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

REP

APPOINT, CHANGE, OR REMOVE AN AUTHORIZED REPRESENTATIVE: ORGANIZATION

Fill out and submit the Appoint, Change, or Remove an Authorized Representative: Organization form, F-10126B, to appoint, change, or remove an organization as your authorized representative. To change the organization's contact person, either you or the organization must contact 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.

To appoint a **person** as your authorized representative, fill out and submit the Appoint, Change, or Remove an Authorized Representative: Person form, F-10126A, 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 an organization that 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.

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. Next, read the statements of understanding. If you agree, sign and date the form.

Section 2 — A person who can act on behalf of the organization needs to complete Section 2. The person will need to provide the organization's name and contact information as well as their own. The person will also need to read the statements of understanding and sign and date the form if the organization and contact person agree to the statements.

REP

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 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 D** of Section 1. Leave Part B blank.

Part A: Personal Information

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

Date of Birth	Case Number (if you have one)

REP

Part B: Authorization Information

I appoint the following organization to be my authorized representative:

I want my authorized representative to get copies of letters about my eligibility and benefits. Please note that the letters will be sent to the organization's contact person.

☐ Yes ☐ No

Part C: Statements of Understanding

I understand and agree that:

- I have the right to choose any organization 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 an organization that I am removing it 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.
- 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 D: Signature and Date

SIGNATURE — Applicant/Member	Date Signed

REP

SECTION 2 To Be Filled Out by Authorized Representative

Part A: Contact Information

Name — Organization			
Street Address			
City	State	Zip Code	Phone Number (include area code)
Name — Organization Contact (Last, First, Middle Initial)			
Job Title — Organization Contact	Email Address — Organization Contact (optional)		

Part B: Statements of Understanding

I understand and agree that:

- I am authorized to act on behalf of the organization listed in Section 2, Part A.
- As an authorized representative, the organization is 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
- The organization is expected to be familiar with the applicant's or member's circumstances.
- The organization must report to the applicant's or member's agency any changes to the contact listed in Section 2, Part A.
- The applicant or member can remove the organization from being their authorized representative at any time.
- The applicant or member does not need to notify the organization that it has been removed from serving as their authorized representative.
- The organization is the applicant's or member's authorized representative until they request a different authorized representative or choose not to have an authorized representative.
- The organization and anyone acting on its behalf must provide truthful and accurate information.
- If the organization provides inaccurate or false information, the applicant or member may need to repay any health care benefits received in error.
- If the organization intentionally violates program rules, it must repay any FoodShare benefits that were misused or received in error.

REP

- The organization and anyone acting on its behalf must comply with applicable state and federal laws and regulations, including 42 C.F.R. Part 431, Subpart F; 42 C.F.R. § 447.10; and 45 C.F.R. § 155.260(f), concerning conflicts of interest and confidentiality of information.
- By signing this form, I am saying that I understand and agree to the statements above on behalf of the organization listed in Section 2, Part A.
- By signing this form, I am saying that the organization listed in Section 2, Part A will serve as the authorized representative for the applicant or member listed in Section 1.

Part C: Signature and Date

SIGNATURE — Organization Contact	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).