Washington State Health Care Authority

Retroactive Health Care Coverage Request form – MAGI Medicaid

Use this form to request three months coverage prior to an application for health care coverage.

Primary Applicant / Head of Household Information				
First Name, Middle Initial, Last Name		Date of Birth		
ID number (Ex: DSHS Client ID, SSN, Washington Healthplanfinder application, ProviderOne ID)				
Full name of each household member who needs retroactive coverage	**List months with unpaid bills (mm/yyyy)**			**Were they WA residents during all months?**
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

List Months (mm/yyyy)	**List your total monthly household income and deductions**				
Month 1:	Income from a job $	Social Security $	Self-Employment $	Other Income $	Deductions $
Month 2:	Income from a job $	Social Security $	Self-Employment $	Other Income $	Deductions $
Month 3:	Income from a job $	Social Security $	Self-Employment $	Other Income $	Deductions $

Other Income: Circle the type of the other countable income listed above

-Unemployment	-Farming Income	-Income from a trust	-IRA distributions
-Rental Income	-Other taxable income	-Dividend, Stock or shares	-Royalty Income
-Alimony/ spousal support	-Capital gains	-Interest Income	-Railroad Retirement Benefits
-Annuity or Pension	-Foreign Income	-Taxable tribal income	

Countable Deductions: Circle the type of the deduction listed above

-Alimony/spousal support	-Health savings account contributions	-Certain claimable business expenses	-Self-employment retirement plan
-Student loan interest	-Penalty on early withdrawal of savings	-Self-employment health insurance	-Self- employment tax
-Educator expenses	-Domestic production activities		- Pre-tax retirement account contributions
-Moving costs for a job this year			

Declaration and Signature

By signing below, I certify under penalty and false swearing that my answers are correct and complete to the best of my knowledge. I also understand the penalties for giving false information or breaking the law.

Signature of Primary Applicant	Print Name	Date
Signature of Authorized Representative	Print Name	Date

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

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