Washington State Department of Social & Health Services
HRSA Health & Recovery Services Administration

APPLICATION FOR CHILDREN'S MEDICAL BENEFITS

Washington Apple Health for Kids

This application is for medical coverage only for children and teens under 19. Anyone can apply on behalf of a child. Children may apply on their own behalf. **We will send the person listed in box 1 all follow-up information.** If you have questions or would like help filling out this form, just call 1-877-543-7669. We'll be happy to help you!

Please print in black or blue ink. Do not use pencil. **(List parent, guardian or contact person who will receive follow-up information)**

1. FIRST NAME	MIDDLE INITIAL	LAST NAME		
2. ADDRESS WHERE YOU LIVE	STREET	CITY	STATE	ZIP CODE
3. MAILING ADDRESS (IF DIFFERENT)		CITY	STATE	ZIP CODE

4. TELEPHONE NUMBERS	5. Do you have trouble speaking, reading or writing English? ☐ Yes ☐ No What language or alternative format do you need? _____ Do you need an interpreter? (If yes, we will help you through an interpreter). ☐ Yes ☐ No What language do you speak? _____
HOME ( )	
WORK ( )	
MESSAGE ( )	6. Does a child under 19 have a medical condition that needs attention right away? ☐ Yes ☐ No Is anyone in your home pregnant? ☐ Yes ☐ No If "yes", who? _____

General Information

7. List family members **living together.** (If needed, attach a separate sheet of paper to list more family members).

NAME (FIRST, MIDDLE,LAST)	SEX M or F	RELATION TO YOU	BIRTH DATE (MO/DA/YR)	SOCIAL SECURITY NUMBER *=OPTIONAL	U.S. CITIZEN YES NO	PLACE OF BIRTH (CITY/STATE)	COMPLETE IF CHILD IS **NOT** A U.S. CITIZEN	
							LIST DATE CHILD ARRIVED IN U.S.	DOES CHILD HAVE A SPONSOR? YES NO
A. Parent, Guardian or Self				*	☐ ☐			
B. Spouse or Other Parent (If living in the home)				*	☐ ☐			
C. List Children & Teens Under 19 Years of Age **(who want medical benefits)**					☐ ☐			☐ ☐
D.					☐ ☐			☐ ☐
E.					☐ ☐			☐ ☐
F.					☐ ☐			☐ ☐
G. List Other Adults/Children in the Home **(who do not want medical benefits)**				*		Note: Please attach any documents showing children's status.		
				*				

8. Is a child under age 19 in your household disabled? ☐ Yes ☐ No If "Yes", who?

Expenses This information can help your children qualify.

9. Do you pay for childcare while you work? ☐ Yes ☐ No If "Yes", how much per month? $
Do you pay someone to take care of a disabled dependent adult while you work? ☐ Yes ☐ No If "Yes", how much per month? $

10. Do you pay court ordered child support for a child who is not living in your home? ☐ Yes ☐ No If "Yes", how much per month? $

Barcode label

14380

Income Enter GROSS pay (before taxes or expenses). (Please attach proof of income)

11. PARENT'S EMPLOYER NAME AND TELEPHONE NUMBER	( )	OTHER HOUSEHOLD INCOME	AMOUNT RECEIVED IN LAST 30 DAYS	WHICH FAMILY MEMBER EARNS THIS INCOME?
START DATE:		15. CHILD SUPPORT	$	
12. Amount you received in the last 30 days before taxes and expenses were taken out: $		16. ALIMONY	$	
		17. SOCIAL SECURITY PAYMENT	$	
How much of this income is from self-employment?* $		18. UNEMPLOYMENT BENEFITS	$	
13. SPOUSE'S (OR OTHER PARENT LIVING IN THE HOME) EMPLOYER NAME AND TELEPHONE NUMBER	( )	19. INVESTMENT INCOME/ INTEREST/DIVIDENDS	$	
START DATE:		20. VETERANS BENEFITS	$	
14. Amount your spouse (or other parent living in the home) received in the last 30 days before taxes and expenses were taken out: $		21. LABOR & INDUSTRIES	$	
		22. MILITARY ALLOTMENTS	$	
How much of this income is from self-employment?* $		23. OTHER (Please Explain):	$	
*If you or your spouse (or other parent living in the home) are self-employed, you may get other deductions. Please call 1-877-KIDS-NOW for more information or application assistance.		24. Do you need help paying for unpaid medical bills – within the last 3 months – for any of the children you are applying for? ☐ Yes ☐ No If "Yes",* please send copies of all household income for the months you would like us to review.		

Health Insurance Information Tell us about any health insurance your **children** already have.

25A. Do any of the **children** you are applying for already have health insurance? ☐ Yes ☐ No	25B. If "Yes", does that health insurance cover doctor, hospital, x-ray (radiology) and laboratory services? ☐ Yes ☐ No	26A. Have your **children** been covered by job-related health insurance in the last 4 months? ☐ Yes ☐ No	26B. If "Yes", did the premium cost less than $50 per month for dependents? ☐ Yes ☐ No

27. If you checked "Yes" to any of the above questions (25 A or B or 26 A or B), please list the name of the insurance company or employer providing health insurance for your children.

INSURANCE COMPANY OR EMPLOYER	POLICY NUMBER	POLICY HOLDER'S NAME	POLICY HOLDER'S SOCIAL SECURITY NUMBER (OPTIONAL)

Children's Race/Ethnic Background (Voluntary Information)

We ask you to voluntarily tell us your children's race or ethnic background. This information will not be used in considering your eligibility for benefits.

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

Discrimination is prohibited in all programs and activities administered by the Department of Social and Health Services. No one shall be excluded from these programs and activities on the basis of race, color, creed, political beliefs, national origin, religion, age, sex or disability.

Read Carefully Before Signing

This application is for medical benefits for children only. If anyone in your family already receives, or would like to apply for cash benefits, basic food or other benefits, please contact your local DSHS Community Services Office (CSO).

- DSHS may ask you to prove the information you are giving them to tell if you are eligible. You can ask DSHS for help in getting proof.
- Your information may be reviewed by other state or federal agencies. This information will NOT be shared with Immigration and Naturalization Services (INS).
- By asking for and getting health care benefits, you give the state of Washington all rights to any medical support and to any third party payments for health care.
- DSHS may share your child's immunization history with the Child Profile Immunization Tracking System.

DECLARATION AND SIGNATURE: I have read and understood the information in this application. I declare, under penalty of perjury, the information I have given in this application is true, correct, and complete to the best of my knowledge.

SIGNATURE OF APPLICANT	DATE

How to Submit

MAIL TO: **Department of Social and Health Services**
PO Box 45531
Olympia, WA 98504-5531

FOR HELP: If you need help or have questions, please call 1-877-543-7669