STATE OF WISCONSIN
DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 10137 (10/06)

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MEDICAID CHANGE REPORT

If you are receiving Medicaid or BadgerCare, you must report any changes in the make up of your household (if anyone moves in or out of your household, if anyone gets married, becomes pregnant, or gives birth to a child), address, income or employment status **within ten days**. People age 65 or older, blind or disabled must also report changes in assets **within 10 days.** If such a change has occurred, fill out this report and mail it or take it to the office shown in the box below, or contact your worker by telephone or in person about any changes. If this report does not provide enough room to document a change, attach a sheet of paper with the additional information written on it to this report.

(Medicaid office address)
**COLUMBIA COUNTY DEPT. OF HEALTH & HUMAN SERVICES
PO BOX 136
PORTAGE WI 53901**

Your Name	Case Number	Worker Name

If you intentionally fail to report any changes or provide false information, you may be fined, have to pay back any Medicaid benefits you wrongfully received, be prosecuted, or all three. You may be required to provide proof of any changes you report.

SECTION I - CHANGE IN ADDRESS

If you move, you must report your new address.

Date of change	New telephone number

New address (street, city, state, zip code)

SECTION II - CHANGE IN HOUSEHOLD COMPOSITION

You must report if anyone moves in or out of your household, if anyone gets married, becomes pregnant, or gives birth to a baby (include information about the person who gave birth and the newborn.)

Name(s) (Last, First, MI)	Date of change

Social Security Number (SSN)*	Date of birth	Relationship to Case Head

Describe the change

*Providing or applying for an SSN is voluntary; however any person who wants Wisconsin Medicaid but does not provide their SSN or apply for one will not be eligible for benefits [§49.82(2) Wis. Stats.].

SECTION III - CHANGE IN INCOME

You must report a change in your gross income amount, a new source of income, changes in your employment status (part-time to full-time or full-time to part-time, loss of employment), changes in salary or rate of pay, changes in the amount of Social Security, Veterans benefits, Unemployment Insurance, Worker's Compensation, or any other change in the amount of money your household receives.

Name (Last, First, MI)	Date income changed

Source of income	Monthly amount	How often Paid

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SECTION IV - CHANGE IN ASSETS

Those who are age 65 or older, blind or disabled must report changes in their cash, bank accounts, bonds, stocks, vehicles or other assets.

Name of owner (Last, First, MI)		Date of change
Type of asset	Describe the change	New value or amount $

Name of owner (Last, First, MI)		Date of change
Type of asset	Describe the change	New value or amount $

SECTION V – CHANGE IN VEHICLES

Those who are age 65 or older, blind or disabled must report if you obtain, sell or give away a car, truck, motorcycle, boat, snowmobile, camper, or another type of vehicle.

Name of owner (last, first, MI)					Date of change
Type of vehicle	Make	Model	Year	Amount received $	Describe change (bought, sold, etc.)

SECTION VI - OTHER CHANGES

Report any other changes that you believe may affect your Medicaid eligibility. Examples of other changes include someone getting or dropping health insurance or someone becoming disabled or recovering from a disability. Include the date of any other change.

Describe change

Do you expect that the changes reported on this form will remain the same next month? ☐ Yes ☐ No

If No, explain.

SECTION VII – SIGNATURE

I understand that there are penalties for hiding information or giving false information. I also understand that I may have to pay back any benefits I receive because I do not fully report changes in my circumstances. I agree to provide proof of any changes, if asked to do so. My answers on this form are correct and complete to the best of my knowledge.

SIGNATURE – Participant	Date signed	Telephone number

RETAIN COMPLETED FORM IN CASE FILE (FOR MEDICAID OFFICE USE ONLY)