Washington State Health Care Authority

Application for Pregnant Teen Health Care Coverage (for Teens Under Age 19)

First name	Middle initial	Last name

Address where you live *(If you don't have a fixed address, please provide mailing address below.)*

Street address	City	State	ZIP Code

Mailing address *(If you prefer to have all mail sent to an authorized representative, please complete below.)*

Street address	City	State	ZIP Code

Preferred phone numbers

Are these phone numbers where a physician/provider can leave a message? ☐ Yes ☐ No If no, do not fill in this section.

Contact number:	Voicemail number:

Language and disability services

Do you have trouble speaking, reading, or writing English? ☐ Yes ☐ No

Do you need an interpreter? ☐ Yes ☐ No

Do you need translated materials? ☐ Yes ☐ No

What language do you prefer to speak? _____

What language do you prefer to read? _____

Questions *(Your response to these questions will not affect your coverage.)*

Are you a U.S. citizen or immigrant legally residing in the U.S.? ☐ Yes ☐ No

Are you American Indian or Alaska Native? ☐ Yes ☐ No

Do you want your pregnancy to be kept confidential? ☐ Yes ☐ No

Do you have any unpaid medical expenses incurred during your pregnancy? ☐ Yes ☐ No

Date of birth *(mm/dd/yyyy)*	Pregnancy end date *(mm/dd/yyyy)* *(If you don't know, estimate.)*	Social Security number *(If you don't have one, leave blank.)*

Optional authorized representative (An AREP is someone you allow the Health Care Authority to talk with about your coverage and/or to receive mail regarding your Pregnant Teen Health Care Coverage.) *To have an AREP, please complete the information below.*

AREP's name	Organization name	Phone number

Street address	City	State	ZIP Code

Check either or both: ☐ Send my mail to my mailing address. ☐ Send my mail to this AREP's address.

Read carefully before signing below

I understand that:

- My situation is subject to verification by the Health Care Authority or other state or federal agencies.
- If I asked for my pregnancy to be kept confidential above, no other insurance will be billed for services I receive through this program.

Declaration and signature

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

Signature of applicant	Date

MEDS, P.O. Box 45531, Olympia, WA 98504-5531 • 1-360-725-1898 (fax) • 1-800-562-3022 (voice)