

Application For Children's Health Program

Please answer all questions and send in proof of income. Send completed application and documents to: PO Box 45531, Olympia, WA 98599-5531 or Fax to 1-866-720-2892.

Check here if you would like information about cash or food assistance programs.

1. First Name		Middle Initial	Last Name		
2. Address Where You Live		Street	City	State	Zip Code
3. Mailing Address (if different)		Street	City	State	Zip Code
4. Telephone Number	5. Do you have trouble speaking, reading or writing English? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what language do you speak?				
6. A person in my household is pregnant. Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, who?				Expected date of delivery	
7. A person in my household has a medical emergency now or within the last three months.. Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, who?					

GENERAL INFORMATION

8. **LIST ALL FAMILY MEMBERS** living in your household. If you do not have a Social Security Number, leave it blank. **If you have documents showing immigration status, please provide copies.** This information will NOT be shared with U.S. Citizenship and Immigration Services (USCIS).

Name (First, Middle, Last)	Relation to you?	Date of Birth (Mo-Day-Year)	Social Security Number	Sex M/F	U.S. Citizen? Yes No		Complete if NOT a U.S. Citizen		Date arrived in U.S.
							Do you have a document showing immigration status? Yes	No	
	SELF				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

9. Do any of the children living with you already have health insurance?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
10. Did any of the children living with you have unpaid medical bills in the past 3 months?		Yes <input type="checkbox"/>	No <input type="checkbox"/>



EARNED INCOME

Enter GROSS pay (before taxes and expenses). Please provide proof of income for example: pay stubs, statement from employer, bank statements that show direct deposit or statement from another person that knows your circumstances..

11. a) Your employer's name and telephone number. _____ () _____	12. a) Spouse's (or other parent living in the home) employer's name and telephone number. _____ () _____
b) Amount you expect to receive in the month of application before taxes and expenses are taken out: \$ _____	b) Amount they expect to receive in the month of application before taxes and expenses are taken out: \$ _____
c) Are you self employed? Yes <input type="checkbox"/> No <input type="checkbox"/>	c) Are they self employed? Yes <input type="checkbox"/> No <input type="checkbox"/>
d) I have no earned income. Yes <input type="checkbox"/> No <input type="checkbox"/>	d) They have no earned income. Yes <input type="checkbox"/> No <input type="checkbox"/>

UNEARNED INCOME/EXPENSES

Other Income	Amount You Expect to Received in the Month of Application	Which Family Member Gets This Income?
13. Unemployment benefits		
14. Child Support		
15. Other (please explain)		
16. Do you pay someone to take care of your child(ren) or a dependent adult while you work? Yes <input type="checkbox"/> No <input type="checkbox"/>		If yes, how much per month?
17. Do you pay child support for a child who is not in your home? Yes <input type="checkbox"/> No <input type="checkbox"/>		If yes, how much per month?

VOLUNTARY INFORMATION

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

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

READ CAREFULLY BEFORE SIGNING

This application is for medical benefits for the Children's Health program 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.
- 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
Name of Helper or Representative	Telephone Number

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.