Washington State Health Care Authority

Application for Family Planning Only services

Are you currently pregnant? ☐ Yes ☐ No If you answered Yes, you are not eligible for family planning services, but may be eligible for health coverage. Apply online at **wahealthplanfinder.org**

Are you seeking family planning services? ☐ Yes ☐ No

1. Applicant and Contact Information

First Name (use your full legal name) | Middle Initial | Last Name

☐ Male ☐ Female | Date of birth | Social Security Number | ☐ Yes ☐ No Resident of Washington?

Address where you live | Apt. # | City | State | Zip Code

Mailing address | Apt. # | City | State | Zip Code

Home/cell/preferred number | Work/message number | E-mail address

Do you have trouble speaking, reading, or writing English? ☐ Yes ☐ No

Do you need an interpreter? ☐ Yes ☐ No What language do you speak? _____

U.S. Citizen? ☐ Yes ☐ No If no, are you lawfully present? ☐ Yes ☐ No If yes, please provide immigration documents.

Within the last 30 days, have you been denied Apple Health (Medicaid) coverage through **wahealthplanfinder.org**?
☐ Yes ☐ No
If Yes, stop here and move to section (8) below to complete the application.
If No, you must apply for coverage at wahealthplanfinder.org (unless you meet one of the exceptions below).

Do you have Private health insurance or Apple Health (Medicaid) coverage? ☐ Yes ☐ No
If you answered Yes, you are not eligible for family planning services unless you meet one of the exceptions below:
☐ I am seeking confidential family planning services and I am 18 years old or younger; OR
☐ I am a victim of domestic violence and I am covered under my abuser's health insurance.

2. Income From Employment / Self-Employment

Earned by you

Name of current employer (1st Job) | Telephone Number

Gross monthly income before taxes | ☐ Yes ☐ No Self-Employed?

Name of current employer (2nd Job) | Telephone Number

Gross monthly income before taxes | ☐ Yes ☐ No Self-Employed?

Earned by other household members

Name of current employer (1st Job) | Telephone Number

Gross monthly income before taxes | ☐ Yes ☐ No Self-Employed?

Name of current employer (2nd Job) | Telephone Number

Gross monthly income before taxes | ☐ Yes ☐ No Self-Employed?

If a household member currently has more than two employers, attach on a separate sheet of paper.

3. Other Household Income (gross monthly amount)

	Monthly amount:	Who receives this:
☐ Alimony/spousal support	_____	_____
☐ Rental, and/or royalty income	_____	_____
☐ Social Security/Railroad Retirement benefits	_____	_____
☐ Unemployment	_____	_____
☐ Retirement income, including: pension, annuity, and/or IRA distribution	_____	_____
☐ Dividend, stocks, shares, capital gains, farming, fishing, foreign, trust/ other investment income	_____	_____
☐ Taxable tribal income	_____	_____
☐ Other taxable income	_____	_____

4. Household Deductions

	Monthly amount:	Who pays this:
☐ Alimony/spousal support **PAID**	_____	_____
☐ Contribution/IRA or pre-tax retirement account contributions	_____	_____
☐ Student loan interest payments	_____	_____
☐ Moving costs for members of the armed forces	_____	_____
☐ Educator expenses	_____	_____
☐ Health savings account contributions	_____	_____
☐ Penalty on early withdrawal of savings	_____	_____
☐ Certain claimable business expenses	_____	_____

5. Tax Filing Status

What will your tax filing status be for this year? ☐ Single Filer ☐ Married Filing Separately ☐ Married Filing Jointly ☐ Tax Dependent of Someone from Household ☐ Tax Dependent of Someone Outside Household ☐ Non-Tax Filer

Are you legally married? ☐ Yes ☐ No If yes, your spouse's full legal name (first, middle, last name): _____

If you file a tax return, how many tax dependents do you claim? _____

If you do not file a tax return, how many children do you have? _____

6. Recent Job Loss

Have **you** quit or lost a job in the last 90 days?

☐ Yes ☐ No

If yes, the business's name: _____

Employment end date: _____

Has **your spouse** quit or lost a job in the last 90 days?

☐ Yes ☐ No

If yes, the business's name: _____

Employment end date: _____

7. Race/Ethnic Background

We ask you to voluntarily tell us your race or ethnic background. This information will not be used in considering your eligibility for services.

☐ Caucasian
☐ Black or African American
☐ Vietnamese/Laotian/Cambodian
☐ Hispanic
☐ American Indian or Alaskan Native
☐ Other Asian or Pacific Islander

Other: _____

Tribe name: _____

8. Read Carefully Before Signing Below

I understand that:

- HCA may ask me to prove the information I provide. HCA may help me get the proof or contact other agencies or persons for it.
- My information may be reviewed by other state or federal agencies. This information will NOT be shared with U.S. Customs and Immigration Services (USCIS).
- By asking for and receiving medical coverage assistance, I assign to the state of Washington all rights to any medical support and to any third party payments for medical care.
- I understand this application is for family planning services to prevent pregnancy only. If I need other medical coverage assistance, I can apply at Washington Healthplanfinder (**wahealthplanfinder.org**). If I need financial assistance or food stamps, I can apply at a DSHS Community Services Office or Washington Connection (**washingtonconnection.org**).
- **I must respond** to any requests for additional information within 15 business days or my application will be denied and I may be responsible for all charges incurred through my family planning provider's office.

9. Optional Authorized Representative (AREP)

(An AREP is someone you allow HCA to talk with about your benefits, and/or receive family planning mail for you.)

Name / Organization _____ Street _____

Mailing address _____ Apt. # _____ City _____ State _____ Zip Code _____

10. Declaration and Signature

I have read and understood the information in this application. I declare, under penalty of perjury, the information I have given in this application is true, correct, and complete to the best of my knowledge.

Signature of Applicant _____ Date _____

Return the completed form to the Health Care Authority using one of the following:

- **Mail:** HCA MEDS, PO Box 45531, Olympia WA 98504-5531
- Fax: **1-866-841-2267**
- **Phone: 1-800-562-3022**
- Email: **apple@hca.wa.gov**