DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-12023 (08/2019)

STATE OF WISCONSIN
BadgerCare Plus HMO Program
Wis. Stat. § .49.45

BIRTH TO 3 PROGRAM EXEMPTION REQUEST

_____ COUNTY

INSTRUCTIONS: To request that a child eligible for the Wisconsin Birth to 3 Program be exempted from BadgerCare Plus Health Maintenance Organization (HMO) enrollment, this form must be completed. The Social Security number (if available) is required per DHS 103.03(4), Wis. Admin. Code. Personally identifiable information about BadgerCare Plus applicants and recipients is confidential and used only for BadgerCare Plus program administration. If all the information requested on the form is not completed, the exemption request may be denied.

Complete all pages of the form and type or print clearly. For question about an exemption, call the HMO Enrollment Specialist at **800-291-2002**. Copies of the evaluation results and Individualized Family Service Plan (IFSP) must be made available to the Department of Health Services upon request.

Form Submission
Submit your completed form by email:

Wisconsin HMO Enrollment Broker Maximus
Birthtothree@maximus.com

SECTION 1 — Information About the Person Who Applied for the Exemption

Name – Member to be Exempted (First, Last, Middle Initial)	Date of Birth-Member

Medicaid ID/Social Security Number-Member	

Name-Head of Household	Medicaid ID/Social Security Number-Head of Household

Street Address- Head of Household	Telephone Number- Head of Household

City	State	Zip Code

Name of Agency Completing Birth to 3 Program Evaluation	Date of Evaluation

SECTION 2 — Statements of Understanding and Signatures

I would like the BadgerCare Plus Program to exempt the member named above from HMO enrollment. By signing below, I am saying, under penalty of perjury and false swearing, that the information I have given on this form is true.

SIGNATURE – Head of Household	Date Signed
Print First and Last Name	Telephone Number

SIGNATURE – Agency Representative completing the form	Date Signed
Print First and Last Name	Telephone Number

SIGNATURE – County Birth to 3 Program Coordinator	Date Signed
Print First and Last Name	Telephone Number