Washington State Health Care Authority

Washington State Department of Social & Health Services

*Transforming lives*

# Washington Apple Health Application

## for Aged, Blind, Disabled/Long-Term Services and Supports

**Use this application to see what health care coverage may qualify for if:**

- You need Long-Term Services and Supports (LTSS) such as nursing home care, assisted living facility, adult family home, in-home care programs, or Tailored Supports for Older Adults (TSOA).
- You or someone in your household has Medicare.
- You need help paying Medicare premiums or coinsurance costs.
- You or someone in your household is age 65 or older.
- You or someone in your household has a disability and does not have Medicare.
- For TSOA: You are 55 or older, and you or your unpaid caregiver need support.

**Note:** Apply for or renew your Apple Health coverage online through Washington Healthplanfinder at **wahealthplanfinder.org** or by calling 1-855-923-4633 if you are:

- An adult age 19 to 64 years old.
- Applying for children.
- A parent or caretaker applying with children.
- Pregnant or applying for someone who is pregnant.

**Apply faster online**

- You can submit the online application at **washingtonconnection.org**

**Information you will need to apply:**

- Social security numbers
- Birthdates
- Immigration status
- Income information
- Resource and asset information (such as bank account balances, stocks, bonds, trusts, retirement accounts)

**Why do we ask for so much information?**

- We will use the information to determine what health care coverage you may qualify for. We keep the information you provide confidential as required by law.

**Where to send your completed and signed application**

**For disability-based Apple Health, Refugee coverage and coverage for seniors 65+, and programs that help pay for Medicare premiums and expenses**

- Mail your application to:
  DSHS
  Community Services Division - Customer Service Center
  PO Box 11699, Tacoma, WA 98411-6699
- Fax your application to 1-888-338-7410
- Take your application to a local Community Services Office (CSO).
- See **dshs.wa.gov/esa/community-services-find-an-office** for locations
- Apply online at **washingtonconnection.org**
- Apply by phone at 1-877-501-2233

**For long-term services and supports coverage such as nursing home care, in-home personal care, assisted living facility, adult family home programs, and TSOA**

- Mail your application to:
  DSHS
  Home and Community Services
  PO Box 45826, Olympia, WA 98504-5826
- To locate a local Home and Community Services (HCS) office visit **dshs.wa.gov/office-locations**
- Fax your application to 1-855-635-8305
- Apply online at **washingtonconnection.org**
- For more LTSS resources visit **dshs.wa.gov/altsa/resources**
- For more TSOA resources call 1-855-567-0252 or contact your local Area Agency on Aging (AAA) to speak with a Family Caregiver Specialist. Find your local AAA office: **waclc.org**

# Health Care Coverage Rights and Responsibilities

## Your rights (we must) for all health care coverage programs

**Help you read and fill out all requested forms.** You can contact the Department of Social and Health Services (DSHS) at 1-877-501-2233 for assistance.

**Provide interpreter or translator services** at no cost to you and without delay when communicating with DSHS or the Health Care Authority (HCA).

**Keep your personal information private** but we may share some information with other state and federal agencies financial institutions, and HCA contractors for purposes of eligibility and enrollment.

**Give you the opportunity to appeal** if you disagree with a determination made by DSHS or HCA that affects your eligibility for health coverage, long-term services and supports (LTSS), or a health plan. If you ask for an appeal, your case will be reviewed. For information about appeals for DSHS programs, you may contact DSHS Customer Service Contact Center at 1-877-501-2233 or visit your local Community Services Office.

If the appeal is for a decision on Washington Apple Health coverage, which is unresolved by a case review, you will be scheduled an Administrative Hearing.

**Treat you fairly. Discrimination is against the law.** DSHS and HCA comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. DSHS and HCA does not exclude people or treat them differently because of their race, color, national origin, age, disability, or sex.

DSHS and HCA also comply with applicable state laws and do not discriminate on the basis of creed, gender, gender expression or identity, sexual orientation, marital status, religion, honorably discharged veteran or military status, or the use of a trained dog guide or service animal by a person with a disability.

DSHS and HCA:

- Provide free aids and services to people with disabilities so they can communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide 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 1-877-501-2233.

If you believe that DSHS or HCA has failed to provide these services or discriminated in another way, you can file a grievance with:

- **DSHS**
  ATTN: Constituent Services
  PO Box 45131
  Olympia, WA 98504-5131
  1-800-737-0617
  Fax: 1-888-338-7410
  **askdshs@dshs.wa.gov**
- **HCA Division of Legal Services**
  ATTN: Compliance Officer
  PO Box 42704
  Olympia, WA 98504-2704
  1-855-682-0787
  Fax: 1-360-586-9551
  **compliance@hca.wa.gov**

You can file a grievance in person or by phone, mail, fax, or email. If you need help filing a grievance, the DSHS Constituent Services or HCA Division of Legal Services 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 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
1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html**.

## Your responsibilities (you must) for all health care coverage programs

**SSN and Immigration Status Disclosure.** With some exceptions, you must provide a Social Security Number (SSN) or immigration document number of yourself or anyone else in your household who wants to apply for health care coverage. An SSN is required to apply for health insurance premium tax credits. We use this information to determine your eligibility by confirming your identity, citizenship, immigration status, date of birth, and availability of other health care coverage. We do not share this information with any immigration agency.

It is possible to apply for coverage for some members of your household, but not others. If you do not have an SSN or immigration document number for all household members, others can still apply for and get coverage. For example, you can apply for your child even if you aren't eligible for coverage. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.

There are also some Washington Apple Health programs for people who cannot show they are in the country legally. But if you choose not to provide an SSN or immigrant document number for someone in your household, we will need to follow up with you to get information about the non-applicant's income.

If requested by the agency, provide any information or proof needed to decide if you are eligible.

## Things you should know for all health care coverage programs

**There are certain state and federal laws** that govern the operation of Washington Connection and state-administered application systems, your rights and responsibilities as someone who uses them and the coverage you get from using them. By using these systems, you agree to comply with the laws that apply to someone using them and the coverage they get as a result.

**The National Voter Registration Act of 1973** requires all states to provide voter registration assistance through their public assistance offices. Applying to register or declining to register to vote will not affect the services or benefits that you will be provided by this agency. You can register to vote at **www.vote.wa.gov** or order voter registration forms by calling 1-800-448-4881.

**Health Insurance Portability and Accountability Act (HIPAA)** restrictions prevent HCA and DSHS from discussing the health information of you or any member of your household with anyone, including an authorized representative, unless that individual has power of attorney or you have signed a consent form authorizing the disclosure of this information. This includes disclosure of mental health information, HIV, AIDS, STD test results, or treatment and chemical dependency services.

**The Affordable Care Act** prevents DSHS and HCA from giving the personally identifiable information (PII) of you or any member of your household to anyone who is not authorized to receive it, and without your consent.

**The information that you give DSHS and HCA** is subject to verification by federal and state officials for purposes of determining your eligibility for health care coverage. Verification can include follow-up contacts from agency staff.

**HCA and DSHS are not responsible for administering your health insurance plan.** Your health insurance carrier can provide you more information about your benefits. **If you have questions about the terms of your health insurance plan, including what benefits you are eligible for, and making a benefit claim or appealing a denial of benefits, you should contact your health insurance carrier.**

**You may apply for support enforcement services through the Division of Child Support (DCS).**
To get an application for these services, go to **www.childsupportonline.wa.gov** or contact your local DCS office.

## Your rights (we must) for Washington Apple Health only

**Explain to you your rights and responsibilities** if you ask.

**Allow you to submit a partial application** that includes at minimum, your name, address, and signature or the signature of the applicant's authorized representative. The day we get a partial application is your application date, which may affect when your coverage becomes effective. We will not make a final decision about your coverage until after you complete the application.

**Allow you to submit an application or partial application** using any method listed under WAC 182-503-0005.

**Process your application promptly** and no later than the timelines described in WAC 182-503-0060.

**Give you 10 calendar days** to provide information we need to determine eligibility. If you ask for more time, we will give you more time. If you don't give us the information or ask for more time, we may deny, close, or change your health care coverage.

**Help you** if you have trouble getting any information or proof needed for us to decide if you are eligible. If we require a document that will cost you money, we will send for it and pay the cost.

**Notify you, in most cases, at least 10 days** before we stop your health care coverage.

**Give you a written decision,** in most cases, within 45 days. Health care coverage for some disability cases may take up to 60 days. We give a written decision on pregnancy medical within 15 days.

**Allow you to refuse to speak** to an investigator if we audit your case. You do not have to let an investigator into your home. You may ask the investigator to come back at another time. Such a request will not affect your eligibility for health care coverage.

**Continue Washington Apple Health coverage** while we decide if you are eligible for another program per WAC 182-504-0125.

**Give you equal access services** as described in WAC 182-503-0120 if you are eligible.

## Your responsibilities (you must) for Washington Apple Health only

Report changes as required in WAC 182-504-0105 and WAC 182-504-0110 within 30 days of the change. Read your approval letter to see what changes you must report.
**Complete renewals** when asked.
**Give medical providers information** needed to bill us for health care services.
**Apply for Medicare** if you are entitled to it.
**Cooperate with Quality Assurance** staff when asked.
**Apply for and make a reasonable effort** to get potential income from other sources when you ask for or receive Washington Apple Health coverage.

## Things you should know for Washington Apple Health only

**By asking for and receiving Washington Apple Health,** you give the state of Washington all rights to any medical support and to any third party payments for health care.

**The Agency may share** your child's immunization history with the Child Profile Immunization Tracking System.

**Information you report** may be provided to DSHS to determine eligibility and monthly benefits for programs such as health care coverage, cash assistance, food assistance and child care subsidies.

**By law, the State of Washington may recover the costs it paid for certain types of medical services from your estate through Estate Recovery (RCW 41.05A.090, RCW 43.20B.080, and Chapter 182-527 WAC)**. Estate Recovery doesn't happen until after your death, the death of your surviving spouse, and your surviving children are age 21 or older. It also doesn't happen if a surviving child was blind/disabled at your time of death. Recoverable costs include:

- Certain Washington Apple Health long-term services and supports, if you're age 55 or older at the time you received the services;
- Certain state-only funded services, regardless of your age at the time you received the services.

You can find a list of services subject to cost recovery under WAC 182-527-2742. You can find a list of assets excluded from recovery under WAC 182-527-2746.

The State may also file a pre-death lien on your real property, at any age, if you become permanently institutionalized (WAC 182-527-2734). The State may recover from a sale of the property, or your estate, unless:

- Your spouse lives at the property;
- Your sibling lives at the property, is a co-owner, and meets certain conditions.
- Your child lives at the property, and is blind/disabled; or
- Your child lives at the property and is younger than age 21.

You can find a list of services subject to cost recovery under a pre-death lien in WAC 182-527-2734.

**You may be restricted to one health care provider,** pharmacy, and/or hospital if you seek out unnecessary health care services from providers.

[English] Language assistance services, including interpreters and translation of printed materials, are available free of charge. Call 1-800-562-3022 (TRS: 711).

[Amharic] የቋንቋ እገዛ አገልግሎት፣ አስተርጓሚ እና የሰነዶችን ትርጉም ጨምሮ በነጻ ይገኛል። 1-800-562-3022 (TRS: 711) ይደውሉ።

[Arabic] خدمات المساعدة في اللغات، بما في ذلك المترجمين الفوريين وترجمة المواد المطبوعة، متوفرة مجاناً، اتصل على رقم 1-800-562-3022 (TRS: 711).

[Burmese] ဘာသာပြန်ဆိုသူများနှင့် ထုတ်ပြန်ထားသည့် စာရွက်စာတမ်းများဘာသာပြန်ခြင်းအပါအဝင် ဘာသာစကားအထောက်အကူဝန်ဆောင်မှုများကို အခမဲ့ရရှိနိုင်ပါသည်။ 1-800-562-3022 (TRS: 711) ကိုဖုန်းခေါ်ဆိုပါ။

[Cambodian] សេវាជំនួយភាសា រួមមានទាំងអ្នកបកប្រែផ្ទាល់មាត់ និង ការបកប្រែឯកសារបោះពុម្ព គឺអាចរកបានដោយឥតគិតថ្លៃ។ ហៅទូរស័ព្ទទៅលេខ 1-800-562-3022 (TRS: 711)។

[Chinese] 免费提供语言协助服务，包括口译员和印制资料翻译。请致电 1-800-562-3022 (TRS: 711)。

[Korean] 통역 서비스와 인쇄 자료 번역을 포함한 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-562-3022 (TRS: 711)번으로 전화하십시오.

[Laotian] ການບໍລິການດ້ານພາສາ, ລວມທັງນາຍແປພາສາ ແລະ ການແປເອກະສານຕີພິມ, ມີໄວ້ໃຫ້ຟຣີໂດຍບໍ່ຄິດຄ່າ. ໂທຫາເລກ 1-800-562-3022 (TRS: 711).

[Oromo] Tajajilli gargaarsa afaanii, nama afaan hiikuu fi ragaalee maxxanfaman hiikuun, kaffaltii malee ni argattu. 1-800-562-3022 (TRS: 711) irratti bilbilaa.

[Persian] خدمات کمک زبانی، از جمله مترجم شفاهی و ترجمه اسناد و مدارک (مطالب) چاپی، بصورت رایگان ارائه خواهد شد.با شماره 1-800-562-3022 (TRS: 711) تماس بگیرید.

[Punjabi] ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ—ਦੁਭਾਸ਼ੀਏ ਅਤੇ ਪ੍ਰਿੰਟ ਕੀਤੀ ਹੋਈ ਸਮੱਗਰੀ ਦੇ ਅੰਨੁਵਾਦ ਸਮੇਤ—ਮੁਫ਼ਤ ਉਪਲੱਬਧ ਹਨ। 1-800-562-3022 (TRS: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

[Romanian] Serviciile de asistență lingvistică, inclusiv cele de interpretariat și de traducere a materialelor imprimate, sunt disponibile gratuit. Apelați 1-800-562-3022 (TRS: 711).

[Russian] Языковая поддержка, в том числе услуги переводчиков и перевод печатных материалов, доступна бесплатно. Позвоните по номеру 1-800-562-3022 (TRS: 711).

[Somali] Adeego caawimaad luuqada ah, ay ku jirto turjubaano afka ah iyo turjumid lagu sameeyo waraaqaha la daabaco, ayaa lagu helayaa lacag la'aan. Wac 1-800-562-3022 (TRS: 711).

[Spanish] Hay servicios de asistencia con idiomas, incluyendo intérpretes y traducción de materiales impresos, disponibles sin costo. Llame al 1-800-562-3022 (TRS: 711).

[Swahili] Huduma za msaada wa lugha, ikiwa ni pamoja na wakalimani na tafsiri ya nyaraka zilizochapishwa, zinapatikana bure bila ya malipo. Piga 1-800-562-3022 (TRS: 711).

[Tagalog] Mga serbisyong tulong sa wika, kabilang ang mga tagapagsalin at pagsasalin ng nakalimbag na mga kagamitan, ay magagamit ng walang bayad. Tumawag sa 1-800-562-3022 (TRS: 711).

[Tigrigna] ተርንምትን ናይ ዝተፅሓፉ ማተርያላት ትርጉምን ሓዊሱ ናይ ቋንቋ ሓገዝ ግልጋሎት፤ ብዘይ ምንም ክፍሊት ይርከቡ። ብ 1-800-562-3022 (TRS: 711) ደውሉ።

[Ukrainian] Мовна підтримка, у тому числі послуги перекладачів та переклад друкованих матеріалів, доступна безкоштовно. Зателефонуйте за номером 1-800-562-3022 (TRS: 711).

[Vietnamese] Các dịch vụ trợ giúp ngôn ngữ, bao gồm thông dịch viên và bản dịch tài liệu in, hiện có miễn phí. Gọi 1-800-562-3022 (TRS: 711).

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# Washington Apple Health Application
## for Aged, Blind, Disabled/Long-Term Services and Supports

**1** **Applicant name and contact information**

First name (Self) | M.I. | Last name

Client ID number (If applicable) | Signature of applicant or authorized representative

Address where you live (Required)

County | City | State | Zip code

☐ **Check this box if you do not have a physical address**

Mailing address (if different)

County | City | State | Zip code

Primary phone number | Cell | Email

**If living in a facility, list the facility name and address, if not the same as above:**

Name of facility

Address of facility

County | City | State | Zip code

18005

## 2 Program applying for

I, my spouse, or someone in my household is applying for:

- ☐ In-Home Caregiver Services
- ☐ Assisted Living/Adult Family Home
- ☐ Nursing Home Care
- ☐ Tailored Supports for Older Adults (TSOA)
- ☐ Health Care Coverage for Aged, Blind, or Disabled
- ☐ Medicare Savings Program
- ☐ Apple Health for Workers with Disabilities (HWD)

## 3 Unpaid medical bill information

Do you or anyone you are applying for need help paying for unpaid medical bills incurred in any of the 3 months immediately before the current month? ☐ Yes ☐ No If yes, list who:

_____ _____ _____

## 4 Language information

Will you or anyone you're applying for need an interpreter or to receive documents in another language? ☐ Yes ☐ No

If yes, what language or alternative format do you need? List all that apply: _____

## 5 Information about you and your family

List yourself, spouse, and dependents living with you even if you are not applying for them (attach additional sheets, if necessary).

| Name (First, Middle, Last) | Sex assigned at birth | Relation to you? | Date of birth |
|---|---|---|---|
| | | SELF | |

Social Security number (SSN)* Do you want coverage for this person? ☐ Yes ☐ No

Citizen or Non-citizen status: (check one)

U.S. citizen ☐ Yes ☐ No Washington resident ☐ Yes ☐ No

Are you Hispanic, Latino, or Spanish origin? (OPTIONAL)

- ☐ Cuban
- ☐ Mexican/Mexican-American/Chicano
- ☐ Not Spanish/Hispanic
- ☐ Other Spanish/Hispanic
- ☐ Puerto Rican

**Race (OPTIONAL – select up to five that apply)**

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Guamanian
- ☐ Korean
- ☐ Laotian
- ☐ Other Pacific Islander
- ☐ Thai
- ☐ Vietnamese
- ☐ White

☐ Black or African American ☐ Hawaiian ☐ Other Race

☐ Cambodian ☐ Japanese ☐ Samoan

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Name (First, Middle, Last) | Sex assigned at birth | Relation to you? | Date of birth

Social Security number (SSN)* | Do you want coverage for this person? ☐ Yes ☐ No

Citizen or Non-citizen status: **(check one)**

U.S. citizen ☐ Yes ☐ No Washington resident ☐ Yes ☐ No

**Are you Hispanic, Latino, or Spanish origin? (OPTIONAL)**

☐ Cuban ☐ Mexican/Mexican-American/Chicano ☐ Not Spanish/Hispanic

☐ Other Spanish/Hispanic ☐ Puerto Rican

**Race (OPTIONAL – select up to five that apply)**

☐ American Indian or Alaska Native ☐ Chinese ☐ Korean ☐ Thai

☐ Asian ☐ Filipino ☐ Laotian ☐ Vietnamese

☐ Asian Indian ☐ Guamanian ☐ Other Pacific Islander ☐ White

☐ Black or African American ☐ Hawaiian ☐ Other Race

☐ Cambodian ☐ Japanese ☐ Samoan

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Name (First, Middle, Last) | Sex assigned at birth | Relation to you? | Date of birth

Social Security number (SSN)* | Do you want coverage for this person? ☐ Yes ☐ No

Citizen or Non-citizen status: **(check one)**

U.S. citizen ☐ Yes ☐ No Washington resident ☐ Yes ☐ No

**Are you Hispanic, Latino, or Spanish origin? (OPTIONAL)**

☐ Cuban ☐ Mexican/Mexican-American/Chicano ☐ Not Spanish/Hispanic

☐ Other Spanish/Hispanic ☐ Puerto Rican

**Race (OPTIONAL – select up to five that apply)**

| | | | |
|---|---|---|---|
| ☐ American Indian or Alaska Native | ☐ Chinese | ☐ Korean | ☐ Thai |
| ☐ Asian | ☐ Filipino | ☐ Laotian | ☐ Vietnamese |
| ☐ Asian Indian | ☐ Guamanian | ☐ Other Pacific Islander | ☐ White |
| ☐ Black or African American | ☐ Hawaiian | ☐ Other Race | |
| ☐ Cambodian | ☐ Japanese | ☐ Samoan | |

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Name (First, Middle, Last) _____ Sex assigned at birth _____ Relation to you? _____ Date of birth _____

Social Security number (SSN)* _____ Do you want coverage for this person? ☐ Yes ☐ No

Citizen or Non-citizen status: **(check one)**

U.S. citizen ☐ Yes ☐ No Washington resident ☐ Yes ☐ No

Are you Hispanic, Latino, or Spanish origin? (OPTIONAL)

| | | |
|---|---|---|
| ☐ Cuban | ☐ Mexican/Mexican-American/Chicano | ☐ Not Spanish/Hispanic |
| ☐ Other Spanish/Hispanic | ☐ Puerto Rican | |

**Race (OPTIONAL – select up to five that apply)**

| | | | |
|---|---|---|---|
| ☐ American Indian or Alaska Native | ☐ Chinese | ☐ Korean | ☐ Thai |
| ☐ Asian | ☐ Filipino | ☐ Laotian | ☐ Vietnamese |
| ☐ Asian Indian | ☐ Guamanian | ☐ Other Pacific Islander | ☐ White |
| ☐ Black or African American | ☐ Hawaiian | ☐ Other Race | |
| ☐ Cambodian | ☐ Japanese | ☐ Samoan | |

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Name (First, Middle, Last) _____ Sex assigned at birth _____ Relation to you? _____ Date of birth _____

Social Security number (SSN)* _____ Do you want coverage for this person? ☐ Yes ☐ No

Citizen or Non-citizen status: **(check one)**

U.S. citizen ☐ Yes ☐ No Washington resident ☐ Yes ☐ No

Are you Hispanic, Latino, or Spanish origin? (OPTIONAL)

| | | |
|---|---|---|
| ☐ Cuban | ☐ Mexican/Mexican-American/Chicano | ☐ Not Spanish/Hispanic |
| ☐ Other Spanish/Hispanic | ☐ Puerto Rican | |

**Race (OPTIONAL – select up to five that apply)**

| | | | |
|---|---|---|---|
| ☐ American Indian or Alaska Native | ☐ Chinese | ☐ Korean | ☐ Thai |
| ☐ Asian | ☐ Filipino | ☐ Laotian | ☐ Vietnamese |
| ☐ Asian Indian | ☐ Guamanian | ☐ Other Pacific Islander | ☐ White |
| ☐ Black or African American | ☐ Hawaiian | ☐ Other Race | |
| ☐ Cambodian | ☐ Japanese | ☐ Samoan | |

*HCA does not share this information with any immigration agency for immigration enforcement purposes. Leave this blank if you do not have an SSN.

## 6 General information

**1.** In the past 30 days, I, my spouse, or someone in my household received health care coverage from another state, tribe or other source?

☐ Yes ☐ No If yes, explain _____

**2.** I, my spouse, or someone in my household received Supplemental Security Income (SSI) in another state?

☐ Yes ☐ No If yes, who?_____

**3.** I, my spouse, or someone in my household is a sponsored immigrant?

☐ Yes ☐ No If yes, who?_____

**4.** I, my spouse, or someone in my household has served in the U.S. Armed Forces, National Guard or Reserves or been a dependent or spouse of someone who has served:

☐ Yes ☐ No If yes, who?_____

**5.** I have a tax dependent I have not yet included on my application who does not live with me?

☐ Yes ☐ No If yes, list tax dependent's name(s) _____ _____

_____ _____ _____

**6.** I am: ☐ Single ☐ Married living with spouse ☐ Married living apart from spouse ☐ Divorced ☐ Widowed ☐ In a registered Domestic Partnership ☐ Legally separated

## 7 Employment or self-employment income (Attach proof)

Earned income is money made from employment or self-employment, some examples* include

**Employment:**

- Wages, salary or tips that federal income taxes are withheld on Form W-2, box 1
- Bonuses and commission.
- Pension plan payments.
- Income from a job where your employer didn't withhold tax (such as gig economy work)
- Driving a car for booked rides or deliveries
- Running errands or doing tasks
- Selling goods online
- Providing creative or professional services
- Providing other temporary, on-demand or freelance work
- Benefits from a union strike

**Self-Employment:**

- Own or operate a business
- Own or operate a farm
- Minister or member of a religious order
- Statutory employee and have income

***Source: irs.gov/credits-deductions/individuals/earned-income-tax-credit/earned-income-and-earned-income-tax-credit-eitc-tables**

**1.** I, my spouse, or someone I am applying for has income from work ☐ Yes ☐ No If yes, please complete this section.

**2.** _____ _____ _____
Who earns this income: Employer's name Employer's phone number

_____ Is this job self-employment? ☐ Yes ☐ No
Start date
Gross amount received (Dollar amount before deductions) _____every: ☐ Hour ☐ Week ☐ Two weeks

☐ Twice a month ☐ Month

_____ _____
Hours per week Pay dates (e.g. 1st and 15th, or every Friday)

**3.** _____ _____ _____
Who earns this income: Employer's name Employer's phone

_____ Is this job self-employment? ☐ Yes ☐ No
Start date

Gross amount received (Dollar amount before deductions) _____every: ☐ Hour ☐ Week ☐ Two weeks

☐ Twice a month ☐ Month

## 8 Other Income (For all household members) (Attach proof)

**1.** Examples of other income are:

- Child Support or Spousal Maintenance
- Educational benefits (Student Loans, Grants, Work-Study)
- Gaming Income
- Gifts (Cash Support/Gift Cards)
- Interests/Dividends
- Labor and Industries (L&I)
- Railroad Benefits
- Rental Income
- Retirement or Pension
- Sales Contracts/Promissory Notes
- Social Security
- Supplemental Security Income (SSI)
- Tribal Income
- Trusts
- Unemployment Benefits
- Veteran Administration (VA) or Military Benefits
- Other

**2.** List other income you, your spouse, or anyone you are applying for receives:

| Other income type | Who gets the income | Gross monthly amount | Who gets the income | Gross monthly amount |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**3.** I, my spouse, or someone in my household receives income from an annuity investment? ☐ Yes ☐ No

| Who owns the annuity | Company or institution | Amount or value | Monthly income | Date purchased |
|---|---|---|---|---|
| Who owns the annuity | Company or institution | Amount or value | Monthly income | Date purchased |

## 9 Housing Expenses (Attach proof if applying for LTSS)

| Rent | Mortgage | Space rent | Homeowners ins. | Property taxes | Other expenses |
|---|---|---|---|---|---|

Do you receive help from another person or agency, such as subsidized housing that pays all or part of these expenses?

☐ Yes ☐ No If yes, who? _____

## 10 Deductions

**1.** I, my spouse, or someone I am applying for pays or is supposed to pay:

| | Monthly amount | Who pays |
|---|---|---|
| Child or adult dependent care | | |
| Court ordered child support | | |
| Payee fees | | |
| Guardianship fees | | |
| Court ordered attorney fees | | |
| Recurring medical expenses (include Medicare or other health insurance premiums you pay) | | |

**2.** I, my spouse, or someone I am applying for owes medical expenses?

| Medical expense type | Date incurred | Amount owed | Who owes |
|---|---|---|---|
| Medical expense type | Date incurred | Amount owed | Who owes |
| Medical expense type | Date incurred | Amount owed | Who owes |

**3.** I, my spouse, or someone I am applying for has a disability and is working and has expenses that support employment? These are called Impairment Related Work Expenses (IRWE):

☐ Yes ☐ No If yes, give IRWE amount _____

## 11 Resources (Attach Proof)

**(Skip this section if only applying for Medicare Savings Programs (MSP) or Apple Health for Workers with Disabilities (HWD))**

**1.** A resource is anything you own or are buying that can be sold, traded, or converted into cash or money held by others. A resource does not include personal property such as furniture, household goods, or clothing. Examples of resources are:

- Cash
- Checking accounts
- Savings accounts
- CDs
- Money market account
- Savings bonds
- Bonds
- Mutual funds
- Stocks
- Annuities
- Trusts
- IRA
- 401K
- Retirement fund
- Houses, including the one you live in
- Burial funds
- Condominium
- Land
- Sales contract
- Buildings
- Life estate
- Life insurance
- Prepaid funeral plans
- College funds
- Time-share
- Business equipment
- Farm equipment
- Livestock

**2.** List the resources you, your spouse, or anyone you are applying for owns or is buying:

| Resource type | Who owns | Location | Value | Who owns | Location | Value |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

**3.** I, my spouse, or someone I'm applying for has cars, trucks, vans, boats, RVs, trailers, or other motor vehicles:

| Year (e.g., 2010) | Make (e.g., Ford) | Model (e.g., Escort) | Amount owed |
|---|---|---|---|
| | | | |

☐ Check if leased ☐ Check if used for medical purposes

| Year (e.g., 2010) | Make (e.g., Ford) | Model (e.g., Escort) | Amount owed |
|---|---|---|---|
| | | | |

☐ Check if leased ☐ Check if used for medical purposes

## 12 Additional LTSS Resources (Complete only if you are applying for LTSS services)

**1.** I, my spouse, or someone I am applying for owns or is buying a home which is a primary residence:

| Property address | Current value (Per assessor) | Loan amounts owed on property |
|---|---|---|
| | | |
| | | |

**2.** I, my spouse, or someone I am applying for has sold, traded, given away, or transferred a resource in the last five years (including property trusts, vehicles, cash, or life estates)? ☐ Yes ☐ No If yes, complete the following: (attach additional sheets, if necessary)

| Type of resource | Date of transfer | Value of resource transferred | Who was it transferred to |
|---|---|---|---|
| Type of resource | Date of transfer | Value of resource transferred | Who was it transferred to |

## 13 Long-Term Care Insurance (Not needed for Medicare Savings Programs)

I/we have long-term care insurance? ☐ Yes ☐ No Is this a qualified LTC Partnership (LTCP) policy? ☐ Yes ☐ No
If yes, please list the name(s) of the insurance company and who the policy covers:

| Insurance company | Policy number | Policy holder's name | Covered person | Dollar value (if LTCP) |
|---|---|---|---|---|
| Insurance company | Policy number | Policy holder's name | Covered person | Dollar value (if LTCP) |

**To include any additional comments for this application, attach a sheet with the information.**

## 14 Authorized Representative Information

An authorized representative is any adult who is aware of the household circumstances and is authorized by the household to act on behalf of the household for eligibility purposes.

By designating an authorized representative, you are giving permission for your authorized representative to:

- Sign the application on your behalf;
- Receive notices related to your application and account; and
- Act on your behalf for all matters related to the application and account.

1. Are you designating an authorized representative? ☐ Yes ☐ No
2. Do you want your authorized representative to receive notices related to your application and account? ☐ Yes ☐ No
3. Does this authorized representative have legal guardianship ☐ Yes ☐ No If yes, for who: _____
4. Does this authorized representative have power of attorney? ☐ Yes ☐ No If yes, for who: _____

Authorized representative name / organization

Phone number

Email address

Mailing address of authorized representative

## 15 Read carefully before signing

### Repaying the State for Health Care Coverage and Long-Term Care:

By law, the State of Washington may recover the costs it paid for certain types of medical services from your estate through Estate Recovery (RCW 41.05A.090, RCW 43.20B.080, and Chapter 182-527 WAC). Estate Recovery doesn't happen until after your death, the death of your surviving spouse, and your surviving children are age 21 or older. It also doesn't happen if a surviving child is blind/disabled at your time of death. Recoverable costs include:

Certain Washington Apple Health long-term services and supports, if you're age 55 or older at the time you received the services.

Certain state-only funded services, regardless of your age at the time you received the services.

You can find a list of services subject to cost recovery under WAC 182-527-2742. You can find a list of assets excluded from recovery under WAC 182-527-2746.

The State may also file a pre-death lien on your real property, at any age, if you become permanently institutionalized (WAC 182-527-2734). The State may recover from a sale of the property, or your estate, unless:

- Your spouse lives at the property;
- Your sibling lives at the property, is a co-owner, and meets certain conditions.
- Your child lives at the property, and is blind/disabled; or
- Your child lives at the property and is younger than age 21.

You can find a list of services subject to cost recovery under a pre-death lien in WAC 182-527-2734.

### Assignment of Rights and Cooperation:

You understand that you assign third party payments for medical care to the State of Washington when you receive Washington Apple Health coverage. This means that the State of Washington will bill any other insurance plan that is legally obligated to cover any of your medical expenses (this could be the insurance plan of an ex-spouse or a parent that you no longer live with). The subscriber of that insurance plan could receive information about your medical expenses that are paid by that plan. If you are afraid that this could endanger you or your children, you can ask us not to pursue third party payments for medical care.

### Annuity Disclosure:

If you or your spouse has an interest in an annuity and you accept Washington Apple Health (Medicaid) Long-Term Care benefits, you must name the State of Washington as a remainder beneficiary of the annuity.

### Administrative Hearing Rights:

If you disagree with a decision we have made regarding your health care coverage or long-term care services, you have the right to appeal the decision through the administrative hearing process. You may also ask a supervisor and administrator to review the disputed decision or action without affecting your rights to an administrative hearing.

## 16 Authorization

I understand the information I provide to apply for or renew assistance will be subject to verification by federal and state officials to determine if it is correct. I authorize the Washington State Health Care Authority (HCA) and Department of Social and Health Services (DSHS) to conduct asset verification to determine my eligibility and to verify the accuracy of my financial information. I understand the HCA and DSHS may investigate and contact any financial institution as part of the asset verification process. I understand this authorization ends when a final adverse decision is made on my application, my eligibility for benefits ends, or if I revoke this authorization at any time by providing HCA or DSHS with written notice. Should I revoke or refuse to provide authorization, I understand that I will not be eligible for any Washington Apple Health Aged, Blind or Disabled (SSI-Related) Medicaid program.

Revocation or refusal to authorize asset verification does not affect eligibility for Tailored Supports for Older Adults (TSOA).

## 17 Voter registration

The Department offers voter registration services, including automatic voter registration.
**Applying to register or declining to register to vote will not affect the services or amount of benefits that you may receive from this agency.** If you would like help filling out the voter registration form, we will help you. The decision whether to seek or accept help is yours. You may fill out the voter registration form in private. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Washington State Election Division, PO Box 40229, Olympia, WA 98504, email **elections@sos.wa.gov**, or call 1-800-448-4881.

**Do you want to register to vote or update your voter registration?** ☐ **Yes** ☐ **No**

**If you do not check either box, we will consider you to have decided not to register to vote at this time, unless you are eligible for, and do not decline, automatic voter registration.**

Unless you checked "No" above, you may be eligible for automatic voter registration. You are eligible for automatic voter registration if you will be at least 18 years old by the next election, you are a citizen of the United States of America, and DSHS has your name, residential and mailing address, date of birth, verification of citizenship information, and your signature attesting to the truth of the information provided on this application.

**Do you want to be automatically registered to vote?** ☐ **Yes** ☐ **No**

**If you checked the box marked "Yes," or do not check either box and you meet automatic voter registration eligibility requirements, DSHS will send your information to the Office of the Secretary of State and you will be automatically registered to vote.**

To share comments or include more information, attach an additional sheet.

## 18 Declaration and Signature

I have read and understood the information in this application. I declare, under penalty of perjury under the laws of the State of Washington, that the information I have given in this application, including the information concerning citizenship and immigration status of the members applying for benefits, is true, correct, and complete to the best of my knowledge.

| | | |
|---|---|---|
| Signature of client | Phone number | Date |
| Signature of spouse | Phone number | Date |
| Signature of parent for minor child client | Phone number | Date |
| Signature of authorized representative or helper | Phone number | Date |