Washington State Health Care Authority

# Take Charge Application for Family Planning Services

## Fax Completed Application to 1-866-841-2267

If you already have health insurance that covers family planning services, you are not eligible for Take Charge, **UNLESS you are a** (check if yes):

- ☐ Minor child age 18 or younger, covered under your parent's health insurance and you do not want your parents to know you are seeking family planning services.
- ☐ Victim of domestic violence and covered under the perpetrator's health insurance.

If you checked one of the boxes above, what is the name of your insurance? ☐ Medicare ☐ Tricare ☐ Indian Health Services ☐ Long-Term Care Insurance ☐ Other health insurance: ______

| PROVIDER NAME | PROVIDER TELEPHONE NUMBER |
|---|---|
| | |

| 1. FIRST NAME | MIDDLE INITIAL | LAST NAME |
|---|---|---|
| | | |

| 2. ADDRESS WHERE YOU LIVE | STREET | CITY | STATE | ZIP CODE |
|---|---|---|---|---|
| 3. MAILING ADDRESS (if different from above): | STREET | CITY | STATE | ZIP CODE |

| 4. TELEPHONE NUMBER(S) | HOME, CELL, PREFERRED NUMBER | WORK/MESSAGE NUMBER | E-MAIL ADDRESS |
|---|---|---|---|
| | | | |

| 5. Do you have trouble speaking, reading, or writing English? ☐ Yes ☐ No | Do you need an interpreter? ☐ Yes ☐ No | What language do you speak? |
|---|---|---|

### General Information

| SEX ☐ Male ☐ Female | DATE OF BIRTH | Do you intend to use a birth control method to prevent unintended pregnancy? ☐ Yes ☐ No |
|---|---|---|
| SOCIAL SECURITY NUMBER | U.S. CITIZEN OR NATIONAL? ☐ Yes ☐ No | If not a U.S. citizen or national, are you in the country legally? (Provide a copy of immigration documents) ☐ Yes ☐ No |

6. To determine eligibility for this program, we need to know your family size (spouse and/or dependent children living with you). Including yourself, what is your family size?

7. If you are married and living with your spouse, enter spouse's name and Social Security Number (SSN) :
   (First, Middle, Last): SSN

### Race/Ethnic Background

8. We ask you to voluntarily tell us your race or ethnic background. This information will not be used in considering your eligibility for services.

☐ Caucasian ☐ Black or African American ☐ Vietnamese/Laotian/Cambodian ☐ Other Asian or Pacific Islander

☐ Hispanic ☐ American Indian or Alaskan Native; tribe name: ______

☐ Other: ______

### Optional Authorized Representative (AREP)

(An AREP is someone you allow the department to talk with about your benefits, and/or receive Take Charge mail for you). To name an AREP, complete the information below.

| NAME / ORGANIZATION | TELEPHONE NUMBER |
|---|---|
| | |

| MAILING ADDRESS | STREET | CITY | STATE | ZIP CODE |
|---|---|---|---|---|
| | | | | |

☐ Send my Take Charge mail to my address. ☐ Send my Take Charge mail to this AREP's address.

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| CLIENT NAME | SOCIAL SECURITY NUMBER |
|---|---|
| | |

## Income

| Have you quit or lost a job in the last 90 days? | Has your spouse quit or lost a job in the last 90 days? |
|---|---|
| ☐ Yes ☐ No Date last worked | ☐ Yes ☐ No Date last worked |
| **Your income from employment / self-employment** | **Spouse's income from employment / self-employment** |
| EMPLOYER NAME / TELEPHONE NUMBER | EMPLOYER NAME / TELEPHONE NUMBER |
| Gross income before taxes or expenses: $ ______ | Gross income before taxes or expenses: $ ______ |
| ☐ Weekly ☐ Every two weeks ☐ Twice a month | ☐ Weekly ☐ Every two weeks ☐ Twice a month |
| ☐ Monthly Hours worked each week: | ☐ Monthly Hours worked each week: |

| OTHER INCOME | AMOUNT | HOW OFTEN DO YOU GET THIS INCOME? | WHICH FAMILY MEMBER GETS THIS INCOME? |
|---|---|---|---|
| 9. Child support or alimony | | | |
| 10. Social Security payment | | | |
| 11. Unemployment services | | | |
| 12. Veterans services/military allotments | | | |
| 13. Labor and Industries | | | |
| 14. Investment Income | | | |
| 15. Other Income (Examples: supported by parents, student loans) | | | |

## Expenses

| | YES | NO | IF YES, AMOUNT |
|---|---|---|---|
| 16. Do you pay for child care or adult dependent care while you work? | ☐ | ☐ | ______ |
| 17. Do you pay child support for a child who is not living in your home? | ☐ | ☐ | ______ |

## *Read Carefully Before Signing Below*

I understand that:

- HCA may ask me to prove the information I provide. HCA may help me get the proof or contact other agencies or persons for it.
- My information may be reviewed by other state or federal agencies. This information will NOT be shared with U.S. Customs and immigration Services (USCIS).
- By asking for and receiving medical care benefits, I assign to the state of Washington all rights to any medical support, and to any third party payments for medical care.
- I understand this application is for family planning services to prevent pregnancy only. If my family needs other medical services, financial assistance, or food stamps, we must apply through a DSHS Community Services Office.

## 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 |
|---|---|
| | |