

Free or Low-Cost Medical Coverage



If your family's monthly income is at or below the following standards, your children may qualify for free or low-cost medical coverage.

Total Number in Family (Including yourself)	Monthly Income limit for Free coverage	Monthly Income limit for Low-cost coverage*
1	\$1,734	\$2,167
2	\$2,334	\$2,917
3	\$2,934	\$3,667
4	\$3,534	\$4,417
5	\$4,134	\$5,167
6	\$4,734	\$5,917
7	\$5,334	\$6,667
8	\$5,934	\$7,417
9	\$6,534	\$8,167
10	\$7,134	\$8,917

*Low-cost coverage is \$15 per month, per child; up to a maximum of \$45 per month, per family.

Call today!

Cindy Mai

206-296-3949

Children's Health Initiative

Public Health – Seattle & King County

Or call CHAP (Community Health Access Program) 1-800-756-5437



August 2008

Health Insurance for Children Free or Low Cost



Health coverage is available to eligible children through Washington Apple Health for Kids.

To apply:

1. Fill out the *Application* and sign it.
2. Include proof of income for the past 30 days.
(Example: copies of pay stubs)
3. If your child is a U.S. Citizen: Include a copy of the child's birth certificate and, for teens over 15 years, a copy of photo ID.
Or complete and sign the *Citizenship Documentation and Identity Declaration*.
If your child is not a U.S. Citizen: Include a copy of your child's immigration card (if he/she has one.)
4. Sign the *Authorization to Release Information* form
This gives DSHS permission to talk with me (Cindy) about your application. I will forward your application to DSHS Medical. If you do not get a letter from them within 30 days, please call me at 206-296-3949 or call DSHS at 206-341-7433.

Mail your application to:

Cindy Mai
Kent Public Health Center
233 2nd Ave S
Kent, WA 98032

Or fax your application to:

206-296-3950 Attention: Cindy Mai

Or call Cindy if you have questions or would like assistance with this application.

206-296-3949

cindy.mai@kingcounty.gov

APPLICATION FOR CHILDREN'S MEDICAL BENEFITS



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? <input type="checkbox"/> Yes <input type="checkbox"/> No				
HOME ()	What language or alternative format do you need? _____				
WORK ()	Do you need an interpreter? (If yes, we will help you through an interpreter). <input type="checkbox"/> Yes <input type="checkbox"/> No				
MESSAGE ()	What language do you speak? _____				
		6. Does a child under 19 have a medical condition that needs attention right away? <input type="checkbox"/> Yes <input type="checkbox"/> No			
		Is anyone in your home pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> 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				*	<input type="checkbox"/> <input type="checkbox"/>			
B. Spouse or Other Parent (If living in the home)				*	<input type="checkbox"/> <input type="checkbox"/>			
C. List Children & Teens Under 19 Years of Age (who want medical benefits)					<input type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/> <input type="checkbox"/>
D.					<input type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/> <input type="checkbox"/>
E.					<input type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/> <input type="checkbox"/>
F.					<input type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/> <input type="checkbox"/>
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? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", how much per month? \$
Do you pay someone to take care of a disabled dependent adult while you work? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", how much per month? \$

DSHS 14-380 (REV. 07/2008) TRANSLATED



Income Enter GROSS pay (before taxes or expenses).

(Please attach proof of income)

11. PARENT'S EMPLOYER NAME AND TELEPHONE NUMBER () START DATE:	OTHER HOUSEHOLD INCOME	AMOUNT RECEIVED IN LAST 30 DAYS	WHICH FAMILY MEMBER EARNS THIS INCOME?
	15. CHILD SUPPORT	\$	
12. Amount you received in the last 30 days before taxes and expenses were taken out: \$ How much of this income is from self-employment?* \$	16. ALIMONY	\$	
	17. SOCIAL SECURITY PAYMENT	\$	
	18. UNEMPLOYMENT BENEFITS	\$	
13. SPOUSE'S (OR OTHER PARENT LIVING IN THE HOME) EMPLOYER NAME AND TELEPHONE NUMBER () START DATE:	19. INVESTMENT INCOME/ INTEREST/DIVIDENDS	\$	
	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: \$ How much of this income is from self-employment?* \$	21. LABOR & INDUSTRIES	\$	
	22. MILITARY ALLOTMENTS	\$	
	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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	25B. If "Yes", does that health insurance cover doctor, hospital, x-ray (radiology) and laboratory services? <input type="checkbox"/> Yes <input type="checkbox"/> No	26A. Have your children been covered by job-related health insurance in the last 4 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	26B. If "Yes", did the premium cost less than \$50 per month for dependents? <input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black or African American
	<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	
	<input type="checkbox"/> White	<input type="checkbox"/> 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

CITIZENSHIP DOCUMENTATION AND IDENTITY DECLARATION

CLID

U.S. Citizens applying for or receiving Medicaid must provide proof of citizenship and identity.

If you do not have proof of either citizenship or identity for one or more household members who are applying for or receiving medical, please complete the information below for each of them. DSHS can help obtain the documents necessary to continue Medicaid eligibility. If a household member is adopted please complete the form with the adoptive parent's information.

BE SURE TO SIGN AND DATE THE DECLARATION BELOW:

I declare, under penalty of perjury, the information below on each household member applying for or receiving medical coverage is true, correct, and complete to the best of my knowledge. I authorize Washington State Department of Social and Health Services to obtain birth certificate(s) or other necessary documents for me and my family members.

SIGNATURE (Parent, Guardian or Self)

DATE

LIST ONLY UNITED STATES CITIZEN HOUSEHOLD MEMBERS APPLYING FOR OR RECEIVING MEDICAL BENEFITS.

COMPLETE THE INFORMATION BELOW AS LISTED ON THE BIRTH CERTIFICATE.

1. NAME AT BIRTH (FIRST, MIDDLE AND LAST):

DATE OF BIRTH

PLACE OF BIRTH (STATE, COUNTY AND CITY)

FATHER'S NAME (FIRST, MIDDLE AND LAST):

MOTHER'S MAIDEN NAME (FIRST, MIDDLE AND LAST):

- PROOF OF CITIZENSHIP IS NOT AVAILABLE BECAUSE
- PROOF OF IDENTITY IS NOT AVAILABLE BECAUSE

2. NAME AT BIRTH (FIRST, MIDDLE AND LAST):

DATE OF BIRTH

PLACE OF BIRTH (STATE, COUNTY AND CITY)

FATHER'S NAME (FIRST, MIDDLE AND LAST):

MOTHER'S MAIDEN NAME (FIRST, MIDDLE AND LAST):

- PROOF OF CITIZENSHIP IS NOT AVAILABLE BECAUSE
- PROOF OF IDENTITY IS NOT AVAILABLE BECAUSE

3. NAME AT BIRTH (FIRST, MIDDLE AND LAST):

DATE OF BIRTH

PLACE OF BIRTH (STATE, COUNTY AND CITY)

FATHER'S NAME (FIRST, MIDDLE AND LAST):

MOTHER'S MAIDEN NAME (FIRST, MIDDLE AND LAST):

- PROOF OF CITIZENSHIP IS NOT AVAILABLE BECAUSE
- PROOF OF IDENTITY IS NOT AVAILABLE BECAUSE

IF MORE THAN 3 HOUSEHOLD MEMBERS LIST ADDITIONAL ON THE SECOND PAGE



4. NAME AT BIRTH (FIRST, MIDDLE AND LAST):	
DATE OF BIRTH	PLACE OF BIRTH (STATE, COUNTY AND CITY)
FATHER'S NAME (FIRST, MIDDLE AND LAST):	
MOTHER'S MAIDEN NAME (FIRST, MIDDLE AND LAST):	
• PROOF OF CITIZENSHIP IS NOT AVAILABLE BECAUSE	
• PROOF OF IDENTITY IS NOT AVAILABLE BECAUSE	
5. NAME AT BIRTH (FIRST, MIDDLE AND LAST):	
DATE OF BIRTH	PLACE OF BIRTH (STATE, COUNTY AND CITY)
FATHER'S NAME (FIRST, MIDDLE AND LAST):	
MOTHER'S MAIDEN NAME (FIRST, MIDDLE AND LAST):	
• PROOF OF CITIZENSHIP IS NOT AVAILABLE BECAUSE	
• PROOF OF IDENTITY IS NOT AVAILABLE BECAUSE	
6. NAME AT BIRTH (FIRST, MIDDLE AND LAST):	
DATE OF BIRTH	PLACE OF BIRTH (STATE, COUNTY AND CITY)
FATHER'S NAME (FIRST, MIDDLE AND LAST):	
MOTHER'S MAIDEN NAME (FIRST, MIDDLE AND LAST):	
• PROOF OF CITIZENSHIP IS NOT AVAILABLE BECAUSE	
• PROOF OF IDENTITY IS NOT AVAILABLE BECAUSE	
7. NAME AT BIRTH (FIRST, MIDDLE AND LAST):	
DATE OF BIRTH	PLACE OF BIRTH (STATE, COUNTY AND CITY)
FATHER'S NAME (FIRST, MIDDLE AND LAST):	
MOTHER'S MAIDEN NAME (FIRST, MIDDLE AND LAST):	
• PROOF OF CITIZENSHIP IS NOT AVAILABLE BECAUSE	
• PROOF OF IDENTITY IS NOT AVAILABLE BECAUSE	
8. NAME AT BIRTH (FIRST, MIDDLE AND LAST):	
DATE OF BIRTH	PLACE OF BIRTH (STATE, COUNTY AND CITY)
FATHER'S NAME (FIRST, MIDDLE AND LAST):	
MOTHER'S MAIDEN NAME (FIRST, MIDDLE AND LAST):	
• PROOF OF CITIZENSHIP IS NOT AVAILABLE BECAUSE	
• PROOF OF IDENTITY IS NOT AVAILABLE BECAUSE	

AUTHORIZATION

AUTHORIZATION TO DISCLOSE RECORDS OF:															
NAME LAST	FIRST	MIDDLE	DATE OF BIRTH												
The following information may help in locating records:		FORMER NAMES													
CLIENT IDENTIFICATION NUMBER	OTHER IDENTIFICATION NUMBER	DATES OF SERVICE	LOCATION OF SERVICE												
DISCLOSE TO:															
NAME LAST	FIRST	MIDDLE	TITLE												
Mai	Cindy	H.	Outreach Specialist												
ORGANIZATION OR BUSINESS NAME IF APPLICABLE															
Kent Public Health Center															
ADDRESS	CITY	STATE	ZIP CODE												
233 2nd Ave. S.	Kent	WA	98032												
TELEPHONE NUMBER (INCLUDE AREA CODE)	FAX NUMBER (INCLUDE AREA CODE)	E-MAIL ADDRESS													
206-296-3949	206-296-3950	cindy.mai@kingcounty.gov													
REASON FOR DISCLOSURE															
To assist client in getting DSHS Medical benefits and/or other DSHS benefits.															
AUTHORIZATION:															
<p><u>SOURCES:</u> I authorize the following programs to disclose or give access to confidential information about me as described below. Information may be provided verbally or by computer data transfer, mail, fax, or hand delivery.</p> <p><input type="checkbox"/> The following programs only (check all that apply):</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Aging and Disability Services Administration</td> <td><input type="checkbox"/> Children's Administration</td> </tr> <tr> <td><input type="checkbox"/> Economic Services Administration assistance programs</td> <td><input type="checkbox"/> Division of Child Support</td> </tr> <tr> <td><input type="checkbox"/> Financial Services Administration</td> <td><input type="checkbox"/> Juvenile Rehabilitation Administration</td> </tr> <tr> <td><input type="checkbox"/> Medical Assistance Administration</td> <td><input type="checkbox"/> Division of Alcohol and Substance Abuse</td> </tr> <tr> <td><input type="checkbox"/> Division of Vocational Rehabilitation</td> <td><input type="checkbox"/> Mental Health Division including state hospitals</td> </tr> <tr> <td colspan="2"><input type="checkbox"/> Other: _____</td> </tr> </table> <p><input checked="" type="checkbox"/> All parts of the Department of Social and Health Services (DSHS)</p>				<input type="checkbox"/> Aging and Disability Services Administration	<input type="checkbox"/> Children's Administration	<input type="checkbox"/> Economic Services Administration assistance programs	<input type="checkbox"/> Division of Child Support	<input type="checkbox"/> Financial Services Administration	<input type="checkbox"/> Juvenile Rehabilitation Administration	<input type="checkbox"/> Medical Assistance Administration	<input type="checkbox"/> Division of Alcohol and Substance Abuse	<input type="checkbox"/> Division of Vocational Rehabilitation	<input type="checkbox"/> Mental Health Division including state hospitals	<input type="checkbox"/> Other: _____	
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<input type="checkbox"/> Other: _____															
<p><u>RECORDS:</u> I authorize the following records to be disclosed:</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Client records held by parts of DSHS marked above</td> <td><input checked="" type="checkbox"/> All my client records</td> </tr> <tr> <td><input type="checkbox"/> Confidential records held by parts of DSHS marked above</td> <td><input type="checkbox"/> Records on the attached list</td> </tr> <tr> <td colspan="2"><input type="checkbox"/> The following records only:</td> </tr> </table> <p>I want to limit the records to be disclosed as follows (by date, type of record, etc.):</p>				<input type="checkbox"/> Client records held by parts of DSHS marked above	<input checked="" type="checkbox"/> All my client records	<input type="checkbox"/> Confidential records held by parts of DSHS marked above	<input type="checkbox"/> Records on the attached list	<input type="checkbox"/> The following records only:							
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<input type="checkbox"/> The following records only:															
<p>PLEASE NOTE: If your client or confidential records include any of the following information, you must also complete the below section to allow disclosure of these records.</p> <p><u>SPECIAL RECORDS:</u> I give my permission to disclose the following records (check all that apply):</p> <p><input type="checkbox"/> HIV/AIDS and STD test results, diagnosis or treatment records (RCW 70.24.105)</p> <p><input type="checkbox"/> Mental health records (RCW 71.05.620) including:</p> <p><input type="checkbox"/> Chemical Dependency (CD) records (42 CFR Part 2) including:</p>															
<ul style="list-style-type: none"> • This permission is valid for <input type="checkbox"/> 90 days or <input type="checkbox"/> until _____ (date or event). • I may revoke or withdraw my permission in writing at any time, but that will not affect information already disclosed. • I understand that my records may no longer be protected under the laws that apply to DSHS after this disclosure. • A copy of this form is valid to give my permission to disclose records. DSHS may charge to provide copies of its records. 															
AUTHORIZED BY (SIGNATURE)		DATE SIGNED	TELEPHONE NUMBER (INCLUDE AREA CODE)												
PRINT NAME		WITNESS/NOTARY (SIGN AND PRINT NAME, IF APPLICABLE)													
<p>If I am not the person who is the subject of the records, I am authorized to sign because I am the: (attach proof of authority)</p> <p><input type="checkbox"/> Parent of minor <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Personal Representative <input type="checkbox"/> Other:</p>															

Notice to those receiving information: If these records contain information about HIV, STDs, or alcohol or drug abuse, you may not further disclose that information under federal and state law without specific permission of the subject and meeting specific legal requirements.