

VOLUNTARILY DECLINING AID

Personal Information you provide may be used for secondary purposes [Privacy Law, s. 15.04 (1)(m), Wisconsin Statutes].

Name – Participant	Case Number	Date Signed
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1. Declining Aid for the Case

I voluntarily decline aid for:

Wisconsin Works (W-2)

Child Care Assistance (CC)

Other _____

I understand that I can later request that my case be reconsidered for the aid I am now declining.

SIGNATURE - Participant

Date Signed

For an Individual Declining Aid

I voluntarily decline aid for: **[Check Program(s), this does not apply to W-2 services]**

Name	<input type="checkbox"/> CC	<input type="checkbox"/> Medicaid	<input type="checkbox"/> FS
Name	<input type="checkbox"/> CC	<input type="checkbox"/> Medicaid	<input type="checkbox"/> FS
Name	<input type="checkbox"/> CC	<input type="checkbox"/> Medicaid	<input type="checkbox"/> FS
Name	<input type="checkbox"/> CC	<input type="checkbox"/> Medicaid	<input type="checkbox"/> FS

I understand that if I want aid for this/these person(s) in the future, I can request reconsideration at any time. I also understand that income and assets for this/these person(s) may be considered in determining eligibility and benefits for my case.

SIGNATURE - Participant

Date Signed

2. Request a Change

I would like to change my earlier decision to voluntarily decline aid for my case or for a person in my case. Please redetermine eligibility for the following person(s) and/or program(s).

Check Program(s): Wisconsin Works (W-2), Child Care Assistance (CC), Medicaid, and/or FoodShare (FS)

Name	<input type="checkbox"/> W-2	<input type="checkbox"/> CC	<input type="checkbox"/> Medicaid	<input type="checkbox"/> FS
Name	<input type="checkbox"/> W-2	<input type="checkbox"/> CC	<input type="checkbox"/> Medicaid	<input type="checkbox"/> FS
Name	<input type="checkbox"/> W-2	<input type="checkbox"/> CC	<input type="checkbox"/> Medicaid	<input type="checkbox"/> FS
Name	<input type="checkbox"/> W-2	<input type="checkbox"/> CC	<input type="checkbox"/> Medicaid	<input type="checkbox"/> FS

SIGNATURE - Participant

Date Signed

Copy: Participant

Original: Case Record

RETAIN COMPLETED FORM IN CASE FILE