income beneficiaries of property

- Jury duty pay given to the employer because the juror was paid a salary during duty
- Reforestation expenses
- Attorney fees and court costs paid to recover a judgment or settlement for a claim of unlawful discrimination, a claim against the U.S. Government, or a claim under section 1862(b)(3)(A) of the Social Security Act
- Attorney fees relating to awards to whistleblowers
- Contributions to section 501(c)(18)(D) pension plans
- Contributions by certain chaplains to section 403(b) plans

If any of these apply to you, you can get the deduction. For more information about these, see the instructions for completing IRS Form 1040.

Income Disregards

The amount of your income equal to 5% of the federal poverty level will be disregarded in counting your income for BadgerCare Plus eligibility. Children, pregnant women, and people enrolled in Family Planning Only Services will get an additional disregard in the amount of their income equal to 1% of the federal poverty level.

For all adults, the 5% disregard is already included in the program's income limit of 100% of the federal poverty level.

For children, pregnant people, and people enrolled in Family Planning Only Services, both disregards (5% and 1%) will be applied by comparing their income to 306% of the federal poverty level (instead of 300%).

Example: Marcy is pregnant, not married, and has no children. She is expecting one baby, so her group size is two. Her income is \$5,500 each month, which is 305% of the federal poverty level. Although the income limit for pregnant people is 300% of the federal poverty level, or \$5,409.99 each month, she will still be able to enroll in BadgerCare Plus because of the income disregards.

Marcy's boyfriend, Al, has a group size of one and a monthly income of \$1,370, or 103% of the federal poverty level. As an adult, his income limit is 100% of the federal poverty level, or \$1,330, and the 5% disregard is already included in the income limit. As a

result, he is over the income limit and will not be able to enroll in BadgerCare Plus.

Most income limits for children will also apply the 6% disregard (for example, the income limit for backdated coverage—see page 71). Children will only get a 1% disregard of their income when determining if they are charged a premium.

Katie Beckett Medicaid

Katie Beckett Medicaid allows children with disabilities to receive comprehensive health care coverage through Wisconsin Medicaid. Katie Beckett covers the same services as other types of full coverage Medicaid and is one of several types of Medicaid for the Elderly, Blind, or Disabled.

Katie Beckett Medicaid helps children who:

- Have complex medical needs.
- Have long-term disabilities.
- Have mental health needs.
- Want to receive home and community-based services instead of living in a hospital or institution.

Children may qualify even if:

- They aren't eligible for other Medicaid programs because of their parents' or guardians' income or assets.
- They're covered by private health insurance.

How to apply

To apply for Katie Beckett Medicaid, families can use the ACCESS website at access.wi.gov or contact the Katie Beckett Central Office by:

- Phone at 888-786-3246.
- Email at DHSKatieBeckett@wisconsin.gov.
- Fax at 888-786-3261.

Who is eligible

To be eligible for Katie Beckett Medicaid, an applicant must be found eligible under all three of the following:

- Financial and demographic review.
- A level of care determination.
- A disability determination.

Eligibility Criteria

- Be under age 19.

- Meet the definition of disabled under the Social Security Act.
- Be a U.S. citizen or qualifying immigrant.
- Be a Wisconsin resident.
- Live at home, in a foster care setting, or in another eligible community-based setting.
- Require the kind of care typically provided by a hospital or long-term care facility.
- Receive safe and appropriate care at home.
- Not have income in their name that is more than the current income limit for those living in an institution (\$2,982 in 2026).
- Not receive care at home that costs more than the care they would receive in a long-term care facility covered by Medicaid.

Income and assets

Unlike some other types of Medicaid, only the child's income is considered. Parents do not need to report or meet income requirements. Assets are not considered for children or parents.

Fee-for-service

Katie Beckett Medicaid is fee-for-service Medicaid. Members cannot enroll in an HMO through Katie Beckett Medicaid.

Medicaid for the Elderly, Blind, or Disabled

Medicaid provides health care coverage to people who are age 65 or older, blind, or disabled. Disability and blindness determinations are made by the Disability Determination Bureau in the Department of Health Services.

How to Apply

You can apply for all plans listed below online at access.wi.gov, by phone, by mail, by fax, or in person:

- Institutional Medicaid (hospital, nursing home, institutions for mental diseases)
- Medicaid
- Medicaid Purchase Plan
- Emergency Services
- Medicare Savings Program

If you choose to apply by mail or fax, fill out the Medicaid for the Elderly, Blind, or Disabled Application Packet, F-10101. You can get the application online at

dhs.wi.gov/forwardhealth/apply.htm, by calling Member Services at 800-362-3002, or from your agency.

Send the signed and completed application, along with any required proof (see Appendix D: Examples of Proof), to:

If you live in **Milwaukee County**:

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

Fax: 888-409-1979

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

CDPU
PO Box 5234
Janesville, WI 53547-5234

Fax: 855-293-1822

To apply for long-term care services through Family Care, Family Care Partnership, IRIS, or PACE, you must contact your local aging and disability resource center (ADRC). To get the address and phone number of your ADRC, go to [FindMyADRC.org](https://www.findmyadrc.org) or call 1-844-WIS-ADRC (1-844-941-2372). If your county does not have an ADRC, contact your local social or human services department for information on requesting these services.

To apply for long-term care support services for a child under the age of 21, you should contact your county waiver agency. To get the address and phone number of your county waiver agency, go to dhs.wi.gov/clts/contact.htm.

You will get a written notice about your enrollment within 30 days from the day the agency gets your application.

Enrollment Date

You cannot get benefits until the agency gets your application and you have met all program rules.

The earliest enrollment date will usually be the first day of the month that your agency gets your completed and signed application. For most programs, you may ask for backdated coverage for up to three calendar months

before the month you submitted your application. Some programs, like Qualified Medicare Beneficiary (see page 42), Family Care, Family Care Partnership, IRIS, or PACE cannot offer backdated coverage.

NOTE: Enrollment for Qualified Medicare Beneficiary begins the first day of the month following the month you are determined eligible. You can't get benefits starting in the month that you submit your application.

Income Credits

Determining which Medicaid plan you can be enrolled in will be based in part on your countable income. Countable income is your gross income minus allowed credits. The credits subtracted from your income may vary depending on the plan.

The credit needs to meet the rules of the Medicaid plan before it can be subtracted from your income. In most cases, you must provide proof/verification of the expense to get the credit. The credits you get will determine if you are able to enroll in Medicaid and under what plan. It will also determine if you will have a cost share.

The following are credits you may be able to get and how they are calculated or what they are for.

1. **\$65 and One-Half Credit for Earned Income:**

This credit is only available to people with job income or wages. The \$65 and One-Half Credit is calculated by (1) subtracting \$65 from your monthly gross job income and wages, (2) dividing the remaining amount by two, and (3) adding back the \$65.

For example: If your monthly gross income from employment is \$500, your credit would be \$282.50.

\$500.00	\$435.00	\$217.50
- \$65.00	÷ 2	+ \$65.00
= \$435.00	= \$217.50	= \$282.50

2. **Community Waivers (Group B or B Plus) Basic Needs Credit:** As of May 1, 2026, this allowance is \$1,192.

3. **Community Waivers Personal Maintenance Credit:** This allowance is for room, board, and

personal expenses, and it consists of three components: (1) the Community Waivers Basic Needs Credit, (2) the \$65 and One-Half Credit for Earned Income, and (3) the Special Housing Credit.

	\$1,192	Community Waivers Basic Needs Credit
+		\$65 and ½ Credit for Earned Income
+		Special Housing Credit
=		Community Waivers Personal Maintenance Credit

The total of these three components cannot exceed \$2,982.

The special housing credit is the total of housing costs (listed) minus \$350.

	\$	Rent
+		Insurance (renter/homeowner)
+		Mortgage
+		Property tax
+		Utilities (heat, water, sewer, electric)
-	\$350	
=	\$	Special Housing Credit

4. **Cost Associated with Real Property Credit:** If you are residing in a nursing home and own property that is listed for sale, you can use some of your income to pay for minimal heat and electricity costs to avoid damage to the home while it is listed for sale. You may be able to get a credit for these costs.
5. **Depreciation:** If self-employed, you may be able to deduct depreciation from your self-employment income. The amount of the depreciation credit you may be able to get is the same as the amount you claim on your tax forms.
6. **Excess Self-Employment Expenses Credit:** When there is more than one self-employment business, the losses of one can be credited against the profits of another.
7. **Health Insurance Premiums Credit:** You may be able to get a credit for the cost of health insurance premiums you are obligated to pay for you or your spouse.

If you and your spouse apply but only one pays the premium, divide the premium equally. Prorate premiums over the months the payments cover.

NOTE: For Institutional Medicaid and Community Waivers Group B or B Plus, the member does not get credit for a premium deduction if they are not paying the premium.

8. **Impairment-Related Work Expenses (IRWE) Credit:** You may be able to get a credit for costs you expect to incur due to a physical or mental impairment and your employment.

The following are examples of impairment-related work expenses:

- Modified audio/visual equipment
- Typing aids
- Specialized keyboards
- Prostheses
- Reading aids
- Vehicle modification (plus installation, maintenance, and associated repair costs)
- Wheelchairs

9. **Maintaining Home/Apartment Credit:** If you are in a medical institution and you have a house or an apartment or you were residing in an assisted living facility prior to being institutionalized, you may be able to get a credit equal to the cost of maintaining the home, apartment, or room at the assisted living facility, up to \$1,191.75, if **both** of the following apply:
 - Your doctor certifies (verbally or in writing) that you are likely to return to the home, apartment, or room within six months.
 - Your spouse is not living in the home, apartment, or room.
10. **Medical/Remedial Expenses Credit:** Medical/remedial expenses are used in Institutional Medicaid and Home and Community-Based Waivers programs for cost share calculations and in Medicaid Purchase Plan for premium calculations. If over \$500 monthly, they are used in the MAPP eligibility calculation. They are also used to see if you may be able to enroll in a Medicaid deductible plan. Your care manager or an agency worker can help you in calculating your medical/remedial expenses.

Medical expenses are services or goods prescribed or provided by a licensed professional medical

practitioner. The amount of the credit is the expense for diagnosis, cure, treatment, or prevention of disease or for treatment affecting any part of the body. You will only get a credit for the costs that you are required to pay and that are not paid for by any other source, such as Medicaid, private insurance, or your employer.

Remedial expenses are costs for goods or services that are provided for the purpose of remedying, relieving, or reducing a medical condition. You will only get a credit for the costs that you are required to pay and that are not paid for by any other source, such as Medicaid, private insurance, or your employer.

11. Personal Needs Allowance for Institutional Medicaid: This credit is \$55.

12. Special Exempt Income Credit: You may be able to get a credit for the following:

- Income used for supporting others (see number 14)
- Court-ordered attorney fees
- Court-ordered guardian and guardian ad litem fees
- Legal Expenses Credit: The expense for establishing and maintaining a court-ordered guardianship or protective placement, including court-ordered attorney or guardian fees
- Expenses associated with a self-support plan (see number 15)
- Impairment-related work expenses (see number 8)

13. Standard Credit: This credit is \$20.

14. Support Payments Credit: You may be able to get a credit for support payments. These are payments that a Medicaid for the Elderly, Blind, or Disabled member makes to another person outside of the home to support and maintain that person. These payments can be either court-ordered or not court-ordered.

15. Plan to Achieve Self-Support (PASS) Credit: A member whose enrollment is based on blindness or disability may get a credit for an approved PASS.

To qualify for this credit, the member must perform in accordance with the self-support plan. The plan must:

- Be specific, current, and in writing.
- Be approved by the Social Security Administration as verified by submission of the plan and the Social Security Administration's approval letter.
- Specify the amount to be set aside and the expected cost and time required to accomplish the objective.
- Provide for identification and segregation of goods and money accumulated and conserved.

NOTE: Income and asset limits may change each year. You can get current amounts by contacting your agency or by calling Member Services at 800-362-3002.

Program Income and Asset Limits

The following sections explain how income and assets are counted for each Medicaid plan. Below are definitions of some of the terms used.

Job income and wages: Earned income that you get from a job or employment. Usually this is the gross income that you earn in the form of wages or salary. It also includes net earnings from self-employment.

Other income: Income that you get from sources other than active employment. Examples include Social Security income, annuity or trust income, alimony/maintenance payments, pension or retirement benefits, and veterans benefits.

Counted income: Your gross income minus allowed credits. Each Medicaid plan describes what credits are allowed and how each is calculated.

Income not counted: Income sources that may not be considered when comparing your income to the Medicaid income limits.

Examples of income that is not counted include:

- Department of Veterans Affairs (VA) allowances
 - Aid and attendance
 - Unusual medical expenses
- Some payments to Native Americans

Assets

Some Medicaid plans have different asset limits. The asset limits are listed in each individual plan description. You must include assets you own yourself or own jointly with another person. Do not include the value of personal household belongings (for example, televisions, furniture, and appliances).

Assets can be in the form of cash, property, or other holdings that can be converted to cash. The following are some examples of assets:

- Cash
- Savings or checking accounts
- Certificates of deposit
- Life insurance policies
- Trust funds
- Stocks and bonds
- Retirement accounts
- Interest in annuities
- U.S. savings bonds
- Property agreements, contracts for deeds, timeshares, rental property, life estates, livestock, tools, and farm machinery
- Keogh plans or other tax shelters and personal property being held for investment purposes

For a complete list of counted assets, contact your agency.

Medicaid does not count some assets. Those **not** counted may include the following:

- One vehicle
- Certain burial assets (including insurance, trust funds, and plots)
- Tribal property
- Clothing
- Other personal items

SSI-Related Medicaid

SSI-Related Medicaid is a full-benefit plan.

Asset Limit

The asset limit for SSI-Related Medicaid is \$2,000 for a single person or \$3,000 for a married couple.

Income Test

There are two steps used for calculating your income to determine whether you qualify for SSI-Related Medicaid:

1. Certain credits are subtracted from your monthly gross income to calculate the counted income. The credits included in the following equation are allowed in this income calculation.

\$	Gross income
-	\$65 and ½ Credit for Earned Income
-	Special Exempt Income Credit
-	\$20.00 Standard Medicaid Credit
=	\$ Counted income
2. Your counted income is compared to the Medicaid income limit. The income limit is based on whether you are single or married.

SSI-Related Medicaid Income Limit

The following are the SSI-Related Medicaid income limits for a single person and a married couple.

Group Size 1:	Group Size 2:
\$1,330.00	\$1,803.33

Medicaid Deductible

An individual with counted income above \$1,330.00 or a couple with counted income above \$1,803.33 can qualify for SSI-Related Medicaid by meeting a Medicaid deductible.

If your counted income is higher than the SSI-Related Medicaid income limit, your Medicaid deductible is calculated for a six-month period based on the difference between your monthly counted income and \$1,330.00 (single) or \$1,803.33 (couple).

Your deductible amount will be listed on the enrollment letter you get after your application is processed.

Calculating Your Deductible

The following equation shows how your deductible is calculated:

For each month of the six-month period, determine:

\$	Counted income
-	\$1,330.00 or Income limit for individual or
	\$1,803.33 couple
=	\$ Amount over income limit

Add together the amounts you were over the income limit in each of the six months to get the deductible amount.

You can use the cost of unpaid and recently paid bills for medical or remedial expenses to meet your deductible. You will need to provide proof of the expenses to your local agency. Once your deductible has been met, Medicaid will pay for covered services until the end of the six-month period.

Examples of medical costs include:

- Health insurance premiums.
- The portion of medical bills you must pay for yourself, your spouse, and your minor children after Medicare and private insurance have paid.

Once you have met your deductible, you will have a copay for certain Medicaid-covered services. See Appendix B: Covered Services and Copays for BadgerCare Plus and Medicaid Programs for more information about covered services.

Medicaid Purchase Plan

The Medicaid Purchase Plan (MAPP) is a full-benefit plan that provides health care coverage for people with disabilities who are working or are enrolled in the Health and Employment Counseling (HEC) Program.

Asset Limit

The total countable assets of a MAPP applicant or member cannot be more than \$15,000.

Assets owned by the applicant’s spouse do not count toward this limit. Independence Accounts (see next section) also do not count toward this limit.

Independence Accounts

MAPP members can set up one or more Independence Accounts to set aside some of their job earnings for retirement or other purposes. There are no restrictions on how the money can be used.

You can deposit up to 100% of your gross earned income into your Independence Account(s). Money you deposit while you are enrolled in MAPP does not count towards the asset limit. At renewal, if we find that you deposited more than 100% of your actual gross earnings over the past 12 months into your Independence Account(s), you will be charged a premium penalty.

Income Limit

The income limit for MAPP is 250% of the federal poverty level (see Appendix A: Program Income Limits).

Income Test

Your monthly income—and your spouse’s monthly income if you are living together—is counted for the MAPP income test.

\$	Gross earned income
-	\$65 and ½ Credit for Earned Income
-	Impairment-Related Work Expenses Credit
+	Gross other income
-	\$20 Standard Medicaid Credit
-	Special Exempt Income Credit
-	Out of pocket medical and remedial expenses if total is above \$500
=	\$ Counted income for MAPP

Your counted income is compared to the federal poverty level (see Appendix A: Program Income Limits). If your counted income is equal to or less than 250% of the federal poverty level for your group size, you may be enrolled in MAPP. In determining your group size, you, your spouse, and your minor dependent children (biological or adopted) living with you are included. Your stepchildren are not included in the group size.

Medicaid Purchase Plan Premiums and Copays

MAPP members with monthly gross income that is more than 100% federal poverty level (FPL) for a group size of one will have a premium. (see Appendix A: Program Income Limits). Your premiums are based only on your income. In addition to a monthly premium, you may also have copays (see Appendix B: Covered Services and Copays for BadgerCare Plus and Medicaid Programs).

Premiums are due by the 10th of the month. If you owe a premium but cannot pay that premium because of a difficult situation, you may ask for a temporary waiver of your premium. A temporary waiver means that you are asking to not pay your premium for a short time.

The Medicaid Purchase Plan (MAPP) Consumer Guide has more information about premiums and temporary waiver of premiums. You may get the most up-to-date Medicaid Purchase Plan (MAPP) Consumer Guide at any time at dhs.wi.gov/library/p-00181.htm.

To calculate your monthly premium amount, your agency will:

1. Determine your premium gross income by adding together your monthly gross earned income and gross unearned income.
2. Determine countable net income by subtracting the following deductions from your premium gross income:
 - Your verified monthly impairment-related work expenses (any amount)
 - Your verified monthly out-of-pocket medical/remedial expenses (any amount)
 - The current cost of living adjustment disregard from January 1 through the date the FPL is effective for that year, if applicable
3. Determine premium net income by subtracting 100% of the FPL for a group size of one from the countable net income. If this results in a negative number, it will be changed to zero.
4. Multiply the premium net income by 3% (0.03).
5. Add the \$25 base premium amount and round down to the nearest whole dollar.
6. If applicable, add the Independence Account overage amount.

The result is your monthly premium amount.

Example: Sarah, a MAPP member, has gross monthly income of \$2,200. When her allowable deductions are taken in the premium calculation, her countable net income is \$1,750. Her monthly MAPP premium will be calculated as shown below:

	\$2,200	Premium Gross Income
-	\$300	Monthly IRWE deduction
-	\$150	Monthly medical/remedial deduction
=	\$1,750	Countable Net Income
-	\$1,330.00	(100% of the FPL)
=	\$420.00	Premium Net Income
	\$420.00	Premium Net Income
x	0.03	(3%)
=	\$12.60	
+	\$25	Base Premium Amount
=	\$37.60	(round down to nearest whole dollar)

Sarah's monthly MAPP premium is \$37.

Long-Term Care Services

Some people who are age 65 or older, blind, or disabled need help doing activities of daily living and caring for their health. This help, referred to as long-term care, includes many different services, such as personal care, housekeeping, or nursing.

Long-term care is provided in people's homes, in residential care facilities or group homes, in nursing facilities, and in the workplace.

Long-term care includes any service or support that a person needs due to age, disability, or chronic illness that limits their ability to perform everyday tasks. Long-term care services go beyond the SSI-Related Medicaid-covered services and are designed to meet the special needs of older people and people with disabilities.

Long-term care services and supports include the following:

- Nursing facility services
- Personal care services
- Home health services
- Therapies
- Disposable medical supplies
- Durable medical equipment

Long-term care settings may include the following:

- People's own homes
- Nursing homes
- Residential facilities
- Community settings
- Hospitals
- Institutions for mental disease

Long-term care programs include Institutional Medicaid and Home and Community-Based Waivers, which include Children's Long-Term Support Services, Family Care, Family Care Partnership, IRIS, and PACE.

Asset Limit

The asset limit for a person applying for a long-term care plan is \$2,000. If the person applying for the long-term care plan has a spouse living in the community, the spouse will be able to keep some assets above the \$2,000 limit without affecting the long-term care applicant's enrollment. See the section on Spousal Impoverishment Protections for the asset limit when a spouse is living in the community.

Income Test

The following are the monthly income limits for the specific long-term care plans (these income limits are explained in the sections that follow):

- Community Waiver/Family Care Medicaid Level 1—monthly income limit: \$2,982
- Institutional Medicaid Level 1—monthly income limit: \$2,982

Institutional Medicaid

Institutional Medicaid provides coverage of medical services for those who reside in medical care facilities, such as skilled nursing facilities, intermediate care facilities, institutions for mental disease, and hospitals. For you to qualify for Institutional Medicaid, your assets must be lower than the asset limit. The asset limit for one person is \$2,000. The asset limit for a married couple is described in the Spousal Impoverishment Protections section.

There are two ways you may qualify for Institutional Medicaid:

1. Your monthly gross income (job income and wages and other income) is first compared with the Level 1 income limit (see Income Test section). If your monthly gross income is less than the Level 1 income limit, you may be able to enroll in Institutional Medicaid.
2. If your monthly gross income is greater than the Level 1 income limit, your monthly gross income is compared to the cost of your monthly medical needs. If your monthly gross income is less than your monthly medical needs, you may be able to enroll in Institutional Medicaid.

Medical Need

The following expenses are used when determining your medical needs for Institutional Medicaid.

\$55	Personal needs allowance
+	Private care rate of institutional care where you live*
+	Cost of health insurance
+	Special Exempt Income Credit
+	Other medical costs
= \$	Medical need

*This is the actual cost of the institutional care.

Institutional Medicaid Patient Liability Calculation

There may be a monthly cost for someone enrolled in Institutional Medicaid.

Depending on your income and marital status, you may have to pay toward your cost of care. This is called your patient liability. Medicaid will pay for the rest of the Medicaid-covered services.

Your patient liability calculation will differ depending on your marital status and whether you have dependents living with your spouse.

The Institutional Medicaid patient liability is calculated as follows:

\$	Gross income
-	\$65 and ½ Credit for Earned Income
-	Cost of the institutionalized person's health insurance premium
-	Special Exempt Income Credit
- \$55	Personal needs allowance
-	Maintaining Home/Apartment Credit
-	Income allocation to a community spouse or dependents
-	Medical Remedial Expense Credit
= \$	Cost share

Home and Community-Based Waivers for Adults

These plans are called Family Care, Family Care Partnership, PACE, and IRIS. They enable people who are age 65 or older, blind, or disabled to live in community settings rather than in state institutions or nursing homes. They pay for community services that normally are not covered by Medicaid. To get long-term care services through these programs, you must:

- Meet level-of-care requirements as determined by the ADRC, your care manager, or the IRIS consultant agency.
- Meet all program rules.
- Reside in a setting allowed by Home and Community-Based Waivers policies.
- Have a disability determination if you are under the age of 65 and not enrolled in another form of full-benefit Medicaid or BadgerCare Plus.
- Contribute toward the cost of your waiver services if required.
- Have assets at or below the applicable asset limit.

Family Care

Family Care provides long-term care services for people who are age 65 or older, blind, or disabled. The Family Care income rules are the same as the income rules for Home and Community-Based Waivers. Family Care also provides long-term care services for people who do not need nursing home level of care but need help to accomplish activities of daily living and caring for their health if **both** of the following apply:

- The member meets the program rules for any full-benefit health care plan, such as BadgerCare Plus or Medicaid.
- Long-term care services are requested.

Family Care Partnership

Family Care Partnership is a full-benefit plan that covers health care and long-term support services for people who are age 65 or older, blind, or disabled. Services are provided in the member’s home or in a setting of their choice.

Family Care Partnership covers services like those under Family Care, plus acute and primary care services.

~~The~~ Family Care Partnership is not yet available in all counties.

Long-term Care Support Services for Children

The Children's Long-Term Support (CLTS) Waiver Program is a Home and Community-Based Waiver program that provides support to children and youth who live at home or in the community and have substantial limitations in multiple daily activities as a result of one or more of the following:

- Intellectual and/or developmental disabilities
- Severe emotional disturbances
- Physical disabilities

To participate in the CLTS Waiver Program, your child must:

- Be under 22 years of age.
- Be eligible for Wisconsin Medicaid.
- Live at home, in a foster care setting, or in another community-based setting.
- Be screened for eligibility based on the level of care they need.
- Be able to get safe and appropriate care at home and/or in the community.

NOTE: CLTS does not have an asset limit.

The three different Home and Community-Based Waivers groups are Group A, Group B, and Group B Plus. You cannot be in more than one group at the same time. You may have a cost share that must be paid each month to keep getting Home and Community-Based Waivers benefits. Your decision letter will let you know if you have a cost share and how much it is. In addition to a cost share, certain services you get will require a copay.

Group A Waivers

Members enrolled in Group A must meet all Home and Community-Based Waivers functional eligibility rules, as well as the income/asset and all other rules for BadgerCare Plus, Medicaid, or the Medicaid Purchase Plan. No additional financial test is required.

As a Group A member, you are not required to pay a monthly cost share, but you still must pay any monthly amount associated with the BadgerCare Plus, Medicaid, or Medicaid Purchase Plan.

Group B Waivers

Members enrolled in Group B must meet all Home and Community-Based Waivers functional eligibility rules and have monthly gross income less than the Community Waiver/Family Care Medicaid Level 1 income limit.

If you are a Group B member, you may have to pay a cost share. The Group B cost share is based on your income and allowable credits. The Group B cost share is calculated as follows:

	\$	Monthly gross income
-		Community Waivers Personal Maintenance Credit
-		Family maintenance allowance
-		Special Exempt Income Credit
-		Health Insurance Premiums Credit
-		Medical Remedial Expenses Credit
=	\$	Cost share

Group B Plus Waivers

If your monthly gross income is greater than the Level 1 income limit, which is \$2,982, you may be able to enroll in Group B Plus Waivers if you:

- Meet all Home and Community-Based Waivers functional eligibility rules **and**
- Have counted income that is less than your medical needs.

Most Group B Plus members will have to pay a cost share. The Group B Plus cost share is based on your income and allowable credits. The Group B Plus cost share is calculated the same as the Group B cost share.

Spousal Impoverishment Protections

Special financial protections are allowed for the spouse and dependents of a long-term care member to keep assets and income that are above Medicaid financial limits.

Spousal Impoverishment Asset Limit

For long-term care cases where one spouse is still living in the community, special asset protection rules apply at the time of application.

Asset Assessment

An asset assessment is done by your agency to establish the asset limit for your Medicaid long-term care (Institutional Medicaid, Home and Community-Based Waivers, or Family Care) application.

During the asset assessment, you will be required to provide proof of assets that you and your spouse owned on the date of the first continuous period of institutionalization that lasted 30 days or longer, or on the date you were first determined functionally eligible for Family Care, Family Care Partnership, IRIS, or PACE, whichever occurs earlier.

Based on the proof you provide, your agency will determine the total countable assets of the couple and the community spouse asset share.

The asset limit for an applicant is \$2,000 plus the community spouse asset share. The community spouse asset share is the amount of countable assets above \$2,000 that the community spouse or the institutionalized person, or both, can have at the time the institutionalized person wants to enroll in Medicaid long-term care.

Once the spouse in the institution is enrolled, the assets of the community spouse are considered unavailable to the institutionalized spouse.

The following are details of how the community asset share and asset limit are determined:

- If the total countable assets of the couple are \$325,320 or more, then the community spouse asset share is \$162,660; the Medicaid long-term care asset limit at the time of application in long-term care is \$164,660 (\$162,660 + \$2,000).
- If the total countable assets of the couple are less than \$325,320 but greater than \$100,000, then the community spouse asset share is half of the total countable assets; the Medicaid long-term care asset limit is half of the total countable assets plus \$2,000.
- If the total countable assets of the couple are \$100,000 or less, then the community spouse asset share is \$50,000; the Medicaid long-term care asset limit is \$52,000 (\$50,000 + \$2,000).

The institutional spouse cannot be enrolled in Medicaid long-term care as long as the total assets of the community spouse and institutionalized spouse are above the combined asset limit of \$2,000 plus the community spouse asset share.

Excess assets (assets that are above the asset limit) can be reduced to allowable limits if they are used to pay for nursing home or home care costs, as well as other expenses, such as home repairs or improvements, vehicle repair or replacement, clothing, or other household expenses.

Spousal Impoverishment Calculation

The long-term care income limit is the same whether the institutionalized person has a spouse or any dependent relatives in the community. However, for an institutionalized person who does have a spouse in the community, the person applying for or enrolled in the long-term care program is allowed to give some income back to the community spouse and any dependent relatives living with the community spouse. This is referred to as an income allocation.

Community Spouse Income Allocation

The community spouse income allocation is calculated by subtracting the gross income of the community spouse from the maximum community spouse income allocation.

Full Coverage Health Care Plans

\$	Maximum community spouse allocation
-	Gross income of community spouse
=	Community spouse income allocation

The maximum community spouse income allocation is the lesser of the following:

- \$4,066.50 (as of January 1, 2026)
- \$3,606.66 (as of July 1, 2026) plus an excess shelter allowance (see below)

These amounts may be updated each year.

Community Spouse Excess Shelter Allowance

As of July 1, 2026, the community spouse excess shelter allowance is any shelter expense over the shelter base amount of \$1,082.00. This amount may be updated each year.

Excess Shelter Allowance

\$	Rent
+	Mortgage (principal and interest)
+	Property taxes
+	Homeowners or renters insurance
+	Condominium fee
+	Standard utility amount
=	\$ Total shelter expense
-	\$1,082.00 Shelter base amount
=	\$ Excess shelter allowance

Dependent Family Member Income Allocation

The dependent family member income allocation is calculated by subtracting the dependent family member's income from the dependent family member income allocation standard (\$2,705.00 as of July 1, 2026) and dividing the result by three.

\$2,705.00	Dependent family member income allocation standard
-	Dependent family member's income
=	\$
/	3
=	\$ Dependent family member income allocation

Family Maintenance Allowance

The family maintenance allowance is for the support of the long-term care recipient's minor children when spousal impoverishment protections do not apply.

When an Institutional Medicaid or Group B or B+ Waivers member is the parent of one or more children under the age of 18 and there is no community spouse,

the family maintenance allowance is calculated using the following steps:

1. Add together the gross monthly income of all of the member's minor children who are not living with a community spouse.
2. Compare the children's gross income with 100% of the federal poverty level (FPL) for a family size equal to the number of minor children not living with a community spouse.
3. The amount of the family maintenance allowance is the difference between the children's total gross income and the applicable FPL amount. If the children's gross income is more than the applicable FPL standard, no family maintenance allowance is deducted.

SSI Payment Level Plus the E Supplement for One Person

This amount is \$1,191.75 as of May 1, 2026.

If the spouse's adjusted income is greater than the SSI payment level plus the E (exceptional expense) supplement for one person, there is no family maintenance allowance.

If the spouse's adjusted income is less than the SSI payment level plus the E supplement for one person, the family maintenance allowance is calculated as follows:

\$1,191.75	SSI payment level plus the E supplement for one person
-	Spouse's adjusted income
=	\$ Family maintenance allowance

Divestment

Divestment means to give away resources, such as income, non-exempt assets, and property, for less than fair market value. Divestment can include giving gifts of cash or trips or establishing trusts for family members, whether they are adults or children. Fair market value is an estimate of the price an asset could have been sold for on the open market at the time it was given away or sold below value. Divestment is also an action taken to avoid receiving income or assets that you are entitled to get.

Divesting financial resources within 60 months before your application for Medicaid long-term care services, or after you are enrolled, may result in a divestment penalty period.

Transfer of non-exempt assets or homestead property for less than fair market value by the community spouse within the first five years after the Medicaid member is found eligible is also considered divestment and will result in a divestment penalty for the Medicaid member.

Medicaid will not pay for long-term care benefits through Institutional Medicaid, Family Care, Family Care Partnership, PACE, or IRIS plans during a divestment penalty period. The divestment penalty period is calculated as follows:

\$

÷

=

Divestment amount

Average nursing home daily rate

(\$352.06 as of January 1, 2026)

Length of the divestment penalty period

(in days)

Estate Recovery Program

The Wisconsin Estate Recovery Program gets back money paid by Medicaid or BadgerCare Plus for certain long-term care services, after a member has died. This is called recovery. Recovery is made from the estates of members after they die, the estates of their surviving spouses, certain non-probate property (property not given out by a deceased person’s will), and liens placed on their homes.

The funds recovered are returned to the programs they came from and used to pay for care for other members. For more information on the Estate Recovery Program:

- Read the Estate Recovery Program Handbook at dhs.wi.gov/library/P-13032.htm.
- Go to dhs.wi.gov/medicaid/erp.htm.
- Contact your local agency; to find your local agency visit dhs.wi.gov/im-agency.
- Call Member Services at 800-362-3002 (voice) or 711 (TTY).
- Write to:

Department of Health Services
Estate Recovery Program
P.O. Box 309
Madison, WI 53701-0309

ForwardHealth Card

Each person enrolled in BadgerCare Plus or Medicaid will get a ForwardHealth card. You should keep your ForwardHealth card unless you are sent a new card or your agency tells you to throw it away. You will **not** get a new card each time you enroll in benefits unless you ask for a new one.



You can also view your digital ForwardHealth card on the MyACCESS mobile app or download and print a PDF version of your ForwardHealth card. The digital card can be used the same way as the physical card.

You may need to show your digital, paper, or physical ForwardHealth card and identification at each health care provider visit. Your health care providers may include a primary care doctor, mental health provider, specialty doctor, personal care provider, home health care provider, clinic, pharmacy, or hospital.

Your ForwardHealth card does not show the dates that you are enrolled. You will get an enrollment letter in the mail from your agency with your dates of enrollment.

If there is an emergency and you do not have your card with you when you get services, give your ForwardHealth card number to all those who provided services as soon as possible.

Limited Coverage Health Care Plans

Family Planning Only Services

Certain individuals with an income at or below \$4,069.80* per month may be able to get Family Planning Only Services.

*Effective February 1, 2026. This amount may change each year.

See the How Income is Counted section on page 23 to see how income is counted for Family Planning Only Services.

You can apply online at access.wi.gov or by calling your agency.

To be eligible for the Family Planning Only Services Program, you must:

- Be a U.S. citizen or have a qualifying immigration status.
- Be of childbearing or reproductive age.
- Have monthly income at or below 300% of the federal poverty level. (Only your own income is counted; your assets are not counted.)
- Not be enrolled in BadgerCare Plus or Medicaid. (You can be enrolled in private health insurance while you are enrolled in the Family Planning Only Services Program.)

NOTE: The amount of your income equal to 6% of the federal poverty level will be disregarded. See the Income Disregards section on page 28 for more information.

NOTE: The following covered services could change. Ask your provider to see if the service you need is covered.

Through an initial or routine family planning-related office visit, the following services may be covered:

- Contraceptive services and supplies (birth control supplies such as birth control pills, condoms, and intrauterine devices). Over-the-counter oral contraceptives are covered with no prescription needed. You must have a prescription from a doctor, nurse practitioner, physician assistant, or nurse

midwife for other contraceptive services and supplies

- Natural family planning supplies
- Pap tests
- Routine preventative primary services that are family planning-related
- Tests and treatment for sexually transmitted diseases/infections like chlamydia, herpes, gonorrhea, and syphilis, as well as certain other lab tests
- Vaccinations for sexually transmitted infections (HPV, Hepatitis A and B, Mpox)
- Voluntary sterilizations for people 21 years old or older

NOTE: Only certain services are covered under the Family Planning Only Services Program. Services **not** covered include, but are not limited to, the following:

- Hysterectomies
 - Inpatient hospital services
 - Mammograms
 - Vaccinations, other than those for sexually transmitted infections
 - Other services provided during a family planning-related visit that are not family planning-related
-

You should tell your health care provider you have this plan before you get services. Your provider must tell you if a service is not covered.

If a service is not covered and you still want and get the service, you will have to pay for it. You may also call the number on the back of your ForwardHealth card and ask if a service is covered.

This is a limited benefit plan. You may be able to enroll in the BadgerCare Plus plan, which is a full-benefit plan. See the BadgerCare Plus section on page 24 for information on applying for BadgerCare Plus.

Federal law allows members to choose their provider, including physicians and family planning clinics, for family planning services and supplies. This means you can also go to any family planning clinic that will accept

your ForwardHealth card, even if the clinic is not part of your HMO.

If you want more information or have questions, go to dhs.wi.gov/fpos/index.htm or call Member Services at 800-362-3002.

Medicare Savings Program

Wisconsin Medicaid may be able to help pay for certain Medicare costs if you request and qualify for the Medicare Savings Program (also called Premium Assistance).

This program is for those who are eligible to take part in Medicare and who have low income and limited assets. The asset limits for the Medicare Savings Program, with an exception for Qualified Disabled Working Individuals, are:

Group Size	Asset Limit
1	\$9,950
2	\$14,910

Not all of your income and assets will be counted when determining if you are able to enroll in the Medicare Savings Program. Income and asset limits may change each year. For current amounts, go to dhs.wi.gov/forwardhealth/resources.htm or call Member Services at 800-362-3002.

Qualified Medicare Beneficiary (QMB)

Medicaid will pay any Medicare Part A and B premiums, Medicare coinsurance, and Medicare deductibles if **all** of the following are true:

- You are entitled to Medicare Part A or Part B Immunosuppressive Drug (B-ID) benefits.
- You have assets at or below the program limit.
- You have monthly income at or below 100% of the federal poverty level after subtracting certain credits.

Specified Low-Income Medicare Beneficiary

Medicaid will pay Medicare Part B or Part B-ID premiums if **all** of the following are true:

- You are currently getting Medicare Part A or Part B-ID benefits.
- You have assets at or below the program limit.
- You have monthly income between 100% and 120% of the federal poverty level after subtracting certain credits.

Specified Low-Income Medicare Beneficiary Plus

Medicaid will pay your Medicare Part B or Part B-ID premiums if **all** of the following are true:

- You are currently getting Medicare Part A or Part B-ID.
- You have assets at or below the program limit.
- You are not enrolled in Medicaid.
- You have monthly income between 120% and 135% of the federal poverty level after subtracting certain credits.

NOTE: You cannot be enrolled in both Specified Low-Income Medicare Beneficiary Plus and a Medicaid full coverage health plan. If you need help choosing which is the better option for you, contact your local Aging and Disability Resource Center (ADRC). To find your ADRC, go to FindMyADRC.org or call 1-844-WIS-ADRC (1-844-941-2372).

Qualified Disabled and Working Individual

The asset limits for qualified disabled and working individuals are:

Group Size	Asset Limit
1	\$4,000
2	\$6,000

Medicaid will pay for Part A premiums if **all** of the following are true:

- You have a disability.
- You are employed.
- You are entitled to Medicare Part A.
- You have assets at or below the program limit.
- You have monthly income at or below 200% of the federal poverty level after subtracting certain credits.
- You are not enrolled in Medicaid.

When Your Payments Will Begin

If you are enrolled in any of the Medicare Savings Program plans, it will take at least two months for payments to begin. This is the time that is needed for payments to be adjusted by Wisconsin Medicaid, Medicare, and the Social Security Administration.

Limited Coverage Health Care Plans

When Medicaid starts paying your Medicare premiums, your Social Security check will increase. If payments do not begin right away, you may get a refund from the Social Security Administration.

Medicare Savings Program Calculations

Your counted income for the Medicare Savings Program is calculated as follows:

\$	Earned income
-	\$65 and ½ Credit for Earned Income
+	Other income
-	Special Exempt Income Credit
-	Standard Medicaid Credit
=	Counted income

SeniorCare Prescription Drug Assistance Program

SeniorCare helps Wisconsin seniors with vaccines and their prescription drug costs. To enroll in SeniorCare, you must:

- Be a Wisconsin resident.
- Be a U.S. citizen or have qualifying immigrant status.
- Be 65 years of age or older.
- Pay a \$30 annual enrollment fee per person.
- Not be enrolled in a full-benefit Medicaid program.

Only certain income is counted for SeniorCare. Assets such as bank accounts, insurance policies, and home property, are not counted.

Coverage Levels

SeniorCare members are subject to certain annual out-of-pocket expenses and/or copays depending on their annual income. Drug coverage may vary by level of enrollment.

There are four levels of enrollment for SeniorCare based on income limits (as of February 1, 2026):

- **Level 1:** For those with annual income at or below \$25,536 (individual) or \$34,624 (couple).
- **Level 2a:** For those with annual income of \$25,537 to \$31,920 (individual) or \$34,625 to \$43,280 (couple).
- **Level 2b:** For those with annual income of \$31,921 to \$38,304 (individual) or \$43,281 to \$51,936 (couple).

- **Level 3:** For those with annual income of \$38,305 or higher (individual) or \$51,937 or higher (couple).

NOTE: There is no asset limit for the SeniorCare program.

You can apply for SeniorCare by completing the SeniorCare Application, F-10076. To get an application or more information about SeniorCare, contact SeniorCare Customer Service at 800-657-2038 or go to dhs.wi.gov/seniorcare/index.htm.

SeniorCare Card

Everyone who is enrolled in SeniorCare will get a SeniorCare card. If this is the first time you are getting SeniorCare benefits, your SeniorCare card should arrive in the mail 10 days after you have been enrolled.



You can view your digital SeniorCare card on the MyACCESS mobile app or download and print a PDF copy of your card. The digital SeniorCare card can be used instead of your physical card at any time. You can also show the paper version of your SeniorCare card instead of the physical or digital card. You may need to show your digital, paper, or physical SeniorCare card and an ID at each pharmacy visit.

If you have questions about your card, contact SeniorCare Customer Service at 800-657-2038.

Tuberculosis-Related Medicaid

Tuberculosis-Related Medicaid helps pay some medical costs for the care of tuberculosis (TB) infection or disease.

To get this benefit, you must meet income and asset rules and have been infected with TB. For one person, the gross monthly income limit is \$2,073.* For a married couple, the gross monthly income limit is

Limited Coverage Health Care Plans

\$3,067.* (See the Income Rules and Limits starting on page 23.)

*Effective January 1, 2026. These amounts may change each year.

Tuberculosis-Related Medicaid only covers services directly related to the care of TB. These include:

- Physician services
- Prescription drugs
- Laboratory tests and x-rays
- Clinic services
- Targeted case management services
- Services designed to encourage completion of treatment
- Services needed due to side effects of prescribed drugs for TB care

NOTE: Tuberculosis-Related Medicaid does not pay for hospital stays or room and board.

Emergency Services Plan

The Emergency Services Plan provides short-term coverage for some people who have an emergency medical condition and meet all program rules except for their immigration status. If you are age 19 through 64, you cannot enroll in the Emergency Services Plan unless you have a disability, are pregnant, or are living with and caring for a child under age 19 who is related to you.

A medical emergency is a problem that could put your health at risk if you do not get medical care right away.

The Emergency Services Plan will only pay for health care you get for an emergency medical condition.

NOTE: The Emergency Services Plan does not guarantee that the care you get will be covered. You will have to pay the cost of health care you get if it is not considered an emergency.

Important Information for All Health Care Plans

Deductible Plans

You may be able to enroll in a deductible plan if you are one of the following:

- A pregnant person with income over 306% of the federal poverty level
- A child under 19 years of age with income over 306% of the federal poverty level
- A child under 19 years of age with income over 156% of the federal poverty level and coverage under employer-sponsored health insurance where the employer pays 80% or more of the premium
- A person who is age 65 or older, blind, or disabled with household income over 100% of the federal poverty level

For children, the deductible is the difference between the family's income and 150% of the federal poverty level over a six-month period. For pregnant people who are not applying for the BadgerCare Plus Prenatal Plan, the deductible is the difference between the family's income and 300% of the federal poverty level over a six-month period.

For the purpose of determining a deductible, family income includes the income of the individual, spouse (if married), and parents (if younger than 19). The income of siblings, tax dependents, and other family members is not included.

Calculating Your Deductible

The following equation shows how a deductible is calculated for a child in a family of three:

For each month of the six-month period, determine:

\$	Counted income
- \$ 3,415.01	Monthly income limit for 3 persons
= \$	Amount over income limit

Add together the amounts you were over the income limit in each of the six months to get the deductible amount.

You can use the cost of unpaid and recently paid bills for medical or remedial expenses to meet your deductible. You will need to provide proof of the

expenses to your local agency. Once your deductible has been met, Medicaid will pay for covered services until the end of the six-month period. You may also prepay all or part of the deductible amount to your local agency.

If you pay the full amount of the deductible, you will be eligible for Medicaid for the entire six-month period.

Examples of medical costs include:

- Health insurance premiums, including Medicare.
- The portion of medical bills you must pay for yourself, your spouse, and your minor children after Medicare and private insurance have paid.

When the pregnant person or the child and their parents have medical expenses that add up to the deductible amount, the child or pregnant person will be enrolled in BadgerCare Plus and will not have any premiums or copayments. Medical expenses of siblings may not be used for a child's deductible.

Limits for Emergency Services

All health care plans have limits on when you can use emergency room and ambulance services. These services can only be used in an emergency situation.

Emergencies are situations that require medical attention right away to prevent death or serious damage to your health. Non-emergencies are illnesses, injuries, or medical needs that are usually taken care of at a doctor's office.

Examples of non-emergencies include the following:

- Needing a prescription refilled
- A minor cut or burn
- A skin rash
- A sprain or strain
- Back pain
- A toothache
- Cold or flu symptoms
- A common headache
- Needing a checkup
- Needing a pregnancy test, medical test, or other lab test
- Having an ongoing condition that has not suddenly changed or worsened

Use of the emergency room or ambulance rides because it is easier for you to use these services will not be covered. To avoid using emergency rooms and ambulance services:

- Have a regular doctor.
- Keep your appointments.
- Call your doctor or nurse helpline about your medical needs if one is available to you.

Prior Authorization for Services

Some services must be approved before you can get them. This is called prior authorization.

Your provider asks for the approval for these services from ForwardHealth. If your provider does not get the services approved, ForwardHealth will not pay for the services. The provider will then be responsible for the cost of care provided. If you choose to get a service after you know the approval was denied, the provider can bill you for the service.

If You Get a Bill

ForwardHealth pays your provider for covered services. A provider should not ask you, your family, or others to pay anything other than a copay for covered services. If you get something that looks like a bill, contact the provider who is billing you. Providers know the ForwardHealth coverage limits. The provider must tell you if ForwardHealth does not cover a service before the service is provided.

Enrollment in a BadgerCare Plus or Medicaid HMO

One of the many benefits of enrolling in BadgerCare Plus or Medicaid is that you and your family will also be enrolled in an HMO.

An HMO has a network of doctors, hospitals, and clinics that can work together to help you manage your health care.

Enrolling in an HMO

Most BadgerCare Plus or SSI Medicaid members are required to enroll in HMO. Some members are not required to join an HMO but can choose to join one. Other members cannot join an HMO. If you are required to enroll in an HMO, or if you have choice, you will get an HMO Enrollment packet in the mail with information

about your HMO options and information about how to choose an HMO. BadgerCare Plus or SSI Medicaid members can use the ACCESS website at access.wi.gov to search for doctors and clinics, compare HMOs in their area, and choose an HMO. Members can also update their HMO choices using the ACCESS website.

After enrolling in an HMO, you will get all your health care from providers who are contracted with your HMO. Your HMO will send you a member packet that lists the doctors, hospitals, and clinics you can use. It will also explain the services your HMO provides.

You may only get care from providers outside your HMO if:

- It is an emergency.
- Your HMO says you may see another doctor.
- The service is a Medicaid-covered service but is not covered by your HMO (for example, dental or chiropractic services).

You are responsible for paying the cost of any services that are not provided by your HMO or a BadgerCare Plus/Medicaid provider.

If you do not choose an HMO and are required to enroll in an HMO, one will be chosen for you. After enrolling in an HMO, you have 90 days to change your HMO if you do not like the one that was chosen for you.

Benefits of an HMO

Better Access to Care

Your HMO's job is to provide you with the care you need when you need it. Your HMO has a variety of doctors, specialists, clinics, and hospitals for you to choose from. Your HMO will support you and help you get appointments with doctors or specialists that could be hard for non-HMO members to get. HMOs make sure you can see a primary care doctor within 30 days of when you call and a behavioral health provider within 30 days after an inpatient mental health stay.

If you have a doctor or provider that is not part of an HMO, your HMO will let you see that provider for 90 days after you enroll to continue your care.

If you currently have approval to get certain services under fee-for-service Medicaid, your HMO will let you continue to get those services from the same provider for 90 days after you enroll.

Personalized and Coordinated Care

Your HMO has a care manager who will:

- Support you.
- Work with you to develop a care plan to make sure you get the care you need.
- Help you schedule appointments with providers.
- Review doctor instructions with you.
- Help you with your medications.
- Follow up with you after a hospital stay or an emergency room visit.

Your care manager can refer you to community resources to help with other issues that might impact your well-being, like housing, employment, legal help, food security, transportation, and child care.

Increased Quality

Your HMO is required to provide you with all of the care you need while also meeting high standards of care. As part of the high-quality care HMOs provide, they will reach out to assess your health care needs so they can connect you to services, and they may provide reminders for important services you need.

Member Safeguards

If you have problems getting health care services through your HMO, there are resources to help you. Resources include advocates at your HMO and at Disability Rights Wisconsin, an ombudsman, and an enrollment specialist.

Fee-For-Service Coverage

Members who do not join an HMO get fee-for-service health care coverage. With fee-for-service coverage, you can get services from any doctor or provider who accepts BadgerCare Plus and/or Medicaid. Check with your health care provider to see if your provider takes BadgerCare Plus and/or Medicaid. Your health care provider will work with BadgerCare Plus and/or Medicaid to decide if a service should or should not be covered. If the service should be covered, then BadgerCare Plus and/or Medicaid will pay the doctor for the service.

If you get services from a provider who does not accept BadgerCare Plus and/or Medicaid, you will be responsible for paying the cost of the services.

If you need help finding a provider who takes fee-for-service BadgerCare Plus and/or Medicaid, call Member Services at 800-362-3002 and ask for help.

If there is an emergency and you do not have your ForwardHealth card with you when you get services, give your ForwardHealth card number to all those who provided the services as soon as possible.

Report Your Changes BadgerCare Plus and Medicaid

For both BadgerCare Plus and Medicaid, you must report the following changes to your agency within 10 days of the change:

- You have a change in where you live or where you are staying, including Wisconsin residency. A homeless person living in Wisconsin must be physically present in Wisconsin.
- Someone moves into or out of your home.
- Someone goes into jail or prison or is released from jail or prison.
- Your household relationships change (someone gets married, divorced, or adopted).

For Medicaid, you must also report changes in your household's assets or expenses.

For BadgerCare Plus, you must also report the following changes:

- Expected tax filing status
- Tax dependents
- Tax deductions

Your enrollment letters (see the Letters About Your Benefits section) will give you the income limit for your household size and the reporting rules. You can also call your agency for this information.

For Medicaid, you must report within 10 days of the change if your household's monthly income (before taxes) goes over a certain monthly income limit for your household size.

For BadgerCare Plus, you must report the following income changes by the 10th of the month following the month in which your household's income goes over a certain income limit for your household size.

- Your household's monthly income (before taxes).

Important Information for All Health Care Plans

- If your BadgerCare Plus eligibility is based on annual income, your household's expected annual income (before taxes).

Family Planning Only Services

If you are enrolled in Family Planning Only Services, changes in your income will not affect your enrollment until your next renewal. However, you must report the following changes to your agency within 10 days:

- You move to a new address.
- You move out of Wisconsin.
- Where you live changes (for example, you go to prison or go into a nursing home or other institution).

Wisconsin Well Woman Medicaid

If you are enrolled in Wisconsin Well Woman Medicaid, you must report the following changes to your agency:

- You reach 65 years of age.
- Your address changes.
- You move out of Wisconsin.
- You get Medicare Part A, Part B, or both.
- You no longer need treatment for breast or cervical cancer or precancerous condition of the breast or cervix.
- You enroll in private or other public insurance that covers your cancer treatment.

How to Report Changes

You can report changes in the following ways:

- Online at access.wi.gov.
- By phone: Contact your agency to report changes.
- By mail or fax:
 - For Medicaid or Caretaker Supplement, you can use the Medicaid Change Report, F-10137.
 - For BadgerCare Plus, Caretaker Supplement, and Family Planning Only Services, you can use the Information Change Report, F-10183.

To get these forms, go to dhs.wi.gov/forms/index.htm or contact your agency.

NOTE: If you get SSI benefits, your changes should be reported to the Social Security Administration.

You may be required to give proof of some of these changes (see Appendix D: Examples of Proof).

Renew Your Benefits

Once you are enrolled in BadgerCare Plus, Medicaid, or Family Planning Only Services, a renewal must be completed at least once each year. The renewal is to make sure you still meet all program rules, and you are getting the correct benefits. If the renewal is not done, your benefits will end.

There are many ways to do a renewal. You can do your renewal online at access.wi.gov, by phone, by mail, by fax, or in person. You will get a letter in the mail the month before your renewal is due.

For example, if your renewal is due in April, your letter will be sent in March. This letter will also tell you how you can complete your renewal.

12-Months Continuous Coverage for Children

Children under age 19 will keep their benefits for 12 months even when their family's household circumstances change during that time. The 12-month period starts with the month of their benefit application, the new certification period at renewal, or when the child otherwise becomes eligible under a qualifying group.

Who qualifies for continuous coverage?

Members under age 19 in the following programs qualify for continuous coverage:

- BadgerCare Plus
- Emergency Services Medicaid
- Family Planning Only Services
- Foster Care Medicaid
- Home and Community-Based Waiver (HCBW) Medicaid
- Institutional Medicaid
- Katie Beckett Medicaid
- Medicaid Purchase Plan (MAPP)
- Medicare Savings Programs
- Special Status Medicaid
- SSI-Related Medicaid
- Supplemental Security Income (SSI) Medicaid
- Tuberculosis-Related Medicaid

- Wisconsin Well Woman Medicaid (WWWMA)

Continuous coverage does not apply to children who are:

- Enrolled under presumptive eligibility (also known as Express Enrollment).
- Required to meet a deductible to enroll in BadgerCare Plus or Medicaid.

How could a child lose coverage?

There are a few things that can end a child's coverage during the 12-month period:

- They turn 19.
- They move out of Wisconsin.
- Their citizenship or immigration status is not verified.
- The child's immigration status changes and they are no longer in an eligible immigration status or designation.
- Their immigration status changes to one that makes them no longer eligible.
- Their eligibility was based on inaccurate information or agency error.
- The family asks to end their coverage.

Monthly Premiums

A premium is a set amount of money you are charged each month for health care coverage. Some children enrolled in BadgerCare Plus and some Medicaid Purchase Plan (MAPP) members are charged premiums. For more information about premiums for MAPP, see page 33.

You can pay your premiums online in ACCESS at access.wi.gov or with the MyACCESS mobile app.

BadgerCare Plus Premiums for Children

Children ages 1 through 18 enrolled in BadgerCare Plus with family income between 200% and 300% of the federal poverty level will be charged a premium.

If you have a child who has a premium, the premium will be set at a specific amount depending on your family's income and will not be more than 5% of your family's counted income.

If you cannot pay your premium, your child will not lose their BadgerCare Plus. Also, premiums for children will not increase during their 12-month certification period.

You cannot be charged a new or higher premium until your next renewal.

Children Who Are Not Charged Premiums for BadgerCare Plus

The following children are **not** charged a premium for BadgerCare Plus:

- Children under age 1
- Children age 1 to 18 with income under 200% of the federal poverty level
- Tribal members and children and grandchildren of Tribal members
- Any members who are eligible to get Indian Health Services
- Children who are pregnant
- Youth who were in out-of-home care (also known as foster care), court-ordered Kinship Care and Long-Term Kinship Care, or Subsidized Guardianship when they turned 18 years of age.
- Children who are in jail or prison
- Children who have met a BadgerCare Plus deductible, during the remainder of the deductible period
- Children in a BadgerCare Plus extension*

*An extension is a period of enrollment given to a parent, caretaker, or child when the assistance group's income increases above 100% of the federal poverty level due to an increase in the parent or caretaker's earned income or spousal support/alimony and they still meet all other program rules.

Paying BadgerCare Plus Premiums for Children

If your **child** has a premium, you will get a BadgerCare Plus premium statement each month.

You can mail your premium payment with the tear off part of the statement in the envelope provided. Make sure the mailing address shows through the window in the envelope. If you do not have your statement, write your case number on your check or money order, and mail your premium to the following address:

BadgerCare Plus
P.O. Box 93920
Milwaukee, WI 53293-3920

You can also pay premiums online through access.wi.gov or with the MyACCESS mobile app.

Copays

Some services require you to pay part of the cost of care. This is called a copayment or copay. More information about copays is in Appendix B: Covered Services and Copays for BadgerCare Plus and Medicaid Programs.

Other Health Insurance

If you or anyone in your family has any other health insurance coverage, you must tell your agency. If you do not inform your agency about any other health insurance, your benefits may be denied or ended.

Anyone requesting BadgerCare Plus is required to make an assignment of Medical Support Liability. Medical Support Liability means that applicants and members must sign over to the State of Wisconsin all rights to payments from court-ordered medical support or from other third-party payers of your medical expenses.

Examples of third-party payers are:

- Other health insurance plans (besides BadgerCare Plus or Medicaid).
- Individuals or entities responsible for payments for an accident or injury if BadgerCare Plus or Medicaid paid for any services due to the accident (see Accident and Injury Claims on the next page).

In some situations, you must cooperate with a child support agency to establish paternity for your child. This means that if you were not married at the time of your child's birth, the child support agency will help you legally name the father.

If your child does not have health insurance and has an absent parent, you must help the child support agency to get insurance information from the absent parent.

The child support agency will also help you get and keep getting health insurance (medical support) for your child through court orders. You must cooperate with the child support agency unless **any** of the following are true:

- You are pregnant.
- You are under age 18.
- You have good cause for not cooperating.

There are different good cause reasons. If you think you may have a good cause reason for not cooperating with the child support agency, tell your local agency. Your

agency will provide more information on good cause and how to claim it.

If you have questions about your other insurance coverage, ask your insurance company. If you have questions or complaints regarding that insurance company, contact:

Office of the Commissioner of Insurance
Division of Market Regulation and Enforcement
PO Box 7873
Madison, WI 53707-7873
800-236-8517

Coverage Through Affordable Employer-Sponsored Health Insurance

BadgerCare Plus provides health care coverage to pregnant people, children, parents, caretaker relatives, and adults with no dependent children living in the home. Pregnant people applying for the BadgerCare Plus Prenatal Program are not eligible if they currently have coverage through any health insurance plan that qualifies as minimum essential coverage. Examples of these plans include coverage through the federal Health Insurance Marketplace, employer-sponsored health insurance, and most other types of major medical insurance. Some children are not eligible for BadgerCare Plus if they currently have coverage through affordable employer-sponsored health insurance or the state employee health insurance plan through their employer. Employer-sponsored health insurance is considered affordable if the employer pays 80% or more of the cost of the premiums for a family plan covering major medical expenses.

The following individuals may be able to enroll in BadgerCare Plus, even if they currently have coverage through employer-sponsored health insurance:

- Newborns under 1 year old
- Children age 1 to 5 years old with family income no more than 185% of the federal poverty level
- Children ages 6 to 18 years old with family income no more than 150% of the federal poverty level
- Youth under age 26 who were in a foster home, court-ordered Kinship Care, or subsidized guardianship when they turned 18 years old.
- People with a disability (must be determined by the Disability Determination Bureau or the Social Security Administration)

- Parents, caretaker relatives, or adults with no dependent children living in the home
- Most pregnant people

Children who have coverage through employer-sponsored insurance may still be able to enroll in BadgerCare Plus by meeting a deductible. For more information about the deductible plans, see Deductible Plans on page 45.

Applying for BadgerCare Plus for Pregnant People

If you are pregnant, applying for BadgerCare Plus, and you are a U.S. citizen or qualifying immigrant, you may be able to enroll, even if you currently have coverage through a health insurance plan that qualifies as minimum essential coverage.

BadgerCare Plus Prenatal Program

If you are pregnant and not eligible for BadgerCare Plus because of your immigration or citizenship status or you are in prison or jail, you may be able to enroll in the BadgerCare Plus Prenatal Program. You will not be able to enroll in the BadgerCare Plus Prenatal Program if you currently have coverage through any health insurance plan that qualifies as minimum essential coverage.

Accident and Injury Claims

If you are in an accident or are injured and you get a cash award or settlement due to the accident or injury and ForwardHealth paid for part or all of your care, you must report this to all of the following:

- Your local agency
- The Wisconsin Casualty Recovery Unit
- Your HMO or managed care organization (MCO) if you are enrolled in one

When Medicaid pays for a claim related to an accident, a letter is sent to you telling you about the requirement to report the information.

If you have hired an attorney or are working with an insurance agency to settle your claim, you must also report this information to your agency, Wisconsin Casualty Recovery Unit, and your HMO or MCO.

You can contact the Wisconsin Casualty Recovery Unit by phone, mail, fax, email, or online.

Wisconsin Casualty Recovery – HMS

5615 High Point Drive

Irving, TX 75038-9984

Phone: 877-391-7471

Fax: 469-359-4319

Email: wicasualty@gainwelltechnologies.com

Online: wicasualty.com/wi/index.asp

When contacting the Wisconsin Casualty Recovery Unit, provide your ForwardHealth ID number, the accident date, and the name of the insurance company or attorney, along with any claims.

Required Proof/Verification for FoodShare and Health Care

You may need to provide proof of your answers for FoodShare, BadgerCare Plus, and Medicaid when applying for benefits, renewing benefits, or reporting changes. Appendix D: Examples of Proof describes what items you can use to provide proof.

NOTE: If you need help getting any proof, contact your agency.

If you have already given proof of citizenship and identity to your agency in the past, you will not have to provide this information again.

You will not have to provide proof of citizenship or identity if you are:

- Currently getting Social Security Disability Insurance.
- Currently getting SSI benefits.
- Currently receiving Medicare.
- Applying for or enrolled in the Emergency Services Plan.
- Applying for or enrolled in the BadgerCare Plus Prenatal Plan.
- Not a U.S. Citizen.

Health Care for People Who Are Incarcerated

If you are a person who is incarcerated in a public institution, such as jail or prison, your BadgerCare Plus or Medicaid may be put on hold. This means that BadgerCare Plus and Medicaid will only pay for services when you are admitted to a hospital as an

inpatient. If you need other health care services, you should follow the process in your jail or prison facility for requesting services.

People under age 21 and Former Foster Care Youth under age 26 who are incarcerated can also receive HealthCheck screening services (see page 67) and targeted case management services 30 days prior to their release from jail or prison. Former Foster Care Youth are people who were in an out-of-home placement (also known as foster care), court-ordered Kinship Care or Long Term Kinship Care or a Subsidized Guardianship Agreement on their 18th birthday.

If you continue to meet program rules when you are released, you can go back to getting BadgerCare Plus or Medicaid without submitting a new application.

If you are a person who is pregnant and incarcerated in a public institution, you may be able to enroll in the BadgerCare Plus Prenatal Program, which is a full-benefit program (See BadgerCare Plus Prenatal Plan). Your BadgerCare Plus Prenatal Program enrollment will continue during your pregnancy and will not be suspended.

Non-Emergency Medical Transportation

The following information is about non-emergency medical transportation. If you have a medical emergency, you should call 911.

Non-emergency medical transportation gives you a free ride to medical appointments if you have no other way to get there. Depending on your situation, you can get a ride, bus tickets, or gas money. Rides can include public transportation (such as a city bus), specialized medical vehicles, or other types of vehicles depending on your unique situation.

Medical Transportation Management (MTM), Inc. is the transportation manager for BadgerCare Plus and Wisconsin Medicaid. You can book and manage your trips through MTM if you are enrolled in one of the following programs:

- BadgerCare Plus
- Wisconsin Medicaid (including IRIS)
- Family Planning Only Services
- Tuberculosis-Related Medicaid

If you are enrolled in Family Care, Family Care Partnership, or PACE, you will get your rides through your managed care organization. If you reside in a nursing home, contact the nursing home regarding your transportation.

NOTE: MTM is required to follow federal and state law and can only schedule and pay for rides if you are not able to get a free ride. They are also required to use the least expensive type of ride to get you to your appointment based on your needs.

Mileage Reimbursement (Gas Payment)

If you have a car and are able to drive yourself to your appointment but cannot afford to pay for gas, you may be able to be reimbursed for gas. Contact MTM before you go to your appointment to see if you can be reimbursed for mileage.

Meals and Lodging

You may be able to get help paying for meals and overnight stays. BadgerCare Plus and Wisconsin Medicaid have rules for when members can get payment for meals and overnight stays when traveling by non-emergency medical transportation to BadgerCare Plus- and Medicaid-covered services.

Schedule a Ride

You must schedule routine rides at least two business days before your appointment. You can schedule a routine ride by calling 866-907-1493 (voice) or 711 (TTY) Monday through Friday from 7 a.m. until 6 p.m. You can also schedule online at mtm-inc.net/wisconsin or use the MTM Link mobile app. .

If you do not schedule a routine ride two business days before an appointment, you may not be able to get a ride, and you will need to reschedule your appointment. Holidays and weekends are not counted as business days. Business days include the day that you schedule the appointment but not the day of your appointment.

NOTE: MTM is able to pay for rides for more family members in certain situations. Call 866-907-1493 for more information.

When you call to schedule a ride, you should have the following information available:

- Your first and last name, date of birth, and phone number
- Your ForwardHealth member number (which is the 10 numbers listed on your ForwardHealth card)
- The street address and phone number of where you want to be picked up
- The name, phone number, address, and zip code of the health care provider you are seeing
- The date and start time of your appointment
- The end time of your appointment if you know it
- Any special ride needs, including if you need someone to ride with you
- General reason for the appointment (for example, checkup or eye appointment)

Non-Emergency Medical Transportation

NOTE: MTM can also provide transportation to urgent appointments within three hours. Verification may be required.

For more information about scheduling rides; meals and lodging; new rules; or complaints, denied transportation, or fair hearings:

- Contact MTM at 866-907-1493 (voice), 711 (TTY), or mtm-inc.net/wisconsin
- Go to dhs.wi.gov/nemt/index.htm.
- Call Member Services at 800-362-3002.

Interpretive Services for Medicaid Appointments

If you have Wisconsin Medicaid and use a language other than English, it is your right to have an interpreter available for your medical appointments at no cost to you. To learn more about interpretive services for Medicaid appointments, visit [dhs.wi.gov/library/collection/p-03492](https://dhs.wisconsin.gov/library/collection/p-03492).

Español (Spanish)

Si usted tiene Wisconsin Medicaid y usa otra lengua que no sea inglés, tiene el derecho de contar con un intérprete disponible para sus citas médicas sin costo alguno. Para saber más sobre los servicios de interpretación para las citas de Medicaid, visite dhs.wisconsin.gov/publications/p03492s.pdf.

Hmoob (Hmong)

Yog tias koj muaj Wisconsin Medicaid thiab siv lwm hom lus uas tsis yog lus Askiv, nws yog koj li kev muaj cai thov kws pab txhais lus rau koj qhov kev teem caij kho mob uas tsis xam nqi them rau koj. Kawm paub ntau ntiv txog cov kev pab cuam txhais lus rau kev teem caij Medicaid, mus saib dhs.wisconsin.gov/publications/p03492h.pdf

العربية (Arabic)

إذا كان لديك Wisconsin Medicaid وتستخدم لغة غير الإنجليزية، فمن حقك أن يكون لديك مترجم فوري متاح لمواعيدك الطبية دون تحمل أي تكلفة إضافية. لمعرفة المزيد حول خدمات الترجمة لمواعيد Medicaid، تفضل بزيارة dhs.wisconsin.gov/publications/p03492ar.pdf

繁體中文 (Chinese)

如果您参加了 Wisconsin Medicaid 计划，且使用非英语语言，则您有权获得免费的预约就诊口译服务。了解更多 Medicaid 预约就诊口译服务信息，请访问 dhs.wisconsin.gov/publications/p03492cm.pdf

Français (French)

Si vous disposez de Wisconsin Medicaid et parlez une autre langue que l'anglais, vous avez le droit de faire appel gratuitement à un interprète lors de vos rendez-vous médicaux. Pour en savoir plus sur les services d'interprétations pour les rendez-vous Medicaid, rendez-vous sur dhs.wisconsin.gov/publications/p03492fr.pdf.

Karen

နမ့်အိန်ဒီး Wisconsin Medicaid ဒီးစူးကါကျိာ်အဂါ လာအတမ့ဝဲအဲကလံးကျိာ်တကျိာ်န့ၣ်, မ့ဝဲဒ်န့ၣ်ယာ် လာနကအိန်ဒီးပုၤကတိၤကျိးထံတၢ် လာနတၢ်ကူၤဆူၣ်ချ့တၢ်သ့ၣ်နံၤဖးသီအဂီၢ် လာတလၢာ်အပုၤန့ၣ်လီၤ. လာကမၤလိၣ်နီၣ်ပာ်အါထီၣ်ဘၣ်သးတၢ်မၤစၢၤတၢ်ကျိးထံတၢ် Medicaid တၢ်သ့ၣ်နံၤဖးသီအဂီၢ်, ကွၢ်ဘၣ်ဖဲ dhs.wisconsin.gov/publications/p03492ka.pdf.

한국어 (Korean)

귀하가 Wisconsin Medicaid에 가입하였고 영어 이외의 언어를 사용하는 경우 병원 예약을 위해 무료 통역 서비스를 신청할 권리가 있습니다. Medicaid 예약 통역 서비스에 대한 자세한 내용 확인은 dhs.wisconsin.gov/publications/p03492kr.pdf /에서 할 수 있습니다.

ພາສາລາວ (Laotian)

ຖ້າຫາກວ່າທ່ານມີ Wisconsin Medicaid ແລະ ໃຊ້ພາສາອື່ນທີ່ບໍ່ແມ່ນພາສາອັງກິດ, ທ່ານມີສິດທີ່ຈະ ມີຜູ້ແປພາສາທີ່ຮ້ອມໃຫ້ບໍລິການສໍາລັບການນັດໝາຍທາງການຂອງທ່ານໂດຍທີ່ບໍ່ເສຍຄ່າໃຊ້ຈ່າຍ. ເພື່ອສຶກສາເພີ່ມຕື່ມກ່ຽວກັບການບໍລິການແປພາສາສໍາລັບການນັດໝາຍຂອງ Medicaid, ໃຫ້ເຂົ້າໄປທີ່ dhs.wisconsin.gov/publications/p03492l.pdf.

Русский (Russian)

Если вы имеете Wisconsin Medicaid и используете язык, отличный от английского, вы имеете право на услуги бесплатного переводчика во время медицинского приема. Чтобы узнать больше об услугах устного перевода на приемах по программе Medicaid, посетите dhs.wisconsin.gov/publications/p03492r.pdf.

Soomaali (Somali)

Haddii aad heysato Wisconsin Medicaid misna isticmaasho luuqad aan Ingiriisi aheyn, waxaad xaq u leedahay turjumaan in uu kuugu diyaarahaado balantaada ayadoon lacag laguugu dalacaynin. Si aad wax uuga barato adeegyada turjumaad ee balamaha Medicaid, booqo dhs.wisconsin.gov/publications/p03492so.pdf.

Tiếng Việt (Vietnamese)

Nếu quý vị có Wisconsin Medicaid và sử dụng ngôn ngữ không phải tiếng Anh, quý vị có quyền yêu cầu có thông dịch viên cho các cuộc hẹn khám bệnh mà không mất bất kỳ chi phí nào. Để tìm hiểu thêm về các dịch vụ thông dịch cho các cuộc hẹn khám bệnh với Medicaid, hãy truy cập dhs.wisconsin.gov/publications/p03492v.pdf.

Other Programs

Caretaker Supplement

This program is a cash benefit for parents who receive SSI payments and who are living with and caring for their minor children. The Caretaker Supplement benefit amounts are \$275 per month for the first eligible child and \$165 per month for each additional eligible child.

For more information, go to dhs.wi.gov/ssi/caretaker.htm

Summer EBT (Electronic Benefit Transfer)

Summer EBT is an income-based program that helps families who qualify buy food for their children while school is out. Summer EBT benefits can be used wherever FoodShare benefits are accepted.

For more information, go to dhs.wi.gov/sebt/index.htm

WIC (Women, Infants, and Children Program)

Young children and pregnant people may be able to get WIC, a special supplemental food program for women, infants, and children. This program provides nutritious food and nutrition and health counseling.

To find out more about WIC, go to dhs.wi.gov/wic/index.htm or call 800-722-2295.

Job Center of Wisconsin

Job Center of Wisconsin is available to you. Job Center is the largest source of job openings in Wisconsin. Visit the Job Center website at jobcenterofwisconsin.com or you can use touchscreen computers at your local job center.

Collection and Use of Information

The information required on your application, including the Social Security number of each household member applying for benefits, is authorized under the Food and Nutrition Act of 2008, as amended PL 110-246 (7 United States Code 2011-2036), and Wis. Stat. § 49.82(2). If you do not have a Social Security number due to religious beliefs or because of your immigration status, you will not be required to give a Social Security number.

The information will be used to determine if your household can get or keep getting benefits.

Information you give will be verified through computer matching programs. This information will also be used to monitor compliance with program rules and for program management.

This information may be given to other federal and state agencies for official examination. This information may also be given to law enforcement officials to apprehend people fleeing to avoid the law if they are applying for or receiving FoodShare benefits.

Providing information on your application, including the Social Security number of each household member, is voluntary. However, any person who is asking for benefits (FoodShare, BadgerCare Plus, or Medicaid) but does not give a Social Security number will not be able to get benefits unless they meet one of the exceptions for FoodShare, Medicaid, or BadgerCare Plus.

Exceptions include applicants applying for BadgerCare Plus Prenatal Plan for immigrants, or for Emergency Services. Another exception is anyone who belongs to a recognized religious group that objects to persons being assigned a Social Security number.

Any Social Security number provided for members who are not enrolled will be used and disclosed in the same way as the Social Security numbers of enrolled household members.

Your application for BadgerCare Plus or Medicaid is also an application for help with paying for private health insurance through the federal Health Insurance Marketplace. If you do not meet the rules to enroll in BadgerCare Plus or Medicaid, your information will be

sent to the Marketplace, and they will send you a letter to explain your option to complete a Marketplace application. To learn more about the Marketplace, visit [HealthCare.gov](https://www.healthcare.gov) or call 800-318-2596 or 711 (TTY).

Ethnicity and race information may be provided voluntarily by individuals but is not required to get benefits. This information is collected to ensure individuals are not discriminated against and to improve our programs.

Your Rights

When applying for or getting FoodShare, Caretaker Supplement, BadgerCare Plus, Wisconsin Medicaid, or Family Planning Only Services, you have the right to:

- Be treated with respect by agency staff.
- Have an adult who knows your situation help you apply for and manage your benefits.
- Have your civil rights upheld. To learn more, see the Nondiscrimination section.
- Have your private information kept private.
- Get an application or have an application mailed on the same day you ask for it.
- Have an application accepted right away by your agency.
- Ask your agency to explain anything in this handbook you do not understand.
- Get a decision about your application within 30 days of the day your agency gets your application.

NOTE: If your agency gets your application (online or on paper) after 4:30 p.m. on a weekday or on a weekend or holiday, the date of receipt will be the next business day.

- Get FoodShare benefits within seven days of applying if you are in immediate need and qualify for faster service.
- Be told in advance if your benefits are going to be reduced or ended and the reason for the change.
- Ask for a fair hearing if you do not agree with any action of your agency.
- See agency records and files relating to you, except information obtained from a confidential source.
- Get free language services.
- Ask the agency for help in getting needed information and proof that has been asked for.

Fair Hearings

Any time your benefits are denied, reduced, or ended and you think your agency made a mistake, contact the agency.

If the agency does not agree, you can ask the agency worker to help you by asking for a fair hearing.

Meeting Before a Fair Hearing

You may be able to come to an agreement with the agency without having to wait for a fair hearing. You can contact your agency to ask questions about the agency's decision and to tell your side of the story. You can do so by phone, in-person, or through an agency conference where you meet with an agency representative.

If the agency finds that it has made a mistake, they will make any necessary updates to the case. It may resolve the need for a fair hearing. If the agency decides that its decision is correct and you still feel the decision is wrong, you have the right to a fair hearing.

NOTE: Contacting the agency does not affect your right to a fair hearing. You can ask for a fair hearing and, if you are satisfied with what you learn from the agency, cancel your request for a hearing. Contacting the agency does not extend the deadline to request a fair hearing. See below for information about the deadline to request a hearing.

Fair Hearing

A fair hearing gives you the chance to tell a hearing officer why you think the decision about your application or benefits was wrong. At the hearing, a hearing officer will hear from you and the agency to find out if the decision was right or wrong. You may bring a friend or family member with you to the hearing. You may also be able to get free legal help. See the Legal Help section to learn more.

When to Use the Fair Hearing Process

Examples of when to ask for a fair hearing include the following:

- You believe your application was denied unfairly or in error.
- Your benefits were suspended, reduced, or ended and you think it was a mistake.
- You do not agree with the amount of benefits you are getting.
- Your application was not acted on within 30 days.

Read each letter you get carefully to help you understand the action taken. If the reason for the change in your benefits is a federal or state rule change, the Division of Hearings and Appeals is not required to give you a fair hearing.

How to Ask for a Fair Hearing

Ask your agency to help you file for a fair hearing, or write directly to:

Department of Administration
Division of Hearings and Appeals
PO Box 7875
Madison, WI 53707-7875

You can get the Fair Hearing Request form online at doa.wi.gov/RequestAHearing or by calling 608-266-7709.

If you choose to write a letter in place of the form, you should include the following:

- Your name
- Your mailing address
- A brief description of the problem
- The name of the agency that took the action or denied the service
- A copy of the notice you received denying your application or suspending, reducing, or ending your benefits (if applicable)
- Your Social Security number
- Your signature

For FoodShare, your agency can take your request verbally.

For health care or Caretaker Supplement, a request for a fair hearing must be made no later than 45 days after the date of the action being appealed. For FoodShare, a request must be made no later than 90 days after the date of the action being appealed. You can request a hearing at any time while you are getting FoodShare benefits if you do not agree with the benefit amount. Your latest enrollment letter will have the date by which you must request a hearing.

You, your chosen representative (if you have one), and your agency will get written notice at least 10 days before the hearing with the time, date, and place of the hearing.

Preparing for a Fair Hearing

You have the right to bring witnesses, your own lawyer, or another advisor to the fair hearing. The Department of Health Services will not pay for legal help to represent you, but they may be able to help you find free legal help for questions or fair hearing representation.

You have the right to review any information in your case file that was used to determine your enrollment.

You or your representative has the right to:

- Question anyone who testifies at the fair hearing.
- Present your arguments and written materials that show why you think you are right.

If the fair hearing is about whether or not you are disabled or unable to work due to illness or injury, you have the right to present medical evidence for proof. Your agency can help you get the medical documents you may need and will pay for the cost to get the documents.

If you cannot speak English, you have the right to have an interpreter present at the hearing. The Division of Hearings and Appeals may pay for translation or interpreters if you ask.

Continuation of Benefits

If you are getting benefits and you ask for a hearing before your benefits change, you can keep getting the same benefits until the hearing officer makes a decision.

If the hearing officer decides that your agency was right, you may need to return or repay the extra FoodShare or Caretaker Supplement benefits that you got between the time you asked for your fair hearing and the time that the hearing officer decides about your case.

If you have asked for a fair hearing, you will still need to complete any scheduled renewals. If your agency tells you before the fair hearing that your enrollment period has ended, you must reapply and meet all program rules for your benefits to be continued. If the renewal shows that there have been changes in your circumstances, your benefits may change or end because of these changes.

Effects of the Fair Hearing

If the fair hearing decision is in your favor, no action will be taken against you by the agency. If your benefits

have been ended, you will start receiving them again. The date you will start getting benefits will be listed in the letter of the fair hearing decision you get.

If the fair hearing is decided against you, the action will stand, and you will have to pay back any FoodShare or Caretaker Supplement benefits you should not have received. Ask your agency about any limitations on the recovery of overpayments.

No other action will be taken against you for filing a fair hearing request.

Rehearing

If you do not agree with the fair hearing decision, you have the right to ask for a rehearing if you:

- Have new evidence that was not known or available to you before the hearing that could change the decision.
- Feel that there was a mistake in the facts of the decision.
- Feel that there was a mistake in the legal basis of the decision.

A written request for a rehearing must be received within 20 days after the date of the written decision from the fair hearing. The Division of Hearings and Appeals will then decide within 30 days of getting the written request if you will get a rehearing. If the Division of Hearings and Appeals does not issue a written response to your request within 30 days, your request is denied.

Appealing a Hearing or Rehearing Decision

If you do not agree with the fair hearing or rehearing decision, it is still possible for you to appeal this decision to the circuit court in your county. This must be done within 30 days after you get the written decision about the fair hearing or within 30 days of the denial of the rehearing request. An appeal to the circuit court must be done by filing a petition with the clerk of courts in your county. It is best to have legal help if you decide to appeal a fair hearing decision in circuit court.

Legal Help

You may be able to get legal help from Legal Action of Wisconsin. To get help, call 855-947-2529 or complete an online intake at legalaction.org/get-help/.

Letters About Your Benefits

You will get letters about your benefits. These letters tell you the status of your benefits.

A letter will be sent to you before any change in your FoodShare, Caretaker Supplement, or health care benefits. It is important that you read each letter you get.

These letters will tell you if:

- Your benefits are being reduced or ending.
- Your agency is waiting for anything from you.
- You need to do a renewal to keep getting benefits.

You can choose to get your letters online instead of by regular mail. To make this choice, log in to your ACCESS account at access.wi.gov. If you do not have an ACCESS account, you can create one to view your letters and information about your benefits online.

Nondiscrimination

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, exclude, or treat people differently on the basis of race, color, national origin, age, disability, sex (including pregnancy, sexual orientation, and gender identity), religion, or filing of a prior civil rights complaint.

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, sex (including pregnancy, sexual orientation, and gender identity), religion or filing of a prior civil rights complaint, you can file a grievance with:

Department of Health Services
Attn: Civil Rights Coordinator
201 E. Washington Ave., Room E200B
PO Box 7850 Madison, WI 53707-7850
608-267-4955, TTY: 711, Fax: 608-267-1434
Email: 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 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
800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at hhs.gov/ocr/complaints/index.html.

Nondiscrimination

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 German / Dutch)] schwetzsch, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 844-201-6870 (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) ໂບດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 844-201-6870 (TTY: 711).
繁體中文 (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 اذكر اللغة، 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 flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 844-201-6870 (TTY: 711).
한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 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 lagu heli karaa. Soo wac 844-201-6870, TTY: 711.

USDA Nondiscrimination Statement

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, *USDA Program Discrimination Complaint Form* which can be obtained online at: www.usda.gov/sites/default/files/documents/ad-3027.pdf from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to:

- (1) **Mail:**
Food and Nutrition Service, USDA
1320 Braddock Place, Room 334
Alexandria, VA 22314; or
- (2) **Fax:**
(833) 256-1665 or (202) 690-7442; or
- (3) **Email:**
FNSCIVILRIGHTSCOMPLAINTS@usda.gov

This institution is an equal opportunity provider.

Appendix A: Program Income Limits

Program income limits are based on federal guidelines, which may change each year. For current guidelines, go to dhs.wi.gov/forwardhealth/resources.htm or call 800-362-3002.

FoodShare Gross Monthly Income Limits/Maximum Benefit Amounts—Effective October 1, 2025

People in Household	Gross Monthly Income Limit at 200% FPL	Gross Monthly Income Limit at 130% FPL	Gross Monthly Income Limit at 100% FPL	Maximum Benefit Amount
1	\$2,610	\$1,696	\$1,305	\$298
2	\$3,526	\$2,292	\$1,763	\$546
3	\$4,442	\$2,888	\$2,221	\$785
4	\$5,360	\$3,483	\$2,680	\$994
5	\$6,276	\$4,079	\$3,138	\$1,183
6	\$7,192	\$4,675	\$3,596	\$1,421
7	\$8,110	\$5,271	\$4,055	\$1,571
8	\$9,026	\$5,867	\$4,513	\$1,789
For each additional person add:				
	\$918	\$596	\$459	\$218

Minimum Monthly FoodShare Benefit allotment: \$24

*See page 26, Income Deductions and Disregards, for more information about pretax and tax deductions.
FPL=federal poverty level

Health Care Monthly Income Limits—Effective February 1, 2026

Group Size	100% FPL	120% FPL	135% FPL	150% FPL	200% FPL	250% FPL	300% FPL
1	\$1,330.00	\$1,596.00	\$1,795.50	\$1,995.00	\$2,660.00	\$3,325.00	\$3,990.00
2	\$1,803.33	\$2,164.00	\$2,434.50	\$2,705.00	\$3,606.66	\$4,508.33	\$5,409.99
3	\$2,276.67	\$2,732.00	\$3,073.50	\$3,415.01	\$4,553.34	\$5,691.68	\$6,830.01
4	\$2,750.00	\$3,300.00	\$3,712.50	\$4,125.00	\$5,500.00	\$6,875.00	\$8,250.00
5	\$3,223.33	\$3,868.00	\$4,351.50	\$4,835.00	\$6,446.66	\$8,058.33	\$9,669.99
6	\$3,696.67	\$4,436.00	\$4,990.50	\$5,545.01	\$7,393.34	\$9,241.68	\$11,090.01
7	\$4,170.00	\$5,004.00	\$5,629.50	\$6,255.00	\$8,340.00	\$10,425.00	\$12,510.00
8	\$4,643.33	\$5,572.00	\$6,268.50	\$6,965.00	\$9,286.66	\$11,608.33	\$13,929.99
For each additional person, add:							
	\$473.33	\$568.00	\$639.00	\$710.00	\$946.66	\$1,183.33	\$1,419.99

*See page 26, Income Deductions and Disregards, for more information about pretax and tax deductions.
FPL=federal poverty level

Appendix B: Covered Services and Copays for BadgerCare Plus and Medicaid Programs

Covered Services and Copays

You may be required to pay a part of the cost of a BadgerCare Plus- or Medicaid-covered service. This payment is called a copay. The table on page 67 lists what services are covered and what the copays are for those services. The table also indicates if you are exempt from copays.

You will not be required to make a copayment for any BadgerCare Plus or Medicaid-covered service if you are in one of the following groups:

- Children under age 19, regardless of income
- American Indians or Alaskan Native Tribal members, the child of a Tribal member, the grandchild of a Tribal member, or anyone otherwise eligible to receive Indian Health Services, regardless of age or income level
- Anyone receiving services through Express Enrollment
- Youth who were in out-of-home care (also known as foster care), court-ordered Kinship Care and Long-Term Kinship Care or a Subsidized Guardianship Agreement on their 18th birthday enrolled in BadgerCare Plus until age 26
- Pregnant people

Additionally, copays will not be charged for members enrolled in the following programs:

- Family Planning Only Services
- Institutional Medicaid (not including childless adults (CLAs) enrolled in BadgerCare Plus and residing in an institution)
- Katie Beckett Medicaid
- Wisconsin Well Woman Medicaid
- Foster Care Medicaid which includes Medicaid coverage for children in an out-of-home care placement (also known as foster care), court-ordered Kinship Care and Long-Term Kinship Care, and active Subsidized Guardianship or Adoption Assistance Agreements.

Providers are required to make a reasonable effort to collect the copay but cannot refuse services to a member who fails to make that payment.

NOTE: Because covered services and copays could change, you should ask your provider what your copay amount will be. If you get more than one service during the same appointment, you may be asked for more than one copay.

Example: If you saw your doctor and you also had an x-ray, you would have two copays: one for the doctor's visit and one for the x-ray.

A provider can charge you for services that are not covered by BadgerCare Plus or Wisconsin Medicaid if **both** of the following are true:

- The provider told you before providing the service that the service was not covered.
- You agreed to pay for the service.

NOTE: To make sure your BadgerCare Plus- or Medicaid-covered prescriptions are paid for, your prescribing provider and your pharmacy must both be Medicaid-enrolled. If not, you may be required to pay for these prescriptions.

Copay Limits

If you are enrolled in BadgerCare Plus and Medicaid and have copays, federal law limits the amount you pay for services each month. You should pay no more than 5% of your household income each month in copays or premiums. To make sure you are not paying any more than 5% of your household income, you may have a monthly copay limit.

Once your copay limit is set, it will remain the same from month to month unless you have changes that affect the copay limit, such as changes in income, changes in the number of people in your household or changes in the benefit program. If your copay limit increases, you will get a letter before your copay limit changes.

If you are enrolled in either SeniorCare or MAPP, you will not have a monthly copay limit based on your

Appendix B: Covered Services and Copays for BadgerCare Plus and Medicaid Programs

income, which means that you could pay more than 5% of your household income in copays or premiums.

Monthly Copays Based on Income

If you have to pay copays, you will have a monthly copay limit set based on your household income and who in your house has copays. If you have a premium, your premium will also count towards your copay limit.

If you pay a monthly amount while living in a nursing home or for services you get through Family Care or other programs that allow a person to live in their home, you must continue to pay these costs. Those monthly costs are not considered copays and do not count towards the monthly copay limit.

If your income is less than the amount listed below for your family size, you will not be charged any copays, and your limit will be \$0.

Family Size	Monthly Income
1	\$665
2	\$901
3	\$1,138
4	\$1,375
5	\$1,611
6	\$1,848

If your income is greater than the amounts listed above, see the table on page 68 to determine your monthly copay limit based on your income. Your monthly household income will determine what your monthly copay limit is. If you are married and both you and your spouse have to pay copays, your copay limits will be split between you and your spouse. Children do not have to pay copays so copay limits will never be split with children who are 18 years or younger.

If you or your spouse are in one of the groups that do not have to pay copays, the copay limit will not be split. Instead, the person who has to pay copays will have the full copay limit for a single individual.

If you or your spouse are enrolled in different benefit programs and both programs have monthly copay limits, you and your spouse's copay limits will be based on whoever has the lower income.

Example 1: Jane and Ben are married with two children aged 12 and 8 years old. They have counted household income of \$2,000 per month. The 100% federal poverty level (FPL) limit for a family of 4 is \$2,750 each month.

Based on their income, they are between 50% and 100% of the FPL. Since both Jane and Ben have to pay copays, they will each have a monthly copay limit of \$13 each month.

Example 2: Christina and Adam are married and enrolled in BadgerCare Plus with income at 75% of the FPL. Christina is pregnant and does not have copays. Her copay limit will be \$0 each month. Adam will have a monthly copay limit of \$26 each month. Once Christina gives birth, if she does have to pay copays again, she and Adam would split the copay limit amount.

Example 3: Chantal and Peter are married. Chantal is eligible for BadgerCare Plus with income at 80% of the FPL. Peter is eligible for Medicaid for the Elderly, Blind, or Disabled with income at 45% of the FPL. Peter's income is below 50% of the FPL, so both Chantal and Peter will each have a copay limit of \$0 each month.

Medicare Savings Programs

If you are enrolled in the Qualified Medicare Beneficiary Program, you will have a copay limit based on your monthly income. If you are enrolled in both the Qualified Medicare Beneficiary Program and any other Medicaid benefit, such as BadgerCare Plus or Medicaid for the Elderly, Blind, or Disabled, your copay limit will be based on your income used for the other benefit program.

If you are enrolled in only a Medicare Savings Program other than the Qualified Medicaid Beneficiary Program, you will not have a copay limit because you do not have copays covered by Medicaid.

Example: Dwayne is eligible for Medicaid for the Elderly, Blind, or Disabled and is enrolled in the Qualified Medicare Beneficiary Program. His income is 60% of the FPL. His copay limit is \$26 each month, based on the income counted for Medicaid for the Elderly, Blind, or Disabled.

Home and Community Based Waivers Group B and B Plus

If you are enrolled in Home and Community Waivers under Group B or Group B Plus, your monthly copay limit will be based on the cost share you pay each month to keep getting Home and Community-Based Waiver benefits. Your cost share amount does not count towards your copay limit.

- If your cost share amount is less than \$27 each month, your copay limit will be \$0 each month.
- If your cost share amount is \$27 or greater, your copay limit will be \$26 each month.

If you and your spouse are both enrolled under Group B or Group B Plus or any other benefit such as BadgerCare Plus or Medicaid for the Elderly, Blind, or Disabled, your copay limit will be based on whoever would have the lower copay limit and split between you and your spouse.

Example: Marge and George are married and enrolled in different health care benefits. Marge is enrolled in Home and Community-Based Waivers Group B with a cost share amount of \$65. George is enrolled in Medicaid for the Elderly, Blind, or Disabled with income at 35% FPL. Since they are married and George's income would set a lower copay limit than Marge's cost share amount, both George and Marge have a copay limit of \$0 each month.

Meeting Your Monthly Copay Limit

Your copay limit, copays, and premiums will be tracked based on the services you get, not just the amount of copays you pay. If you meet your copay limit before the end of the month, you will get a letter telling you the date that you met your copay limit and that you will have no more copays for the rest of the month. Your copays will begin again on the first of the next month. Your doctors and pharmacies will be able to see when you have met your copay limit so they no longer charge you copays for the rest of the month.

NOTE: You may still have a copay when you pick up prescriptions that you filled before the date listed on the letter.

Out-of-State Claims

Emergencies

If you travel outside Wisconsin and need emergency services, health care providers can treat you and send claims to BadgerCare Plus or Wisconsin Medicaid. You will have to pay for any service you get outside Wisconsin if the health care provider refuses to submit claims or refuses to accept Badger Care Plus or Medicaid payment as payment in full.

Non-Emergencies

If you need to see a provider outside Wisconsin for non-emergency services, that health care provider may need to request approval (see the Prior Authorization for Services section).

Services Not Covered Under Any Plan

Services or items **not** covered include (but are not limited to) the following:

- Services that needed approval (prior authorization) before you got them
- Items such as televisions, radios, air conditioners, and exercise equipment (even if prescribed by a physician)
- Procedures considered experimental or cosmetic in nature

HealthCheck

HealthCheck is a Medicaid health care benefit especially created for young people. HealthCheck covers in-depth exams and checkups. It also covers specialized services or products your child may need under HealthCheck "Other Services." The goal of HealthCheck is to prevent illnesses and find and treat health issues early.

Anyone under age 21 who has Medicaid, BadgerCare Plus, or a ForwardHealth card is automatically covered. There are no forms to fill out. All you need to do is call your doctor and make an appointment for a HealthCheck well-child exam.

Members can call 800-362-3002 for help finding a provider. If you are enrolled in a BadgerCare Plus or Medicaid HMO, call the HMO for information on HealthCheck services.

Covered Services

Covered Services for BadgerCare Plus, Medicaid, and Wisconsin Well Woman Medicaid

NOTE: This also includes copay amounts for some services, but many members do not have to pay copays. See page 65 for more information about who has copays.

Ambulatory Surgical Centers

Coverage of certain surgical procedures and related lab services—\$3 copay per service.

Behavioral Treatment

Full coverage of comprehensive and focused behavioral treatment services (with prior authorization). No copay.

Chiropractic Services

Full coverage—\$0.50 to \$3 copay per service.

Dental Services

Full coverage—\$0.50 to \$3 copay per service.

Disposable Medical Supplies (DMS)

Full coverage—\$0.50 to \$3 copay per service and \$0.50 per prescription for diabetic supplies.

Drugs (Prescription)

Coverage of generic and brand name prescription drugs and some over-the-counter (OTC) drugs.

Copay:

- \$0.50 for over-the-counter drugs
- \$1 for generic drugs
- \$3 for brand

Copays are limited to \$12 per member, per provider, per month. Over-the-counter drugs do not count toward the \$12 maximum. Limit of five opioid prescription fills per month.

Durable Medical Equipment (DME)

Full coverage—\$0.50 to \$3 copay per item. Rental items are not subject to copay.

End-Stage Renal Disease (ESRD)

Full coverage. Copay for ESRD services is \$3 when dialysis is not provided on the date of service. Otherwise, no copay.

HealthCheck Screenings for Children

Full coverage of HealthCheck screenings and other services for individuals under 21. No copay.

Hearing Services

Full coverage—\$0.50 to \$3 copay per procedure. No copay for hearing aid batteries.

Home Care Services (Home Health, Private Duty Nursing, and Personal Care)

Full coverage of private duty nursing, home health services, and personal care. No copay.

Hospice

Appendix B: Covered Services and Copays for BadgerCare Plus and Medicaid Programs

Full coverage. No copay.

Hospital Services: Inpatient

Full coverage—\$3 copay per day with a \$75 cap per stay.

Hospital: Outpatient

Full coverage—\$3 copay per visit.

Hospital Services: Outpatient Emergency Room

Full coverage. No copay for a medical emergency

Full coverage—\$8 copay for each non-emergency visit for adults who are enrolled in BadgerCare Plus and who are not living with and caring for related children younger than age 19.

Mental Health and Substance Abuse Treatment

Full coverage (not including room and board).

\$0.50 to \$3 copay per service, limited to the first 15 hours or \$825 of services, whichever comes first, provided per calendar year.

Copays are not required when services are provided in a hospital setting or for residential substance use disorder treatment services.

Nursing Home Services

Full coverage. No copay.

Physician Services

Full coverage, including laboratory and radiology.

\$0.50 to \$3 copay per service, limited to \$30 per provider per calendar year.

No copay for emergency services, preventive services, anesthesia, or clozapine management.

Podiatry Services

Full coverage—\$0.50 to \$3 copay per service; limited to \$30 per provider per calendar year.

Prenatal/Maternity Care

Full coverage, including prenatal care coordination and preventive mental health and substance abuse screening and counseling for pregnant people at risk of mental health or substance abuse problems. This includes services provided by nurse midwives and licensed midwives. No copay.

Reproductive Health Services: Family Planning Services

Full coverage with the exceptions listed below. No copay for services provided by a family planning clinic or contraceptive management.

Does not cover:

- Reversal of voluntary sterilization
- Infertility treatments
- Surrogate parenting and related services, including, but not limited to:
 - Artificial insemination
 - Obstetrical care
 - Labor or delivery
 - Prescription or over-the-counter drugs
- Sterilizations under age 21
- Impotence devices and services

Appendix B: Covered Services and Copays for BadgerCare Plus and Medicaid Programs

- Testicular prosthesis

Routine Vision

Full coverage, including eyeglasses—\$0.50 to \$3 copay per service. No copay for eyeglasses selected from the Medicaid collection.

Therapy: Physical Therapy, Occupational Therapy, and Speech and Language Pathology

Full coverage—\$0.50 to \$3 copay per service. Copay obligation is limited to the first 30 hours or \$1,500, whichever occurs first, during one calendar year (copay limits are calculated separately for each discipline).

Transportation: Ambulance, Specialized Medical Vehicle, Common Carrier

Full coverage of emergency and non-emergency transportation to and from a certified provider for a BadgerCare Plus covered service.

- \$2 copay for non-emergency ambulance trips.
- \$1 copay per trip for transportation by specialized medical vehicle.
- No copay for transportation by common carrier or emergency ambulance.

Table of Copay Limits for BadgerCare Plus and Medicaid Programs

Use the table below to determine your monthly copay limit based on your income.

2026 Member Copay Limit											
Status	Assistance Group Income as a Percentage of the Federal Poverty Level										
	0-50%	>50-100%	>100-150%	>150-200%	>200-250%	>250-300%	>300-350%	>350-400%	>400-450%	>450-500%	>500%
Individual	\$0	\$26	\$53	\$79	\$106	\$132	\$159	\$186	\$212	\$239	\$265
Per person amount for married couples	\$0	\$13	\$26.50	\$39.50	\$53	\$66	\$79.50	\$93	\$106	\$119.50	\$132.50

Appendix C: BadgerCare Plus Premiums for Children

BadgerCare Plus monthly premiums are based on family size, income, and federal poverty level guidelines. If you have a child (age 1 through 18) with family income above 201% of the federal poverty level, you will be charged a premium for that child, unless the child is exempt from being charged a premium. Even if you can't pay the premium, your child will keep their health care coverage.

To see what percentage of the federal poverty level your family's income is, see Appendix A: Program Income Limits. For more information about children who are charged BadgerCare Plus premiums, see page 49.

The following tables will tell you if a child:

- Will be charged a monthly premium and how much the premium is.
- Can get backdated coverage.

Income Limit (Amounts are on page 64)	Children Under Age 1	Children Age 1 Through 5	Children Age 6 Through 18
At or below 150% FPL	Premium: No Backdated Coverage: Yes	Premium: No Backdated Coverage: Yes	Premium: No Backdated Coverage: Yes
From 150% to 185% FPL	Premium: No Backdated Coverage: Yes	Premium: No Backdated Coverage: Yes	Premium: No Backdated Coverage: No*
From 185% to 201% FPL	Premium: No Backdated Coverage: Yes	Premium: No Backdated Coverage: No*	Premium: No Backdated Coverage: No*
From 201% to 300% FPL	Premium: No Backdated Coverage: Yes	Premium: Yes** Backdated Coverage: No*	Premium: Yes** Backdated Coverage: No*

*Backdated coverage is available if the child meets a deductible.

**Excludes children who are Tribal members.

FPL=federal poverty level

BadgerCare Plus Monthly Premiums for Children—current as of February 1, 2026

Family Income	From 201% to 231% FPL	From 231% to 241% FPL	From 241% to 251% FPL	From 251% to 261% FPL	From 261% to 271% FPL	From 271% to 281% FPL	From 281% to 291% FPL	From 291% to 301% FPL	At or over 301% FPL
Monthly Premium Amount for Each Child	\$10	\$15	\$23	\$34	\$44	\$55	\$68	\$82	\$97.53

FPL=federal poverty level

Appendix D: Examples of Proof

When you apply for or renew benefits or report a change, we may need to verify the information. You will get a letter telling you if you need to submit copies of documents as verification. In general, the documents you provide to us should be the most current copy. For income and expenses, the documents should cover the last 30 days before you applied or completed your renewal. If you need help getting proof, call your agency.

Proof of Disability

- Approval letter from the state Disability Determination Bureau
- Award letter from the Social Security Administration

Proof of Identity

- Valid U.S. passport
- Valid state driver's license or state identity card
- School picture ID
- Employee photo ID
- Military dependent ID card
- Military ID or draft record
- Native American Tribal enrollment document
- For children under 18 applying for BadgerCare Plus or Medicaid, a signed Statement of Identity form, F-10154 (You can contact your agency for this form)
- United States Citizenship and Immigration Services (USCIS) photo ID (only for U.S. citizens)

Other/Additional Proof of Identity – FoodShare Only

- Birth certificate
- Hospital birth record
- Adoption record
- Paycheck or wage stub
- Completed Application for a Social Security Card, SS-5
- Confirmation or church membership papers
- Voter registration card
- Family records (birthday books, genealogy, newspaper birth announcement, marriage license, support or divorce papers)
- Life insurance policy
- Other social services program ID
- Labor union or fraternal organization records
- Court order of name change
- Other/Additional Proof of Identity – FoodShare and Health Care
- Medical records (vaccination certificate, doctor's or clinic's records, bills)

Proof of U.S. Citizenship for Adults and Children

Appendix D: Examples of Proof

- Valid U.S. passport
- Certified copy of U.S. birth certificate
- Citizenship ID card
- Certificate of Citizenship or Naturalization
- Adoption papers
- Military, hospital, school, insurance, or nursing home record showing a U.S. birthplace
- Native American ID card or other document issued by a federally recognized Tribe

Proof of Immigration Status (if you are not a U.S. citizen)

- Permanent resident or “green” card
- Certificate of Naturalization
- Any documents issued by USCIS, an alien registration number (“A”), or other USCIS number
- Proof of Tribal Membership and/or Native American or Alaska Native Descent
- Tribal enrollment card
- Written verification or document issued by the Tribe indicating Tribal affiliation
- Certificate of Degree of Indian Blood issued by the Bureau of Indian Affairs
- Tribal census document
- Medical record card or similar documentation issued by an Indian caregiver that specifies Indian descent

Proof of Able-Bodied Adult Exemptions

- Medical Exemption from Work Requirement for Able-Bodied Adults Without Dependents form, F-01598
- Statement from health care, social worker, or alcohol and other drug abuse professional
- Statement of disability from employer or private disability agency
- Collateral contact
- Other acceptable written statement

Proof of Able-Bodied Adult Hours Worked

- Employer form
- Check stub
- Tax document
- Employer Verification of Earnings form (EVF-E)
- Written statement from the employer, work program, or volunteer site
- Employer, work program, or volunteer site contact
- Proof of Child Support and/or Alimony Paid or Received
- Court order
- Payment record from other state

Proof of Assets

- Bank statements
- Titles
- Contracts
- Deeds
- Financial records

Appendix D: Examples of Proof

- Life insurance policies
- Copy of certificates (FoodShare)
- Official letter from financial institution (FoodShare)

Proof of Job Income

- Check stubs (for the last 30 days)
- An Employer Verification of Earnings (EVF-E) form, F-10146 (You can contact your agency for this form. Your employer must complete and sign the form. Return the completed form to the address on the form.)
- A letter from the employer (If you choose a letter, it must have the same information as the EVF-E form.)

Proof of Self-Employment Income

- Copies of tax forms
- A Self-Employment Income Report form, F-00107 (You can contact your agency for this form. This form should only be used if you have not yet filed taxes for your self-employment business or your business has had a significant change in circumstances.)

Proof of Other Income

NOTE: Some examples of other income are alimony, child support, disability or sick pay, interest or dividends, veterans benefits, worker's compensation, and unemployment insurance.

- Pension statement
- Copy of current check
- Unemployment Compensation award letter
- Divorce documents showing financial settlement, maintenance, family support, or child support
- Documentation of court-awarded settlement
- Social Security award letter
- Veterans Affairs award letter
- Compensation award letter
- Financial aid award letter
- Tax records showing unearned income
- Documentation from any other source of income
- Proof of a Kinship Care, Foster Care, or Subsidized Guardian payment or interim caretaker payment (may be verbal or written confirmation from the child protective services agency)

Proof of Wisconsin Residency

- Lease, rental agreement, or receipt or letter from landlord with current address
- Mortgage receipt with current address
- Utility and/or phone bill with current address
- Check stubs with name, current address, and employer
- Subsidized housing program approval document
- Weatherization program approval document
- Current state of Wisconsin driver's license
- Current Wisconsin ID card

Appendix D: Examples of Proof

- Current motor vehicle registration
- Mail with current address

NOTE: Homeless, migrant, or individuals and families newly arrived to Wisconsin do not have to provide verification of Wisconsin residency, but must state that they live in Wisconsin and plan to continue to live in Wisconsin.

Proof of Education

- School /program schedule
- Report card
- Financial aid documents
- Letter from the college, program, or institute of higher education

Proof of Medical Costs

- Billing statement or itemized receipt
- Health insurance policy showing premium, coinsurance, copayment, or deductible
- Medicine or pill bottle with price on label

Proof of Pretax Deductions

- Check stubs
- A letter from the employer

Proof of Tax Deductions

- Receipts
- Bank statements
- Check stubs
- Previous years' tax forms

Proof of Not Being Able to Care for Child and Participate in Approved Activity

Letter from a physician, psychiatrist, or psychologist declaring the parent is unable to care for children and unable to participate in an approved activity

Proof of Child Care Costs

- Written statement from childcare provider
- Cancelled check
- Paid receipt or bill

Proof of Shelter and/or Utility Expenses

- Mortgage payment records
- Rent receipt
- Statement from landlord

Appendix D: Examples of Proof

- Lease
- U.S. Department of Housing and Urban Development (HUD) subsidized housing approval
- Property tax statement
- Utility bill
- Statement from utility company
- Phone bill
- Homeowner's insurance policy or billing statement
- WHEAP/LIHEAP or other energy assistance

Proof of Substantial Lottery or Gambling Winning

- Member statement
- Wisconsin Lottery Winner Claim
- W-2G Certain Gambling Winnings Form
- Letter from the lottery commission or gaming entity
- Another State's Lottery Claim Form
- Any documentation that identifies the source of the payment, winner(s) name, address, date of the winning, and gross amount before taxes

Proof of Drug Test Results

- Drug test results report
- Parole officer statement
- Licensed doctor or qualified health professional statement
- Any document that shows a drug test result with the test date

Appendix E: Important Terms and Acronyms

We have tried to limit the use of acronyms in the ForwardHealth Enrollment and Benefits Handbook. However, some terms are used so often that the acronyms are practical and helpful. In the handbook, the terms have been spelled out when first used, with the acronym following in parentheses.

ADRC – Aging and Disability Resource Center

AODA – alcohol or other drug abuse

B-ID – Medicare Part B immunosuppressive drug

CD – certificate of deposit

CDPU – Central Document Processing Unit

CLTS – Children’s Long-term Support

CSA – community supported agriculture

DHS – Wisconsin Department of Health Services

DME – durable medical equipment

EBT – electronic benefits transfer

ESRD – end-stage renal disease

EVF-E – Employer Verification of Earnings (form)

FPL – federal poverty level

FSET – FoodShare Employment and Training

HCBW – Home and Community-Based Waiver

HEC – Health and Employment Counseling

HMO – health maintenance organization

IRA – individual retirement account

IRIS – Include, Respect, I Self-Direct

IRS – Internal Revenue Service

IRWE – impairment-related work expenses

MAPP – Medicaid Purchase Plan

MCO – managed care organization

MDPU – Milwaukee Document Processing Unit

NOL – net operating loss

PACE – Program of All-Inclusive Care for the Elderly

PASS – Plan to Achieve Self-Support Credit

PHI – protected health information

PIN – personal identification number

SEP – simplified employee pension

SIMPLE – Savings Incentive Match Plan for Employees

SSIS – Supplemental Security Income

SSN – Social Security number

TB – tuberculosis

USCIS – U.S. Citizenship and Immigration Services

USDA – U.S. Department of Agriculture

VA – Department of Veterans Affairs

W-2 – Wisconsin Works

WIC – Women, Infants and Children Program

WIOA – Workforce Innovation and Opportunity Act



WISCONSIN DEPARTMENT
of **HEALTH SERVICES**

Division of Medicaid Services
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