Basic Health™

FAMILY CHANGES FORM

NOTE: *Your Social Security number is voluntary, except where noted.*

Instructions and Guidelines

If you have questions about the information or documentation needed, go online to **www.basichealth.hca.wa.gov** or call Basic Health at **1-800-660-9840**.

If you need additional copies of this form, you can print them from the Internet at **www.basichealth.hca.wa.gov**, call Basic Health to request them, or photocopy this form.

Be sure to refer to the letter you received with this form for details on timing and other documentation Basic Health needs from you.

SECTION ONE

CURRENT SUBSCRIBER

Social Security number (SSN) - -	Last name	First name	Middle initial

House number Street address Apt./unit number	City	County	State	ZIP Code
Mailing address (if different from street address)	City	County	State	ZIP Code

Home phone number ( )	Daytime phone number ( )	Email address

Place of birth (City/State)	Birth date / /	Gender ❑ Male ❑ Female

Are you currently covered by Basic Health? ❑ Yes ❑ No Applying for coverage for yourself? ❑ Yes ❑ No

Are you: ❑ Single ❑ Legally married ❑ Legally Separated ❑ Divorced If married, separated, or divorced, give effective date / /

Disabled and over age 19? ❑ Yes ❑ No If yes, receiving Social Security Disability Benefits (SSDB)? ❑ Yes ❑ No Entitlement date / /

Eligible for Medicare? ❑ Yes ❑ No Receiving state medical benefits? ❑ Yes ❑ No

Do you want coverage for someone who is currently pregnant? ❑ Yes ❑ No

If **yes**, include their Social Security number (SSN) and expected date of delivery.

List the full name and the due date of the person who is pregnant. Name _____

Expected due date / / Doctor's phone number ( )

Are you applying for coverage for a child with an urgent medical need? ❑ Yes ❑ No If yes, include their Social Security number.

Name Social Security number – –

Are you applying for: ❑ Individual/family coverage ❑ Group coverage (employer, financial sponsor, or home care agency) *Submit form to them.*

Are you applying for Basic Health *Plus* or the Maternity Benefits Program for anyone on this form, and want to be referred to Medicaid for help with unpaid medical bills from the last three months? ❑ Yes ❑ No

If **yes**, attach proof of income for those three months and provide the Social Security number for this person.

SPOUSE

If you are legally married, list your spouse even if he or she is not applying for coverage. If your spouse does not live in your household, or if you and your partner are living in the same household but are not married, your spouse or partner needs to fill out a separate application to apply for coverage.

Social Security number (SSN) - -	Last name	First name	Middle initial
Birth date / /	Gender ❑ Male ❑ Female	Applying for coverage for your spouse? ❑ Yes ❑ No	

Place of birth (City/State)

U.S. citizen or lawfully admitted for permanent residence? ❑ Yes ❑ No If yes, date of arrival / /

Disabled and over age 19? ❑ Yes ❑ No

If yes, receiving Social Security Disability Benefits (SSDB)? ❑ Yes ❑ No Entitlement date / /

Eligible for Medicare? ❑ Yes ❑ No	Receiving state medical benefits? ❑ Yes ❑ No

DEPENDENTS

If you are applying for Basic Health *Plus* coverage for your child, you must provide the child's Social Security number. If you have more than four dependents, please provide their information on a separate sheet of paper. If applying for coverage for a dependent who does not live with you, you must include proof that he or she lives in Washington State. Dependent children attending school out of state who continue to maintain their residence in Washington are considered Washington State residents.

1. Last name	First name	Middle initial	Social Security number - -
Birth date / /	Gender ❑ Male ❑ Female	Applying for coverage for this dependent? ❑ Yes ❑ No	Relationship to applicant

Place of birth (City/State)

U.S. citizen or lawfully admitted for permanent residence? ❑ Yes ❑ No If yes, date of arrival / /

Do you want this child enrolled in Basic Health *Plus*? ❑ Yes ❑ No If yes, include Social Security number above.

Do you want to pay for Basic Health coverage for this child while Basic Health *Plus* eligibility is being determined? ❑ Yes ❑ No

Full-time student (age 19-22)? ❑ Yes ❑ No If yes, send proof of registration.

Disabled and over age 19? ❑ Yes ❑ No

If yes, receiving Social Security Disability Benefits (SSDB)? ❑ Yes ❑ No Entitlement date / /

Receiving state medical benefits? ❑ Yes ❑ No	Is child living in Washington? ❑ Yes ❑ No

Is child living in your home? ❑ Yes ❑ No If no, list child's address (only if applying for coverage)

2. Last name	First name	Middle initial	Social Security number - -
Birth date / /	Gender ❑ Male ❑ Female	Applying for coverage for this dependent? ❑ Yes ❑ No	Relationship to applicant

Place of birth (City/State)

U.S. citizen or lawfully admitted for permanent residence? ❑ Yes ❑ No If yes, date of arrival / /

Do you want this child enrolled in Basic Health *Plus*? ❑ Yes ❑ No If yes, include Social Security number above.

Do you want to pay for Basic Health coverage for this child while Basic Health *Plus* eligibility is being determined? ❑ Yes ❑ No

Full-time student (age 19-22)? ❑ Yes ❑ No If yes, send proof of registration.

Disabled and over age 19? ❑ Yes ❑ No

If yes, receiving Social Security Disability Benefits (SSDB)? ❑ Yes ❑ No Entitlement date / /

Receiving state medical benefits? ❑ Yes ❑ No	Is child living in Washington? ❑ Yes ❑ No

Is child living in your home? ❑ Yes ❑ No If no, list child's address (only if applying for coverage)

DEPENDENTS (continued)

3. Last name | First name | Middle initial | Social Security number - -

Birth date / / | Gender ❑ Male ❑ Female | Applying for coverage for this dependent? ❑ Yes ❑ No | Relationship to applicant

Place of birth (City/State)

U.S. citizen or lawfully admitted for permanent residence? ❑ Yes ❑ No If yes, date of arrival / /

Do you want this child enrolled in Basic Health *Plus*? ❑ Yes ❑ No If yes, include Social Security number above.

Do you want to pay for Basic Health coverage for this child while Basic Health *Plus* eligibility is being determined? ❑ Yes ❑ No

Full-time student (age 19-22)? ❑ Yes ❑ No If yes, send proof of registration.

Disabled and over age 19? ❑ Yes ❑ No

If yes, receiving Social Security Disability Benefits (SSDB)? ❑ Yes ❑ No Entitlement date / /

Receiving state medical benefits? ❑ Yes ❑ No | Is child living in Washington? ❑ Yes ❑ No

Is child living in your home? ❑ Yes ❑ No If no, list child's address (only if applying for coverage)

4. Last name | First name | Middle initial | Social Security number - -

Birth date / / | Gender ❑ Male ❑ Female | Applying for coverage for this dependent? ❑ Yes ❑ No | Relationship to applicant

Place of birth (City/State)

U.S. citizen or lawfully admitted for permanent residence? ❑ Yes ❑ No If yes, date of arrival / /

Do you want this child enrolled in Basic Health *Plus*? ❑ Yes ❑ No If yes, include Social Security number above.

Do you want to pay for Basic Health coverage for this child while Basic Health *Plus* eligibility is being determined? ❑ Yes ❑ No

Full-time student (age 19-22)? ❑ Yes ❑ No If yes, send proof of registration.

Disabled and over age 19? ❑ Yes ❑ No

If yes, receiving Social Security Disability Benefits (SSDB)? ❑ Yes ❑ No Entitlement date / /

Receiving state medical benefits? ❑ Yes ❑ No | Is child living in Washington? ❑ Yes ❑ No

Is child living in your home? ❑ Yes ❑ No If no, list child's address (only if applying for coverage)

INFORMATION ON OTHER HEALTH COVERAGE

Please list family members you wish to cover who currently have other health insurance (such as Premera Blue Cross, Group Health Cooperative, or an employer-sponsored plan) or are covered under a health program (such as Tri-Care or Medicaid). Be sure to include yourself and/or family members who are not applying for Basic Health coverage, if applicable. Please list subscriber's name for this coverage first.

Last name	First name	Middle initial	Health insurance company or health program	Phone number of insurance company or health program*	Policy or group number*	Policy end date*
(Subscriber) 1.				( )		/ /
2.				( )		/ /
3.				( )		/ /
4.				( )		/ /

***Complete the last three columns only if applying for Basic Health *Plus* or the Maternity Benefits Program.**

SECTION TWO

COMPLETE THIS SECTION IF YOU ARE APPLYING FOR BASIC HEALTH *PLUS* FOR ANYONE ON THIS FORM

If the other biological parent of your child(ren) is not legally married to you, but lives in your home, provide the information below. This allows the parent to be counted in the household size and the parent's income to be considered as part of the household income for Basic Health *Plus* eligibility. Provide proof of this parent's income for the most recent 30 days or complete calendar month.

Last name	First name	Middle initial	Social Security number (required)
			– –

Birth date	Place of birth (City/State)
/ /	

Please list the full name(s) of this parent's child(ren), as listed on this form.	Daytime phone number
	( )

SECTION THREE

GROUP COVERAGE

Complete this section *only* if your premium is paid in full or in part by your employer, home care agency, or financial sponsor. Return this completed form directly to your employer, home care agency, or financial sponsor.

Employer/organization	Group ID number (if known)

Mailing address	City	State	ZIP Code	Phone number
				( )

SECTION FOUR

HEALTH PLAN SELECTION

You and your family will remain with the health plan that currently provides your Basic Health coverage, unless you are moving to an area not served by your health plan. A list of the health plans available to you, along with their monthly premiums, is in the *How to Apply for Basic Health* booklet or online at **www.basichealth.hca.wa.gov**. All health plans provide the same basic benefits, but premiums and providers vary from plan to plan. I choose to receive Basic Health or Basic Health *Plus* coverage for myself and my family members through the following health plan:

(Name of health plan)

Please note: If you change health plans any time during the year except during open enrollment, the amount you've paid toward your deductible and out-of-pocket maximum for covered members will start over with your new health plan.

SECTION FIVE

EMPLOYER INFORMATION

Fill in the following information for all current employers for yourself and your spouse, if legally married.
If you need more room, use a separate sheet and include your full name and address.

	Subscriber	**Spouse**
Employer/company name		
Employer's Address		
Employer's phone number		
Date you started working for this employer		
Employer/company name		
Employer's Address		
Employer's phone number		
Date you started working for this employer		

SECTION SIX

AGREEMENT (must be signed)

I understand that:

- I must provide proof of my gross family income (before taxes and deductions) and report any income change that would change my premium or eligibility to Basic Health/Medicaid within 30 days after the end of the month that my income changed.
- By signing this form, I have authorized Basic Health and Medicaid to verify my eligibility information and family income with other state or federal agencies or other third-party sources.
- I must report address changes and changes in my family within the timeframes shown in the Basic Health *Member Handbook*.
- My *Family Changes Form* and the documents I send to Basic Health will be used to determine eligibility for Medicaid Programs (Basic Health *Plus* coverage or the Maternity Benefits Program) according to Medicaid Program requirements.
- By asking for and receiving Medical Assistance benefits, my family and I assign to the state of Washington our rights to any third-party payment for medical care of covered medical services while receiving medical benefits.
- Basic Health's deposit of my premium payment does not guarantee coverage. The payment will be refunded if I am determined ineligible for coverage.

I authorize my health plan or medical provider to give medical records for my children or myself to Basic Health for purposes of participation in Basic Health/Medicaid Programs.

The information I have given in this form and the documents I'm enclosing are true, correct, and complete to the best of my knowledge. I understand that if I withhold information or give Basic Health false or misleading information, my family and I will lose coverage. Basic Health may also bill me for up to two times the amount the state paid for my family's coverage. If I have given false information, Basic Health may prosecute me for perjury or charge me for services received through fraud. If I am billed for past premiums or penalties but do not pay, the state may refer me for collection or bill my estate.

Must be signed by you and your spouse.

X _____	_____	X _____	_____
Your signature	Date	Spouse's signature	Date

Signatures of children age 18 and over who receive Basic Health coverage

X _____	_____	X _____	_____
Signature	Date	Signature	Date
X _____	_____	X _____	_____
Signature	Date	Signature	Date

Washington State law may require disclosure of any information you submit as a public record. Basic Health is administered by the Health Care Authority; our Privacy Notice is available upon request by calling 206-521-2035 or online at **www.hca.wa.gov**.

Basic Health™

Please submit all required documentation.

Mail to: Basic Health, P.O. Box 42683, Olympia, WA 98504-2683

Fax to: 360-725-2047