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 (Formerly called Medicaid) or the Children's Health Insurance Program (CHIP) • A new tax credit that can help you pay your health care premiums • Private Qualified Health Plans
Apply faster online	Apply faster online at **www.wahealthplanfinder.org**
Information you will need to apply:	• Social Security numbers • Birthdays • Passport, alien, or other immigration numbers for any legal immigrants who need health care coverage • Income information for all adults and all minors age 14 or older 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 If you don't have all the information we ask for, you should sign and submit your application anyway.
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 visit **www.wahealthplanfinder.org** or call 1-855-WAFINDER (855-923-4633) • 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 available to help pay for health care coverage premiums for individuals and families with income below 400% of the federal poverty level (FPL), but above 100% of the FPL. FPL can be found at **http://aspe.hhs.gov/poverty/13poverty.cfm**

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

Premium: A monthly payment to a health insurance company for health insurance.

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

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" at **www.irs.gov**.

- 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 insurance programs

Help you fill out all requested forms. You can contact Washington Healthplanfinder for assistance.

Provide interpreter or translator services at no cost to you when communicating with Washington Healthplanfinder.

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

Allow you to submit a partial application that includes at minimum, name address and signature or the signature of the applicant's authorized representative.

Your responsibilities (you must) for all health insurance programs

SSN Disclosure. Under Federal Law (42 CFR 435.910) you must provide the Social Security Number (SSN) for anyone in your household, including yourself, who applies for Washington Apple Health (WAH) or Advance Premium Tax Credits (APTC).

If you or someone in your household is not applying for health coverage under one of the above programs, providing the SSN for the non-applicant is voluntary for WAH, but is required APTC. If a non-applicant's income must be counted to determine eligibility for one of our programs and you choose not to provide the SSN, you will be required to provide written documentation of the non-applicant's income as we will be unable to verify this number using our automated data matches.

SSNs are used to check identity, citizenship, alien status and income as well as prevent fraud and verify health care claims. We also use SSN information with other federal and state agencies, including the Internal Revenue Service, to manage our programs and follow the law.

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

Things you should know for all health insurance programs

There are certain state and federal laws that govern the operation of Washington Healthplanfinder, your rights and responsibilities as a user of Washington Healthplanfinder, and the coverage obtained through Washington Healthplanfinder. By using Washington Healthplanfinder, you agree to comply with these laws as they may apply to users of this website and coverage obtained hereunder.

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.

You may ask for an appeal if you disagree with a determination made during your use of Washington Healthplanfinder that affects your eligibility for a health plan, tax

subsidies, or cost-sharing reductions through Healthplanfinder. By asking for an appeal your case will be reviewed. You can find more information about the Healthplanfinder appeals process by visiting the Healthplanfinder Appeals Page at **http://wahbexchange.org/appeals/** or contacting the Healthplanfinder Call Center.

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

You may apply for support enforcement services through the Division of Child Support (DCS), if you do not receive health care coverage. To get an application for these services, go to **www.childsupportonline.wa.gov** or contact your local DCS office **Health Insurance Portability and Accountability Act (HIPAA)** restrictions prevent us 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 information that you give Washington Healthplanfinder is subject to verification by federal and state officials. Verification can include follow-up contacts from agency staff.

If you begin completing an application for health insurance on Healthplanfinder and do not complete the process for any reason, your information will be stored in 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 Healthplanfinder system.

Washington Healthplanfinder is 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 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.

Your rights (we must) for Washington Apple Health only

Give you 10 days to provide information we need. If you don't give us the information or ask for more time we may deny, close, or change your healthcare coverage.

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

Give you a written decision, in most cases, within 30 days. Health care coverage and some disability cases may take 45 to 60 days. Pregnancy medical is authorized within 15 days.

Continue WAH coverage while we decide if you are eligible for another program per WAC 182-504-0125.

Your responsibilities (you must) for Washington Apple Health only

Report changes as required in WAC 182-504-0110 within 30 days of the change.

Cooperate with the Division of Child Support (DCS) if you receive WAH coverage. You must help DCS establish, modify, or enforce child support for the child(ren) in your care, and establish paternity (if necessary). If you can show that you have a good reason to believe that cooperating with DCS puts you, your children, or the children in your care at risk of harm from the noncustodial parent, you may claim good cause not to cooperate.

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 WAH coverage.

Things you should know for Washington Apple Health only

By asking for and receiving WAH, you give the state of Washington all rights to any medical support and to any third party payments for health care. When you receive WAH, you assign your medical support rights to the Division of Child Support (DCS). DCS will provide full child support enforcement services unless you tell them in writing that you want to limit the services to medical enforcement only.

If you stop getting WAH, you must tell DCS about any changes that affect medical support, such as the child moved or address changed.

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

Information you report may be provided to the Department of Social and Health Services to determine eligibility and monthly benefits for programs such as health care coverage, cash assistance, food assistance and child care subsidies.

By law (RCW 41.05A.090 and WAC 182-527), if you are age 55 or older AND receive WAH services, Health Care Authority (HCA) may recover from your estate (assets you own at the time of death) to repay HCA for the costs of health care assistance. This is called ESTATE RECOVERY. Tribal lands and certain properties belonging to American Indians and Alaskan Natives may be exempt from recovery (WAC 182-527-2754). If you have dependent heirs, estate recovery may be delayed for some hardship reasons.

Estate Recovery does not occur until after death and the death of your surviving spouse, if any. HCA may recover the costs for state-only funded long-term care services received at any age. We may also file and recover the Pre-Death liens subject to requirements of 42 US 1396p. Pre-Death Liens and Special Needs Trust can occur before your death.

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 Healthplanfinder and you do not provide enough information for Healthplanfinder to verify your eligibility to purchase a plan or receive a reduced-cost plan, or if any information you provide is not verifiable, you will have 90 days to provide further information to satisfy Washington Healthplanfinder's eligibility requirements.

During this time, you should work with Healthplanfinder staff to try to provide any missing information or resolve any inconsistencies so that your coverage and applicable costs may be effective as soon as possible.

If you enroll in a qualified health plan through Healthplanfinder and you have a change in income, you should notify Healthplanfinder as soon as possible. A change in income could change the tax subsidies or cost-sharing reductions for which you are eligible. You could be eligible for a lower-cost plan following a change of income, or you could be required to pay back a portion of a tax subsidy you receive if your income increases and you do not report the change.

Rates shown are subject to change based on the health insurance carrier's underwriting practices and your selection of available optional benefits, if any. Final rates are always determined by the health insurance carrier.

Rates shown are for your requested effective date ONLY. If the actual effective date of your policy is different from your requested effective date, the actual cost of your policy may differ from the rates above, due to rate increases or policy changes from the insurance company and/or one or more family members having a birthday. (Rates are highly dependent on age.) The carrier you selected may not guarantee their rates for any period of time.

You consent to the Washington State Employment Security Department's release of your wage and employment data to Washington Healthplanfinder. You acknowledge that granting this consent will help to simplify the application and redetermination process for Washington Healthplanfinder. Your personal information will be protected as described in the Healthplanfinder Privacy Policy.

In accordance with federal law and U.S. Department of Health and Human Services (HHS) policy, this institution is prohibited from discrimination on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, contact HHS. Write HHS, Director, Office for Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington D.C. 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TDD). HHS is an equal opportunity provider and employer.

Washington State Health Care Authority

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Application for Health Care Coverage

PART 1

Applicant Name and Contact Information

If you don't have all the information we ask for, you can start your application by filling in your name, signature, and address and sending in this page.

First Name, Middle Name, Last Name & Suffix	Signature of Applicant or Authorized Representative **(Required)**

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.

Address Where You Live	City	State	Zip Code
Mailing Address (If Different)	City	State	Zip Code

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

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 ☐ E-mail ☐ 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

An authorized representative 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. 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
c. Does the authorized representative have legal guardianship? ☐ No ☐ Yes
d. Does the authorized representative have power of attorney? ☐ No ☐ Yes

Authorized Representative Name / Organization	Phone Number ( )
Mailing Address of Authorized Representative	E-mail Address

Information About Your Family

Please include the following individuals on this application: yourself; your spouse, if married; your partner who lives with you, but only if you have children together who need health insurance; your children who live with you; and anyone you include on your federal tax return. (You don't need to file taxes to apply for health insurance.) Anyone else who lives with you will need to file their own application.

Primary Applicant

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**

(Do not answer if not applying for coverage)

Citizen or Non-Citizen Status: (check one) ☐ U.S. Citizen ☐ Non-Citizen Lawfully Present In the U.S. ☐ Other

(Do not answer if not applying for coverage)

Social Security Number (SSN):_____ If lawfully present Non-Citizen, enter the following information:

Passport Number:_____; Country of Issuance:_____; Date of Entry:_____

If you do not have this information, enter your "A" number or other immigration number:_____

Tax Filing Status for Last Calendar Year

- ☐ Individual or Head of Household
- ☐ Married Filing Jointly:
  Name of spouse_____
- ☐ Married Filing Separately
- ☐ Tax Dependent: Of whom_____
- ☐ Did not file a tax return (Non Filer)

Expected Tax Filing Status for the Current Calendar Year

- ☐ Individual or Head of Household
- ☐ Married Filing Jointly:
  Name of spouse_____
- ☐ Married Filing Separately
- ☐ Tax Dependent: Of whom_____
- ☐ Will not file a tax return (Non Filer)

If you are submitting this application between 10/01 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 Alaskan Native, do not enter a race or ethnicity ☐ White ☐ Black or African American ☐ Asian ☐ Native Hawaiian ☐ Pacific Islander ☐ Hispanic or Latino ☐ Other

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)

(Do not answer if not applying for coverage)

Citizen or Non-Citizen Status: (check one) ☐ U.S. Citizen ☐ Non-Citizen Lawfully Present In the U.S. ☐ Other

(Do not answer if not applying for coverage)

Social Security Number (SSN):_____ If lawfully present Non-Citizen, enter the following information:

Passport Number:_____; Country of Issuance:_____ _; Date of Entry:_____

If you do not have this information, enter your "A" number or other immigration number:_____

Tax Filing Status for Last Calendar Year

- ☐ Individual or Head of Household
- ☐ Married Filing Jointly:
  Spouse's name_____
- ☐ Married Filing Separately
- ☐ Tax Dependent: Of whom_____
- ☐ Did not file a tax return (Non Filer)

Expected Tax Filing Status for the Current Calendar Year

- ☐ Individual or Head of Household
- ☐ Married Filing Jointly:
  Spouse's name_____
- ☐ Married Filing Separately
- ☐ Tax Dependent: Of whom_____
- ☐ Will not file a tax return (Non Filer)

If you are submitting this application between 10/01 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 Alaskan Native, do not enter a race or ethnicity ☐ White ☐ Black or African American ☐ Asian ☐ Native Hawaiian ☐ Pacific Islander ☐ Hispanic or Latino ☐ Other

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

(1.) List Children / Tax Dependents

Is this Person Applying for Health Care Coverage	Sex	Relation to You (i.e. child, grandchild, nephew, niece, sibling)
☐ No ☐ Yes	☐ M ☐ F	

(Do not answer if not applying for coverage)

Citizen or Non-Citizen Status: (check one) ☐ U.S. Citizen ☐ Non-Citizen Lawfully Present In the U.S. ☐ Other

(Do not answer if not applying for coverage)

Social Security Number (SSN):_____ If lawfully present Non-Citizen, enter the following information:
Passport Number:_____; Country of Issuance:_____; Date of Entry:_____
If you do not have this information, enter your "A" number or other immigration number:_____

Tax Filing Status for Last Calendar Year	**Expected Tax Filing Status for the Current Calendar Year**
☐ Individual or Head of Household	☐ Individual or Head of Household
☐ Married Filing Jointly: Spouse's name_____	☐ Married Filing Jointly: Spouse's name_____
☐ Married Filing Separately	☐ Married Filing Separately
☐ Tax Dependent: Of whom_____	☐ Tax Dependent: Of whom_____
☐ Did not file a tax return (Non Filer)	☐ Will not file a tax return (Non Filer)

RACE / ETHNICITY CODE (OPTIONAL – check all that apply)
If American Indian or Alaskan Native, do not enter a race or ethnicity ☐ White ☐ Black or African American
☐ Asian ☐ Native Hawaiian ☐ Pacific Islander ☐ Hispanic or Latino ☐ Other

(2.) List Children / Tax Dependents

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

Is this Person Applying for Health Care Coverage	Sex	Relation to You (i.e. child, grandchild, nephew, niece, sibling)
☐ No ☐ Yes	☐ M ☐ F	

(Do not answer if not applying for coverage)

Citizen or Non-Citizen Status: (check one) ☐ U.S. Citizen ☐ Non-Citizen Lawfully Present In the U.S. ☐ Other

(Do not answer if not applying for coverage)

Social Security Number (SSN):_____ If lawfully present Non-Citizen, enter the following information:
Passport Number:_____; Country of Issuance:_____; Date of Entry:_____
If you do not have this information, enter your "A" number or other immigration number:_____

Tax Filing Status for Last Calendar Year	**Expected Tax Filing Status for the Current Calendar Year**
☐ Individual or Head of Household	☐ Individual or Head of Household
☐ Married Filing Jointly: Spouse's name_____	☐ Married Filing Jointly: Spouse's name_____
☐ Married Filing Separately	☐ Married Filing Separately
☐ Tax Dependent: Of whom_____	☐ Tax Dependent: Of whom_____
☐ Did not file a tax return (Non Filer)	☐ Will not file a tax return (Non Filer)

RACE / ETHNICITY CODE (OPTIONAL – check all that apply)
If American Indian or Alaskan Native, do not enter a race or ethnicity ☐ White ☐ Black or African American
☐ Asian ☐ Native Hawaiian ☐ Pacific Islander ☐ Hispanic or Latino ☐ Other

(3.) List Children / Tax Dependents

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

Is this Person Applying for Health Care Coverage	Sex	Relation to You (i.e. child, grandchild, nephew, niece, sibling)
☐ No ☐ Yes	☐ M ☐ F	

(Do not answer if not applying for coverage)

Citizen or Non-Citizen Status: (check one) ☐ U.S. Citizen ☐ Non-Citizen Lawfully Present In the U.S. ☐ Other

(Do not answer if not applying for coverage)

Social Security Number (SSN):_____ If lawfully present Non-Citizen, enter the following information:
Passport Number:_____; Country of Issuance:_____; Date of Entry:_____
If you do not have this information, enter your "A" number or other immigration number:_____

Tax Filing Status for Last Calendar Year	Expected Tax Filing Status for the Current Calendar Year
☐ Individual or Head of Household ☐ Married Filing Jointly: Spouse's name_____ ☐ Married Filing Separately ☐ Tax Dependent: Of whom_____ ☐ Did not file a tax return (Non Filer)	☐ Individual or Head of Household ☐ Married Filing Jointly: Spouse's name_____ ☐ Married Filing Separately ☐ Tax Dependent: Of whom_____ ☐ Will not file a tax return (Non Filer)

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

If American Indian or Alaskan Native, do not enter a race or ethnicity ☐ White ☐ Black or African American ☐ Asian ☐ Native Hawaiian ☐ Pacific Islander ☐ Hispanic or Latino ☐ Other

American Indian & Alaskan Native Information

American Indian and Alaskan 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 Alaskan 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	Descendant of a Federally Recognized Tribe, Band, Pueblo or Rancheria; Shareholder in an Alaska Native Regional or Village Corporation	Eligible for Indian Health Services, Tribal Health Services or Urban Indian Health Services, including as a California Indian, Eskimo, Aleut or other Alaska Native
		☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
		☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
		☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
		☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
		☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes

Residency Information

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

Is everyone applying for health care coverage a Washington State resident? ☐ No ☐ Yes

If no, list anyone who is not a resident:_____

Jail and Prison Information

Are you or anyone you are applying for now in a city or county jail or a state or federal prison? ☐ No ☐ Yes

If yes, enter their name: _____

You could be eligible for free or low cost coverage. To apply for help with the costs of coverage or to apply for Washington Apple Health (Medicaid), you need to complete Part 2 of this application.

Signature for Qualified Health Plan Applicants

If you do not want to apply for free or low cost coverage 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** _____

If you want to be considered for free or low cost health care coverage through Health Insurance Premium Tax Credits (HIPTC) or Washington Apple Health (Medicaid), you must complete Part 2 of this application.

PART 2

Health Insurance Information

Do you or anyone you are applying for have (or will in the next 3 months) 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 and Address (including city, state and zip code)	Insurance Company or Employer Phone Number	Policy Number / Group Number	Subscriber's / Employee's Name	Subscriber's Date of Birth

If you answered no to the question above, 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.
Plan cost: $_____ How often paid (e.g., bi-weekly, monthly, annually)? _____

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

Have you dropped health insurance coverage for your children 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 incurred in any of the 3 months immediately before the current month? ☐ No ☐ Yes If yes, what month(s) do you need help with?

_____ _____ _____

Non-Citizen Emergency Medical Information

Someone who is not a citizen and does not have any immigration status that makes it possible to get broad health care coverage still might qualify for more limited coverage.
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 woman is pregnant.)

If yes, enter her name: _____ Due Date: _____ Number Expected: _____

enter her 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.

You are not required to provide income information for your dependents under age 19 who live in your home unless they are required to file a tax return. If you are under age 19 and living on your own, you must provide your gross monthly income. We will take the information you enter and use it to calculate the MAGI income for your household. Only enter information about the types of income we ask for because some types of income, such as child support, are not used to determine your monthly MAGI income.

Note: American Indians/Alaska Natives do not have to report certain income including: Alaska Native Corporations and Settlement Trusts; distributions from property held in trust; distributions and payments from fishing, natural resource extraction and harvests; distributions from ownership of natural resources and improvements; payments from ownership of items that have unique religious, spiritual, traditional, or cultural significance according to Tribal Law or custom; and student financial assistance from Bureau of Indian Affairs education programs.

You will need to enter **current gross monthly** income information for yourself and anyone listed on this application who is age 19 **and** older and for those under 19 who are required to file a tax return due to the amount of their earnings.

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.

Name of Person Employed	Name of Employer	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 monthly income from self-employment, after deducting your monthly business expenses. Please see page ii for allowable business expenses.

Note: By answering yes to this question, you agree to provide additional documentation of income and expenses upon request by the agency.

Name of Person Employed	Name of Company (If there is one)	Gross monthly income after deducting business expenses (do not enter corporation or S-corporation income here)

Employment Changes: Have you or anyone you are applying for experienced any of the following changes in circumstances?

- Changed jobs in the past six months**:** ☐ No ☐ Yes If yes, who: _____
- Stopped working in the past six months: ☐ No ☐ Yes If yes, who: _____
- Had an increase or decrease in hours worked in the past six months: ☐ No ☐ Yes
  If yes, who: _____
- Started working in the past six months: ☐ No ☐ Yes If yes, who: _____

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.

☐ Dividend Payments
Companies report this income to you on an IRS 1099-DIV form each year
Who _____ $_____ How often _____

☐ Per Capita Income
This is Economic Development funds from a tribe. An example of per capita income is distributions from gaming.
Who _____ $_____ How often _____

☐ Rental Income
This is monthly income from renting a home that wasn't included in self-employment.
Who _____ $_____ How often _____

☐ Unemployment
Who _____ $_____ How often _____

☐ Social Security
Who _____ $_____ How often _____

☐ Railroad Retirement
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:

Spousal maintenance	Health savings account	Self-employment tax
Interest on student loans	Pre-tax retirement account payments (excluding Roth IRA contributions)	Self-employment retirement plan
Tuition and school fees	Moving costs since January of this year	Self-employment health insurance premium

☐ 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 a nursing home. ☐ No ☐ Yes If yes, enter the name of the person: _____

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. Do you need a disability determination because of a disabling condition expected to last 12 months or longer or result in death? ☐ No ☐ Yes

You will be required to complete supplemental form 18-005 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:

In order to simplify the application/redetermination process, I authorize Washington Healthplanfinder to obtain my updated federal tax information for a period of no more than five years. ☐ 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** _____

Chosen Agent/ Broker:
M.H.R.W. Inc dba: Riverbend Insurance Agency
Kevin Wright
118 S. Washington Street
Newport, Wa 99156 Phone # 509-447-0426 www.riverbendins.com
email: riverbend@povn.com National Producer # 3120877

_____ _____
Signature **Date**

_____ _____
Signature **Date**