Washington State Health Care Authority

washington healthplanfinder
click. compare. covered.

Application for
Health Care Coverage
(and to find out if you can get help with costs)

Use this application to see what health care coverage you qualify for:	• Free or low-cost health care coverage from Washington Apple Health (Medicaid), including the Children's Health Insurance Program (CHIP) • A tax credit that can help you pay your health care premiums • Private Qualified Health Plans and Qualified Dental Plans
Apply faster online	Apply faster online at **www.wahealthplanfinder.org**
Information you will need to apply:	• Social Security numbers • Birthdays • Foreign passport, "A" number, or other immigration numbers for any immigrants applying for health care coverage • Income information for all adults and all minors who are required to file a tax return • Information about health insurance available to your family
Why do we ask for so much information?	We need the following information in order to determine what health care coverage you are qualified for. We will keep the information you provide private as required by law.
Send your complete and signed application to:	Washington Healthplanfinder PO Box 946 Olympia, Washington, 98507 or Fax 1-855-867-4467 If you don't have all the information we ask for, you can start your application by filling in your name, date of birth, signature, and address and mail to the address above.
Get help with this application:	• Online: **www.wahealthplanfinder.org** • Phone: Call the Customer Support Center at 1-855-WAFINDER (855-923-4633) or 855-627-9604 (TTY) • In person: To get application assistance search for a Navigator or Broker via the customer support link at **www.wahealthplanfinder.org**. • Language or Disability: To get free help in your language or a disability accommodation, call 1-855-WAFINDER (855-923-4633) or 855-627-9604 (TTY)

Definitions

Health Insurance Premium Tax Credits: Tax credits can be used to lower your monthly premium, the amount you pay each month for your health plan.

Washington Healthplanfinder: An online marketplace for individuals, families and small businesses in Washington to compare and enroll in coverage and gain access to tax credits, reduced cost-sharing, and public programs such as Washington Apple Health.

Premium: The amount you pay each month for your health plan. You must pay your premium even if you do not receive any health care services.

Qualified Health Plan: A health care coverage policy that is sold through Washington Healthplanfinder.

Minimum Essential Coverage: This is the type of coverage an individual needs to have to meet the individual responsibility requirement under the Affordable Care Act. This includes individual market policies, job-based coverage, Medicare, Medicaid, Children's Health Insurance Program (CHIP), TRICARE and other coverage that covers the 10 Essential Health Benefits.

Essential Health Benefits: A set of 10 health care services that all plans must cover, like doctor visits, hospital stays, and prescription drug. Some benefits are free, and some may have co-pays and co-insurance.

Washington Apple Health: The public health insurance programs for eligible Washington residents. Washington Apple Health is the name used in Washington for Medicaid, the Children's Health Insurance Program (CHIP), and state-only funded health care programs.

For people who are self-employed

You can subtract the costs below from your gross income to get an amount for your net self-employment income. For more information, see “Instructions for Schedule C or Schedule F” at **www.irs.gov**.
Some examples of costs are:

- Car and truck expenses (for travel during the workday, not commuting)
- Depreciation
- Employee wages and fringe benefits
- Property, liability, or business interruption insurance
- Interest (including mortgage interest paid to banks, etc.)
- Legal and professional services
- Rent or lease of business property and utilities
- Commissions, taxes, licenses, and fees
- Advertising
- Contract labor
- Repairs and maintenance
- Certain business travel and meals

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. For assistance you can contact Washington Healthplanfinder or if you are an individual who is aged, blind or disabled or in need of long-term services and supports (LTSS) you can contact the Department of Social and Health Services (DSHS).

Provide interpreter or translator services at no cost to you and without delay when communicating with Washington Healthplanfinder, Health Care Authority or DSHS.

Keep your personal information private but we may share some information with other state and federal agencies for purposes of eligibility and enrollment.

Give you the opportunity to appeal if you disagree with a determination made by Washington Healthplanfinder or DSHS that affects your eligibility for health coverage, LTSS, a health plan, health insurance premium tax credits, or cost-sharing reductions. By asking for an appeal, your case will be reviewed. You can find more information about the Washington Healthplanfinder appeals process by visiting the Washington Healthplanfinder Appeals Page at **http://www.wahbexchange.org/appeals/** or contacting the Washington Healthplanfinder Customer Support Center at 1-855-923-4633. For information about appeals for DSHS programs, you may contact DSHS Customer Service Contact Center at 1-877-501-2233 or visit your local Home and 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. The Washington Health Benefit Exchange/Health Care Authority complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Washington Health Benefit Exchange/Health Care Authority does not exclude people or treat them differently because of their race, color, national origin, age, disability, or sex.

The Washington Health Benefit Exchange/Health Care Authority also complies with applicable state laws and does 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.

The Washington Health Benefit Exchange/Health Care Authority:

- Provides 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)
- Provides 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 1-855-923-4633.

If you believe that the Washington Health Benefit Exchange/Health Care Authority has failed to provide these services or discriminated in another way you can file a grievance with:

- **Washington Health Benefit Exchange Legal Department**
  ATTN: Legal Division Equal Access/Equal Opportunity Coordinator
  PO Box 1757
  Olympia, WA 98507-1757
  1-855-859-2512
  Fax: 1-360-841-7653
  appeals@wahbexchange.org

- **Health Care Authority Division of Legal Services**
  ATTN: Compliance Officer PO Box 42700
  Olympia, WA 98501-2700
  1-855-682-0787
  Fax: 1-360-586-9551
  compliance@hca.wa.gov

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Washington Health Benefit Exchange Legal Department/Health Care Authority 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 Healthplanfinder 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 the Health Care Authority (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.

For more information about Washington Healthplanfinder's privacy policy, visit **https://www.wahealthplanfinder.org/_content/Privacy Policy.html**

The Affordable Care Act prevents the Washington Healthplanfinder and DSHS 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 Washington Healthplanfinder and DSHS 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.

If you begin completing an application for health insurance through Washington Healthplanfinder and do not complete the process for any reason, your information will be stored in Washington Healthplanfinder and accessible by you for 90 days. If you do not complete an application after the 90-day period, your information will be deleted from the Washington Healthplanfinder system.

Washington Healthplanfinder, 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, out of pocket expenses under your plan, and making a benefit claim or appealing a denial of benefits, you should contact your health insurance carrier. If you are eligible for COBRA following the termination of any health insurance coverage purchased through Washington Healthplanfinder, administering COBRA and providing you the required COBRA notices and election periods is your employer's responsibility.

Do not cancel any current insurance coverage or decline any COBRA benefits until you receive an approval letter and insurance policy, also known as insurance contract or certificate, from the insurance carrier you selected. Make sure you understand and agree with the terms of the policy, pay special attention to the effective date, waiting periods, premium amount, benefits, limitations, exclusions, and riders.

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 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 182-527-2754.

The State may also file a pre-death lien on your real property, at any age, if you become permanently institutionalized (WAC 182-527-2820). 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 may be restricted to one health care provider, pharmacy, and/or hospital if you seek out unnecessary health care services from providers.

Things you should know for Qualified Health Plans only

If you enroll in a qualified health plan through Washington Healthplanfinder and do not provide enough information to verify your eligibility, or information that cannot be verified, you will have 90 days to provide what is needed. If you do not do so, you could be required to pay back a of the premium tax credits you get.

If you enroll in a qualified health plan through Washington Healthplanfinder and you have a change in income, you should notify Washington Healthplanfinder as soon as possible. A change in income could change the tax credits or cost-sharing reductions you should get. You could be eligible for a lower-cost plan, because of a change in your income, or you could be required to pay back a part of the premium tax credits you get, if your income increases and you do not report it.

Rates shown are subject to change based on the health insurance carrier's underwriting practices and your choice of any available options.

ATTENTION: If you speak [insert language], language assistance services, free of charge, are available to you. Call 1-855-923-4633 (TTY: 1-855-627-9604).

Spanish - ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-923-4633 (TTY: 1-855-627-9604).

Chinese - 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-923-4633 （TTY：1-855-627-9604）。

Vietnamese - CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-923-4633 (TTY: 1-855-627-9604).

Korean - 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-923-4633 (TTY: 1-855-627-9604)번으로 전화해 주십시오.

Russian - ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-923-4633 (телетайп: TTY: 1-855-627-9604).

Tagalog - PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-923-4633 (TTY: 1-855-627-9604).

Ukrainian - УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-855-923-4633 (телетайп: TTY: 1-855-627-9604).

Cambodian (Khmer) - ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរសេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល ,
គឺអាចមានសំរាប់បំពីរអ្នក។ ចូរ ទូរស័ព្ទ1-855-923-4633 (TTY: 1-855-627-9604)។

Japanese - 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-923-4633 （TTY: 1-855-627-9604） まで、お電話にてご連絡ください。

Amharic - ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-855-923-4633 (መስማት ለተሳናቸው: TTY: 1-855-627-9604).

Oromo - XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-855-923-4633 (TTY: 1-855-627-9604).

Somali - MUHIIM AH: Haddii aad ku hadashid Af-soomaali, adeegaha caawimaada luuqada, ee lacag la'aanta ah, ayaad heli kartaa. Wac 1-855-923-4633 (TTY: 1-855-627-9604).

Arabic - ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-923-4633 (رقم هاتف الصم والبكم: TTY: 1-855-627-9604).

Punjabi - ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-855-923-4633 (TTY: 1-855-627-9604) 'ਤੇ ਕਾਲ ਕਰੋ।

German - ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-923-4633 (TTY: 1-855-627-9604).

Lao - ໂປດຊາບ: ຖ້າ ທ່ານ ເວົ້າ ພາສາລາວ,ການ ບໍ ລິ ການຊ່ ວຍເຫ ຼືອ ດ້ ານພາສາ, ໂດຍ ບໍ່ ເສັ ຽ ຄ່ າ,ແມ່ ນ ພ້ ອມໃຫ້ ທ່ ານ.ໂທ 1-855-923-4633 (TTY: 1-855-627-9604).

French - ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-923-4633 (TTY : 1-855-627-9604).

Hindi - ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-855-923-4633 (TTY: 1-855-627-9604) पर कॉल करें।

Farsi (Persian) - **توجه**: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-855-923-4633 (TTY: 1-855-627-9604) تماس بگیرید.

Romanian - ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-855-923-4633 (TTY: 1-855-627-9604).

Washington State Health Care Authority

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click. compare. covered.

Application for Health Care Coverage

PART 1

Primary Applicant Name and Contact Information

First Name, Middle Initial, Last Name & Suffix	Date of Birth (MM/DD/YYYY)	Sex ☐ M ☐ F

Signature of Primary Applicant or Authorized Representative **(Required)**	Social Security Number
X _____	_____

Are You Without A Fixed Address? ☐ No ☐ Yes
Check yes if you do not have a home address. **You still need to provide a mailing address.**
If yes, in what county would you like to receive health care services? _____

Address Where You Live	City	County	State	ZIP code

Mailing Address (If Different)	City	State	ZIP code

Primary Phone Number ☐ Cell ☐ Home ☐ Work	Secondary Phone Number ☐ Cell ☐ Home ☐ Work	E-mail Address

Washington Healthplanfinder may need to contact you regarding the status of your application and/or request additional information. What is your preferred method of contact? ☐ Phone ☐ Email ☐ USPS Mail

Language Information

Do you or anyone you are applying for want an interpreter and to receive documents in a language other than English?
☐ No ☐ Yes If yes, what language or alternative format do you need? List all that apply: _____

Authorized Representative Information

1. An authorized representative (AREP) is any adult who is sufficiently aware of the household circumstances and is authorized by the household to act on behalf of the household for eligibility purposes. This is different than partnering with a Navigator or a Broker.
2. If an applicant is unable to designate an AREP, due to a medical condition, an individual may self-designate as the AREP by completing the Authorization Representative Designation Form (DSHS 14-532) at **www.dshs.wa.gov/sites/default/files/FSA/forms/pdf/14-532.pdf**.
3. 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.

   a. Are you designating an authorized representative? ☐ No ☐ Yes
   b. Do you want your authorized representative to receive notices related to your application and account? ☐ No ☐ Yes

Authorized Representative Name / Organization	Phone Number

Mailing Address of Authorized Representative	E-mail Address

Information About Your Family

You don't need to file taxes to apply for health care coverage. You must include these individuals on your application: your spouse, your children who live with you, all parents living in the home with their child, and anyone you expect to claim on your federal income tax return, if you file one. If you expect to be claimed as a tax dependent on someone's tax return, you must include all members of the tax filing household claiming you and any family members living with you.

Primary Applicant (Self)

First Name	M.I.	Last Name	Date of Birth (MM/DD/YYYY)

Is this Person Applying for Health Care Coverage? ☐ No ☐ Yes | Sex ☐ M ☐ F | Relation to You **SELF**

(For individuals not applying for coverage, providing a social security number (SSN) or citizenship status is optional)

Citizen or Non-Citizen Status: (check one)

☐ U.S. Citizen or U.S. National ☐ Non-Citizen Lawfully Present In the U.S. ☐ Other

Social Security Number (SSN):_____

If you are a lawfully present Non-Citizen, enter the following information:

Foreign Passport Number:	Country of Issuance:
Date of Entry: (MM / DD / YYYY)	Document Expiry Date: (MM / DD / YYYY)

If you do not have this information, enter the document type, your "A" number and receipt number or other immigration number:

Immigration document type:	"A" number:	Receipt number or other number:

Expected Tax Filing Status for the Current Year (select one)

- ☐ Single filing taxes
- ☐ Head of household
- ☐ Qualifying widow(er) with dependent child
- ☐ Married filing separately
- ☐ Married filing jointly:

Name of primary tax filer:_____

- ☐ Tax dependent of someone on the application
- ☐ Tax dependent of someone **not** on the application
- ☐ Person has neither filed taxes nor was tax dependent

Did you have the same tax filing status last year as the current year listed above? ☐ No ☐ Yes

If no, list last year's tax filing status:_____

(Your response to this question does not affect your eligibility for Apple Health)

If you are submitting this application between 11/01 and 12/31 of this calendar year, do you expect to file with the same tax status next year as you do this year? ☐ No ☐ Yes

RACE / ETHNICITY CODE (OPTIONAL – check all that apply)

If American Indian or Alaska native, do not enter a race or ethnicity

☐ White ☐ Black or African American ☐ Asian ☐ Native Hawaiian ☐ Pacific Islander ☐ Hispanic or Latino ☐ Other

Are you an American Indian or Alaska Native? ☐ No ☐ Yes

Spouse or Other Parent (If living in the home)

First Name	M.I.	Last Name	Date of Birth (MM/DD/YYYY)

Is this Person Applying for Health Care Coverage? ☐ No ☐ Yes

Sex ☐ M ☐ F

Relation to You (i.e. spouse, domestic partner, partner)

(For individuals not applying for coverage, providing a social security number (SSN) or citizenship status is optional)

Citizen or Non-Citizen Status: (check one)

☐ U.S. Citizen or US National ☐ Non-Citizen Lawfully Present In the U.S. ☐ Other

Social Security Number (SSN):_____

If you are a lawfully present Non-Citizen, enter the following information:

Foreign Passport Number: ☐☐☐☐☐☐☐☐☐☐☐☐

Country of Issuance: ☐☐☐☐☐☐☐☐☐☐

Date of Entry: ☐☐ / ☐☐ / ☐☐☐☐

Document Expiry Date: ☐☐ / ☐☐ / ☐☐☐☐

If you do not have this information, enter the document type, your "A" number and receipt number or other immigration number:

Immigration document type: ☐☐☐☐☐☐☐☐☐☐

"A" number: ☐☐☐☐☐☐☐☐☐

Receipt number or other number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Expected Tax Filing Status for the Current Year (select one)

☐ Single filing taxes
☐ Head of household
☐ Qualifying widow(er) with dependent child
☐ Married filing separately
☐ Married filing jointly:

Name of primary tax filer:_____

☐ Tax dependent of someone on the application
☐ Tax dependent of someone **not** on the application
☐ Person has neither filed taxes nor was tax dependent

Did you have the same tax filing status last year as the current year listed above? ☐ No ☐ Yes

If no, list last year's tax filing status:_____

(Your response to this question does not affect your eligibility for Apple Health)

If you are submitting this application between 11/01 and 12/31 of this calendar year, do you expect to file with the same tax status next year as you do this year? ☐ No ☐ Yes

RACE / ETHNICITY CODE (OPTIONAL – check all that apply)

If American Indian or Alaska native, do not enter a race or ethnicity

☐ White ☐ Black or African American ☐ Asian ☐ Native Hawaiian ☐ Pacific Islander ☐ Hispanic or Latino ☐ Other

Are you an American Indian or Alaska Native? ☐ No ☐ Yes

(1.) List Children / Tax Dependents/Other Household Members

First Name	M.I.	Last Name	Date of Birth (MM/DD/YYYY)

Is this Person Applying for Health Care Coverage? ☐ No ☐ Yes

Sex ☐ M ☐ F

Relation to You (i.e. spouse, domestic partner, partner)

(For individuals not applying for coverage, providing a social security number (SSN) or citizenship status is optional)

Citizen or Non-Citizen Status: (check one)

☐ U.S. Citizen or US National ☐ Non-Citizen Lawfully Present In the U.S. ☐ Other

Social Security Number (SSN):_____

If you are a lawfully present Non-Citizen, enter the following information:

Foreign Passport Number:

Country of Issuance:

Date of Entry: / /

Document Expiry Date: / /

If you do not have this information, enter the document type, your "A" number and receipt number or other immigration number:

Immigration document type:

"A" number:

Receipt number or other number:

Expected Tax Filing Status for the Current Year (select one)

- ☐ Single filing taxes
- ☐ Head of household
- ☐ Qualifying widow(er) with dependent child
- ☐ Married filing separately
- ☐ Married filing jointly:

Name of primary tax filer:_____

- ☐ Tax dependent of someone on the application
- ☐ Tax dependent of someone **not** on the application
- ☐ Person has neither filed taxes nor was tax dependent

Did you have the same tax filing status last year as the current year listed above? ☐ No ☐ Yes

If no, list last year's tax filing status:_____

(Your response to this question does not affect your eligibility for Apple Health)

If you are submitting this application between 11/01 and 12/31 of this calendar year, do you expect to file with the same tax status next year as you do this year? ☐ No ☐ Yes

RACE / ETHNICITY CODE (OPTIONAL – check all that apply)

If American Indian or Alaska native, do not enter a race or ethnicity

☐ White ☐ Black or African American ☐ Asian ☐ Native Hawaiian ☐ Pacific Islander ☐ Hispanic or Latino ☐ Other

Are you an American Indian or Alaska Native? ☐ No ☐ Yes

(2.) List Children / Tax Dependents/Other Household Members

First Name	M.I.	Last Name	Date of Birth (MM/DD/YYYY)

Is this Person Applying for Health Care Coverage? ☐ No ☐ Yes

Sex ☐ M ☐ F

Relation to You (i.e. spouse, domestic partner, partner)

(For individuals not applying for coverage, providing a social security number (SSN) or citizenship status is optional)

Citizen or Non-Citizen Status: (check one)

☐ U.S. Citizen or US National ☐ Non-Citizen Lawfully Present In the U.S. ☐ Other

Social Security Number (SSN):_____

If you are a lawfully present Non-Citizen, enter the following information:

Foreign Passport Number:

Country of Issuance:

Date of Entry: / /

Document Expiry Date: / /

If you do not have this information, enter the document type, your "A" number and receipt number or other immigration number:

Immigration document type:

"A" number:

Receipt number or other number:

Expected Tax Filing Status for the Current Year (select one)

- ☐ Single filing taxes
- ☐ Head of household
- ☐ Qualifying widow(er) with dependent child
- ☐ Married filing separately
- ☐ Married filing jointly:

Name of primary tax filer:_____

- ☐ Tax dependent of someone on the application
- ☐ Tax dependent of someone **not** on the application
- ☐ Person has neither filed taxes nor was tax dependent

Did you have the same tax filing status last year as the current year listed above? ☐ No ☐ Yes

If no, list last year's tax filing status:_____

(Your response to this question does not affect your eligibility for Apple Health)

If you are submitting this application between 11/01 and 12/31 of this calendar year, do you expect to file with the same tax status next year as you do this year? ☐ No ☐ Yes

RACE / ETHNICITY CODE (OPTIONAL – check all that apply)

If American Indian or Alaska native, do not enter a race or ethnicity

☐ White ☐ Black or African American ☐ Asian ☐ Native Hawaiian ☐ Pacific Islander ☐ Hispanic or Latino ☐ Other

Are you an American Indian or Alaska Native? ☐ No ☐ Yes

(3.) List Children / Tax Dependents/Other Household Members

First Name	M.I.	Last Name	Date of Birth (MM/DD/YYYY)

Is this Person Applying for Health Care Coverage? ☐ No ☐ Yes

Sex ☐ M ☐ F

Relation to You (i.e. spouse, domestic partner, partner)

(For individuals not applying for coverage, providing a social security number (SSN) or citizenship status is optional)

Citizen or Non-Citizen Status: (check one)

☐ U.S. Citizen or US National ☐ Non-Citizen Lawfully Present In the U.S. ☐ Other

Social Security Number (SSN):_____

If you are a lawfully present Non-Citizen, enter the following information:

Foreign Passport Number:

Country of Issuance:

Date of Entry: ☐☐ / ☐☐ / ☐☐☐☐

Document Expiry Date: ☐☐ / ☐☐ / ☐☐☐☐

If you do not have this information, enter the document type, your "A" number and receipt number or other immigration number:

Immigration document type:

"A" number:

Receipt number or other number:

Expected Tax Filing Status for the Current Year (select one)

☐ Single filing taxes
☐ Head of household
☐ Qualifying widow(er) with dependent child
☐ Married filing separately
☐ Married filing jointly:

Name of primary tax filer:_____

☐ Tax dependent of someone on the application
☐ Tax dependent of someone **not** on the application
☐ Person has neither filed taxes nor was tax dependent

Did you have the same tax filing status last year as the current year listed above? ☐ No ☐ Yes

If no, list last year's tax filing status:_____

(Your response to this question does not affect your eligibility for Apple Health)

If you are submitting this application between 11/01 and 12/31 of this calendar year, do you expect to file with the same tax status next year as you do this year? ☐ No ☐ Yes

RACE / ETHNICITY CODE (OPTIONAL – check all that apply)

If American Indian or Alaska native, do not enter a race or ethnicity

☐ White ☐ Black or African American ☐ Asian ☐ Native Hawaiian ☐ Pacific Islander ☐ Hispanic or Latino ☐ Other

Are you an American Indian or Alaska Native? ☐ No ☐ Yes

To include more household members, attach a sheet with the information requested above for each individual.

Information About Your Household

American Indian & Alaska Native Information

American Indian and Alaska Natives may be eligible for special Washington Apple Health (Medicaid) protections and for special benefits through the Health Benefit Exchange. Skip this section if no one you are applying for is of American Indian or Alaska Native descent. Complete the table below for anyone you are applying for that is of American Indian or Alaska Native descent.

Name of Person	Tribe Name	Member of a Federally Recognized Tribe, Band, Pueblo or Rancheria; Shareholder in an Alaska Native Regional or Village Corporation
		☐ No ☐ Yes
		☐ No ☐ Yes
		☐ No ☐ Yes
		☐ No ☐ Yes

Residency

A Washington resident is someone who currently resides in Washington, intends to reside in Washington, including individuals without a fixed address; or someone who entered the state without a job commitment or looking for a job.

Is everyone applying for health care coverage a Washington State resident? ☐ No ☐ Yes
If no, list anyone who is not a resident:_____ _____ _____

Tobacco Use

Has any household member on this application regularly used tobacco products in the past 6 months? ☐ No ☐ Yes
If yes, enter their name:_____ _____ _____
(Your response to this question does not affect your eligibility for Apple Health)

Adult Disabled Dependent

An adult disabled child is an individual who is not capable of employment due to a disability and is dependent on a household member for support.

Do you have an adult child who is a disabled dependent 26 years or older? ☐ No ☐ Yes
If yes, enter their name:_____ _____ _____
(Your response to this question does not affect your eligibility for Apple Health)

Jail and Prison Information

1. Are you or anyone you are applying for in jail or prison? ☐ No ☐ Yes
2. If yes, enter their name: _____
3. Are disposition of charges pending? ☐ No ☐ Yes
4. Is release date within 30 days? ☐ No ☐ Yes

Voter Registration

If you are not registered to vote where you live now, would you like to apply to register to vote? ☐ No ☐ Yes

If you select "Yes" you will be provided a voter registration form.

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided or your eligibility.

If you would like help in filling out the voter registration application, you can receive assistance at Washington's toll free Voter registration Hotline, 1-800-448-4881. The decision whether to seek or accept help is yours. You may fill out an application in private.

If you believe that someone has interfered with your right to register to vote or to decline to register to vote, or your right to privacy in deciding whether to register, 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.

Signature for Qualified Health Plan Applicants

<u>If you do not want to apply for free or low cost coverage</u> but you would like to purchase health care coverage through a Qualified Health Plan (QHP), sign here and do not complete Part 2 of the application.

I have read or had explained to me my Rights and Responsibilities.

By signing this application you are agreeing to the Washington Healthplanfinder sharing your information with other state and federal agencies.

Signature _____ Date _____

You could be eligible for free or low cost coverage. To apply for Health Insurance Premium Tax Credits or Washington Apple Health (Medicaid), you must complete Part 2 of this application.

Health Insurance Information

Do you or anyone you are applying for have health insurance that meets minimum essential coverage other than Washington Apple Health (Medicaid or CHIP)?
(Examples include private or employer sponsored insurance, Medicare, Veterans, Peace Corps and Tri-Care) ☐ No ☐ Yes
If yes, provide the information in the table below. If more than one person has other insurance, use additional paper.

Insurance Company or Employer Name	Policy Number	Group Number	Policy Holder's / Employee's Name	Policy Holder's Date of Birth

List all household members covered under this plan:

_____ _____ _____

_____ _____ _____

Employer-sponsored Insurance

Have you turned down health insurance offered through your employer? ☐ No ☐ Yes

If yes, provide employer information in the table above. Also, below list the cost of your employer's lowest cost, employee-only plan that meets the minimum value standard. An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. You can get this information from your employer.

Monthly plan cost: $_____

How often paid (e.g., bi-weekly, monthly, annually)? _____

(Your response to this question does not affect your eligibility for Apple Health)

Children's Health Insurance

Skip this question and go to the next section (Unpaid Medical Bill Information) if you are not applying for coverage for a child.

Does your health insurance cover your children? ☐ No ☐ Yes

If yes, enter child's name: _____ _____ _____

Have you dropped health insurance coverage for your children, under age 19, within the last four months? ☐ No ☐ Yes
If yes, when did the coverage end? _____

Unpaid Medical Bill Information

Do you or anyone you are applying for need help paying for unpaid medical bills for services received in any of the 3 months immediately before the current month? ☐ No ☐ Yes

If yes, enter name: _____ _____ _____

Non-Citizen Emergency Medical Information

You or family member may be eligible for limited health care coverage even if you are not eligible for broad coverage because of your immigration status.

Check all boxes that apply to any non-citizen you are applying for and enter their name in the space provided

☐ Has been treated for an emergency medical condition this month or during the previous three months:
Who: _____

☐ Needs dialysis or cancer treatment: Who: _____

☐ Needs anti-rejection medication as a result of an organ transplant: Who: _____

☐ Needs nursing home, assisted living, or in-home care: Who: _____

Pregnancy Information

Are you or anyone in your household pregnant? ☐ No ☐ Yes (Use the second line if more than 1 person is pregnant.)

If yes, enter name: _____ Due date: _____ Number expected: _____

enter name: _____ Due date: _____ Number expected: _____

Gross Income Information

This section helps us determine the amount of your household's modified adjusted gross income (MAGI). MAGI income must be used in order to determine if you are eligible for most health care coverage programs. Please answer the following questions for each household member you are applying for as accurately as you can. Only enter information about the type of income listed.

You will need to enter current gross monthly income information for yourself, your spouse and any minors and tax dependents regardless of age, unless the minor or tax dependent will not be required to file taxes. For more information about how to report income, visit **www.wahbexchange.org/how-to-report-income**

Note: American Indians/Alaska Natives (AI/AN) do not have to report any AI/AN income that the Internal Revenue Service excludes from an AI/AN's taxable gross income. In addition, AI/ANs do not have to report certain types of income for Washington Apple Health (Medicaid) as described in WAC 182-509-0340.

Earned Income Received From Employer: Are you or anyone you are applying for currently employed? ☐ No ☐ Yes

If yes, enter the name of the person employed, name of employer, and the employee's ***current*** gross monthly amount received in wages, salaries or as tip income. Do not enter self-employment income in this section. You may choose to provide an average of your income if a change in the future is clearly indicated. Estimate a monthly amount by averaging income over a representative period of time as described in WAC 182-509-0310.

Name of Person Employed	Name of Employer	Address of Employer (including city, state and zip code)	Gross (before taxes are taken out) **monthly** income (wages, salaries, tips, corporation, S-corporation)

Self-Employment Income: Are you or anyone you are applying for currently self-employed? ☐ No ☐ Yes

If yes, please enter the current estimated net monthly income (profits once business expenses are paid) from self-employment. Please see page ii for allowable business expenses. You may choose to provide an average of your income if a change in the future is clearly indicated. Estimate a monthly amount by averaging income over a representative period of time as described in WAC 182-509-0370.

Name of Person Employed	Name of Employer	Gross (before taxes are taken out) **monthly** income (wages, salaries, tips, corporation, S-corporation)

Other Income

NOTE: Do not include child support, non-pension veteran's payments, or Supplemental Security Income (SSI). Check all that apply and tell us who gets it and how much and how often.

- ☐ Alimony / Spousal Support — Who _____ $_____ How often _____
- ☐ Capital Gains or Losses — Who _____ $_____ How often _____
- ☐ Dividend Payments — Who _____ $_____ How often _____
  Companies report this income to you on an IRS 1099 DIV form each year
- ☐ Farm income or losses — Who _____ $_____ How often _____
- ☐ Foreign Earned Income — Who _____ $_____ How often _____
- ☐ Interest payments (both taxable and tax-exempt) — Who _____ $_____ How often _____
- ☐ Income from partnerships S corporations, trusts, etc. other — Who _____ $_____ How often _____
- ☐ Other Claimable Gains or Losses — Who _____ $_____ How often _____
- ☐ Pension/Annuity/IRA — Who _____ $_____ How often _____
- ☐ Per Capita Income — Who _____ $_____ How often _____
  This is Economic Development
- ☐ Railroad Retirement — Who _____ $_____ How often _____
- ☐ Rental Income / Royalties — Who _____ $_____ How often _____
  This is monthly income from renting a home that wasn't included in self- employment or monthly income from patents or other copyrighted work.
- ☐ Social Security — Who _____ $_____ How often _____
- ☐ Unemployment — Who _____ $_____ How often _____

Deductions

We ask you these questions because these expenses can reduce the amount of your income that we count for some kinds of health care coverage, just like the IRS uses them to reduce the amount of taxes you owe. If you choose not to answer, you may still qualify for free or low cost health care coverage.
List below any deductions you claim on your tax return. Allowable deductions include, but are not limited to the following:

- Alimony / Spousal Support
- Student Loan Interest
- Tuition and school fees
- Educator expenses
- Health savings account
- Pre-tax retirement account payments (excluding Roth IRA contributions)
- Moving costs since January of this year
- Domestic production activities
- Certain claimable business expenses of reservists, performing artists, or fee-basis government officials
- Self-employment tax
- Self-employment retirement plan
- Self-employment health insurance premium
- Penalty on early withdrawal of savings

☐ Deductions
Type: _____ Who _____ $_____ How often _____

☐ Deductions
Type: _____ Who _____ $_____ How often _____

☐ Deductions
Type: _____ Who _____ $_____ How often _____

☐ Deductions
Type: _____ Who _____ $_____ How often _____

Supplemental Information

Do you or anyone you are applying for need help with any of the following services?

a. Long-term care services because you are currently living in or expect to move to a medical institution, like nursing home. ☐ No ☐ Yes If yes, enter the name of the person: _____
Type of Facility: _____

b. An in-home care-giver? ☐ No ☐ Yes If yes, enter the name of the person: _____

c. Assisted Living care services? ☐ No ☐ Yes If yes, enter the name of the person: _____

d. Services through the Division of Developmental Disabilities? ☐ No ☐ Yes
If yes, enter the name of the person: _____

e. Hospice care? ☐ No ☐ Yes If yes, enter the name of the person: _____

f. A disability determination because of a disabling condition expected to last 12 months or longer or result in death? ☐ No ☐ Yes If yes, enter the name of the person(s): _____

You will be required to complete HCA form 18-005 (www.hca.wa.gov/assets/free-or-low-cost/18-005.pdf if any of the following apply:

- You are age 65 or older or on Medicare.
- You answered yes to any of the questions in a through f above.
- You are applying for the medically needy (MN) or the Healthcare for Workers with Disabilities programs (HWD).

Read Carefully Before Signing

Disclosure of information to Other State and Federal Agencies:

I authorize Washington Healthplanfinder to electronically verify my tax return information during the annual renewal process for up to 5 years. I understand that I am able to change my consent at any time. By checking this box, I permit tax credits to be applied to my annual renewal without my taking further action.

☐ No ☐ Yes

I can change my consent at any time through the Washington Healthplanfinder.

I have read or had explained to me my rights and responsibilities and received a copy of *Client Rights and Responsibilities*.

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_____ **Date** _____