STATE OF WISCONSIN
DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-10126A (11/2021)

REP

APPOINT, CHANGE, OR REMOVE AN AUTHORIZED REPRESENTATIVE: PERSON

Fill out and submit the Appoint, Change, or Remove an Authorized Representative: Person form, F-10126A, to appoint, change, or remove a person as your authorized representative.

To appoint an **organization** as your authorized representative, fill out and submit the Appoint, Change, or Remove and Authorized Representative: Organization form, F-10126B, instead.

If you have a legal guardian of the estate, legal guardian of the person and the estate, legal guardian in general, or conservator, that person must appoint an authorized representative for you if you want someone besides them to be your authorized representative. If you have a durable power of attorney, you or your power of attorney can appoint an authorized representative.

The personally identifiable information provided on this form will only be used for the direct administration of Wisconsin Medicaid, BadgerCare Plus, FoodShare, Family Planning Only Services, and Caretaker Supplement.

Authorized Representative Information

An authorized representative is a person who is familiar with your household's circumstances and that you trust to act on your behalf. Anyone can serve as your authorized representative **except** for the following:

- People who are disqualified for an intentional FoodShare program violation cannot serve as an authorized representative during their disqualification period unless no one else is able to serve as an authorized representative.
- Homeless meal providers cannot serve as an authorized representative for a homeless food unit. (A food unit is one or more people who live together and buy and make food together.)
- Agency employees who help determine eligibility or benefits may not serve as an authorized representative. Special written approval may be given for them to serve as an authorized representative in certain circumstances.
- Retailers who are authorized to accept FoodShare benefits may not serve as an authorized representative.

Once appointed, your 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
- File grievances and appeals about your eligibility for programs you are applying for or are enrolled in

You can also choose to have your authorized representative get copies of letters about your eligibility and benefits, get your ForwardHealth card, work with ForwardHealth Member Services and your HMO (health maintenance organization) on your behalf, and file grievances and appeals about your health care services (for example, treatment and bills).

You do **not** need to have an authorized representative to apply for or get benefits.

The authorized representative you appoint on this form can act on your behalf for **any** of the following programs: Wisconsin Medicaid, BadgerCare Plus, FoodShare, Family Planning Only Services, and/or Caretaker Supplement. If you are enrolled in any of these programs **and** Wisconsin Works (W-2), your authorized representative may also act on your behalf for W-2.

The authorized representative you appoint on this form **cannot** act on your behalf for the Wisconsin Shares Child Care Subsidy Program. If you are applying for Wisconsin Shares, you need to apply for yourself.

Form Instructions

If required information is missing on this form, including any of the signatures, the form will be considered incomplete, and your authorized representative **cannot** act on your behalf.

Section 1 — You need to complete Section 1. You will need to choose if you are appointing, changing, or removing an authorized representative. You will also need to provide your name and date of birth so we can identify you. If you are appointing or changing an authorized representative, choose if you want your authorized representative to get copies of your letters. If you are also applying for or are enrolled in a health care program, choose if you want to let your authorized representative take more actions on your behalf. Make sure you read and agree to the protected health information authorization before you check Yes. Next, read the statements of understanding. If you agree, sign and date the form.

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Section 2 — Your authorized representative needs to complete Section 2. Your authorized representative will need to provide their name and contact information. They will also need to read the statements of understanding and sign and date the form if they agree to the statements.

Section 3 — If you are appointing or changing an authorized representative, you will need to have someone besides your authorized representative watch you sign this form. This person is called a witness. If you sign this form with an "X," then two witnesses must watch you sign the form. The witness or witnesses will need to provide their name, signature, and the date they signed the form.

Form Submission
You can submit your completed form in one of the following ways:

Online

Scan all pages of the form to ACCESS. You can do this through your ACCESS account, which you can log into at access.wi.gov. (**Note:** If you do not have an ACCESS account, you can go to access.wi.gov and create one.)

Note: You can only scan forms to ACCESS at certain times. If you are unable to scan the form to ACCESS, submit the form using one of the other ways.

Mail

- If you live in **Milwaukee County**, mail the form to:
  MDPU
  P.O. Box 05676
  Milwaukee, WI 53205

- If you do **not** live in Milwaukee County, mail the form to:
  CDPU
  P.O. Box 5234
  Janesville, WI 53547

Fax

- If you live in **Milwaukee County**, fax the form to 888-409-1979.
- If you do **not** live in Milwaukee County, fax the form to 855-293-1822.

In Person

Take the form to your agency. Your agency contact information is on the Wisconsin Department of Health Services (DHS) website at www.dhs.wisconsin.gov/forwardhealth/imagency/index.htm.

For more information about authorized representatives, go to the DHS website at www.dhs.wisconsin.gov/forwardhealth/representative-types.htm.

SECTION 1 To Be Filled Out by Applicant/Member

I am:
☐ Appointing an authorized representative. You must fill out **all** of Section 1.

☐ Changing my authorized representative. You must fill out **all** of Section 1. Make sure you write in the name of your new authorized representative in Part B.

☐ Removing my authorized representative. You must fill out **Part A and E** of Section 1. Leave Part B and C blank.

Part A: Personal Information

Name — Applicant/Member (Last, First, Middle Initial)

Date of Birth	Case Number (if you have one)

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Part B: Authorization Information

I appoint the following person to be my authorized representative:

I want my authorized representative to get copies of letters about my eligibility and benefits.

☐ Yes ☐ No

Part C: Additional Authorization Information — Health Care Programs Only (Optional)

I am applying for or am enrolled in a **health care program** (for example, Wisconsin Medicaid, BadgerCare Plus, or Family Planning Only Services) and want my authorized representative to do all of the following:

- Get my ForwardHealth card instead of me.
- Enroll me in an HMO.
- Talk to ForwardHealth Member Services or my HMO about a bill, service, or other medical information, including protected health information. Make sure you read and agree to the protected health information authorization below before you check Yes.
- File grievances and appeals about my health care services (for example, treatment and bills).

  ☐ Yes ☐ No

Authorization for Use and Disclosure of Protected Health Information
By checking **Yes** above, I am authorizing the Wisconsin Department of Health Services and its contractors, including HMOs, to disclose (share) my protected health information with my authorized representative.

The information that I am authorizing to be shared may include the following types of information: claims, medical records, substance abuse care, reproductive care, mental health, communicable diseases, pharmacy services, HIV/AIDS, dental records, and developmental disabilities.

The information is being shared so my authorized representative can help me manage my health care benefits.

I understand that any information used or shared based on this authorization could be redisclosed (reshared) by the person or entity receiving the information and will no longer be protected by federal privacy regulations.

I understand that this authorization is voluntary and that I may refuse to authorize the release of my protected health information by checking No above. Checking No will not affect the provision of treatment, payment, enrollment in a health plan, or eligibility for benefits unless the authorization is necessary for determining eligibility for the program or enrollment in the program.

This authorization will continue until I remove the authorized representative on this form from being my authorized representative or let my agency know that I do not want my authorized representative to have access to my protected health information any longer. I can let my agency know in writing about this at any time; however, removing the authorization will not affect protected health information that has already been shared.

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Part D: Statements of Understanding

I understand and agree that:

- I have the right to choose any person I want to be my authorized representative.
- I can change or remove my authorized representative at any time. I must let my agency know in writing that I want to change or remove my authorized representative.
- I do not have to tell a person that I am removing them as my authorized representative.
- The authorized representative listed on this form will stay my authorized representative until I change or remove them.
- My authorized representative will have access to my personal information, such as my Social Security number, financial statements, and medical information, to help me manage my eligibility. If I agreed to the protected health information authorization above, I understand that my authorized representative will also have access to this information to help me manage my health care services (for example, treatment and medical bills).
- I must provide my authorized representative with true and accurate information.
- I am responsible for errors and incorrect information that my authorized representative reports. I understand that if either my authorized representative or I give false information or withhold information, I may:
  - Have to pay back benefits I should not have gotten.
  - Be fined.
  - Be banned from a program.
  - Be prosecuted for fraud.
- By signing this form, I am saying that I understand and agree to the statements above.

Part E: Signature and Date

SIGNATURE — Applicant/Member	Date Signed

SECTION 2 To Be Filled Out by Authorized Representative

Part A: Contact Information

Name — Authorized Representative (Last, First, Middle Initial)

Street Address

City	State	Zip Code

Phone Number (include area code)	Email Address (optional)

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Part B: Statements of Understanding

I understand and agree that:

- As an authorized representative, I am limited to doing any or all of the following on the applicant's or member's behalf:
  - Applying for or renewing benefits
  - Reporting changes
  - Working with the applicant's or member's agency on any benefit-related matters
  - Filing eligibility-related grievances and appeals
- I am expected to be familiar with the applicant's or member's circumstances.
- The applicant or member can remove me from being their authorized representative at any time.
- The applicant or member does not need to notify me that I have been removed from serving as their authorized representative.
- I am the applicant's or member's authorized representative until they request a different authorized representative or choose not to have an authorized representative.
- I must provide truthful and accurate information.
- If I provide inaccurate or false information, the applicant or member may need to repay any health care benefits received in error.
- If I intentionally violate program rules, I must repay any FoodShare benefits that were misused or received in error.
- I must comply with applicable state and federal laws concerning conflicts of interest and confidentiality of information.
- By signing this form, I am saying that I understand and agree to the statements above.
- By signing this form, I am saying that I will serve as the authorized representative for the applicant or member listed in Section 1.

Part C: Signature and Date

SIGNATURE — Authorized Representative	Date Signed

SECTION 3 To Be Filled Out by Witness(es)

Name — Witness (Last, First, Middle Initial)

SIGNATURE — Witness	Date Signed

Name — Witness (Last, First, Middle Initial) (if applicant/member signed with an X)

SIGNATURE — Witness	Date Signed

USDA Nondiscrimination Statement

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), 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. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: How to File a Complaint, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

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

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

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

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

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

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

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

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