

Application for Take Charge (Family Planning) Services

Fax Completed Application to 1-866-841-2267

Please read this section carefully before filling out this application

If you are at or below 260% of the Federal Poverty Level for your household size, you must apply and be denied for full-scope Medicaid coverage at www.wahealthplanfinder.org before you can enroll in Take Charge.

Do you have private health insurance or Medicaid (i.e., Apple Health or Healthy Options) coverage? Yes No

If you answer Yes above, you are not eligible for Take Charge unless one of the following applies:

- I am 18 years old or younger, my parents **do not** know I am seeking family planning services, and I want to keep the services that I receive confidential; **OR**
- I am a victim of domestic violence, and I am covered under my abuser's health insurance.

Clinic name	Clinic telephone number
-------------	-------------------------

1. First name (use your full legal name)	Middle initial	Last name
--	----------------	-----------

2. Address where you live	Apt. #	City	State	Zip Code
---------------------------	--------	------	-------	----------

3. Mailing address (if different from above):	Apt. #	City	State	Zip Code
---	--------	------	-------	----------

4. If you would like your mail to be sent to the clinic instead of your mailing address, please initial here: _____

5. Home/cell/preferred number	Work/message number	E-mail address
-------------------------------	---------------------	----------------

6. Do you have trouble speaking, reading, or writing English? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you need an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No	What language do you speak?
---	---	-----------------------------

General Information

<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth	Do you intend to use a birth control method to prevent unintended pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, why do you need Take Charge (e.g., IUD removal)? _____
---	---------------	--

Social Security Number	U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, please provide immigration documents. If immigration documents are not provided you may be denied.
------------------------	---

Income From Employment / Self-Employment

Earned by You		Earned by Your Spouse	
Name of business you currently work for (1st Job)	Telephone number	Name of business you currently work for (1st Job)	Telephone number
Gross monthly income before taxes	Self-Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Gross monthly income before taxes	Self-Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of business you currently work for (2nd Job)	Telephone number	Name of business you currently work for (2nd Job)	Telephone number
Gross monthly income before taxes	Self-Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Gross monthly income before taxes	Self-Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No

If you or your spouse currently has more than two employers, please attach additional information on a separate sheet of paper.

Other Household Income

<input type="checkbox"/> Spousal support, rental income and/or royalties	Monthly amount: _____	Who receives this: _____
<input type="checkbox"/> Social Security/Railroad Retirement income	Monthly amount: _____	Who receives this: _____
<input type="checkbox"/> Unemployment	Monthly amount: _____	Who receives this: _____
<input type="checkbox"/> Pension, annuity, and/or IRA distribution income	Monthly amount: _____	Who receives this: _____
<input type="checkbox"/> Interest/dividend income, capital gains/losses, farm income/losses, other investment income	Monthly amount: _____	Who receives this: _____
<input type="checkbox"/> Economic development funds from tribes	Monthly amount: _____	Who receives this: _____
<input type="checkbox"/> Other income that is taxable (i.e., included in adjusted gross income on your tax return): _____	Monthly amount: _____	Who receives this: _____

Client name	Client Social Security number
-------------	-------------------------------

Household Deductions		
<input type="checkbox"/> Higher education tuition, fees, and books	Monthly amount: _____	Who pays this: _____
<input type="checkbox"/> Contributions to Health Savings Account/IRA	Monthly amount: _____	Who pays this: _____
<input type="checkbox"/> Student loan interest and spousal support	Monthly amount: _____	Who pays this: _____
<input type="checkbox"/> Moving costs since January 1 of this year	Monthly amount: _____	Who pays this: _____
<input type="checkbox"/> Other AGI deductions (i.e., used to calculate adjusted gross income (AGI) on your tax return): _____	Monthly amount: _____	Who pays this: _____

Tax Filing Status	
What will your tax filing status be for this year? <input type="checkbox"/> Single Filer <input type="checkbox"/> Married Filing Separately <input type="checkbox"/> Married Filing Jointly	
<input type="checkbox"/> Tax Dependent of Someone from Household <input type="checkbox"/> Tax Dependent of Someone Outside Household <input type="checkbox"/> Non-Tax Filer	
Are you legally married? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, your spouse's full legal name (first, middle, last name): _____	
Spouse's SSN: _____ 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? _____	

Recent Job Loss	
Have you quit or lost a job in the last 90 days? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has your spouse quit or lost a job in the last 90 days? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, the business's name: _____	If yes, the business's name: _____
Employment enddate: _____	Employment enddate: _____

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.		
<input type="checkbox"/> Caucasian	<input type="checkbox"/> Black or African American	<input type="checkbox"/> Vietnamese/Laotian/Cambodian
<input type="checkbox"/> Hispanic	<input type="checkbox"/> American Indian or Alaskan Native:	<input type="checkbox"/> Other Asian or Pacific Islander
<input type="checkbox"/> Other: _____	Tribe name: _____	

Read Carefully Before Signing Below	
I understand that:	
<ul style="list-style-type: none"> 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 (https://www.wahealthplanfinder.org). If I need financial assistance or food stamps, I can apply at a DSHS Community Services Office or Washington Connection (https://www.washingtonconnection.org). I must respond to any requests for additional information from the Take Charge Eligibility office within 10 business days or my application will be denied and I may be responsible for all charges incurred through my Take Charge Provider's office. 	

Optional Authorized Representative (AREP)	
(An AREP is someone you allow HCA to talk with about your benefits, and/or receive Take Charge mail for you.)	
I am naming the person or organization below as my AREP: Client Initial _____	

Name / Organization			Telephone number	
Mailing address	Street	City	State	Zip Code

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