JANE_DOE
GENERAL
DELIVERY
TACOMA WA 98409

04/01/2019

Application ID:
0001

Washington Apple Health Renewal - Action Required

Dear Jane Doe,

You must take action to keep getting health care coverage for the individuals listed below:

- Jane Doe

If you do not complete your renewal by 05/31/2019, the health care coverage for the individuals listed above will end on 05/31/2019.

Please review your attached account information and **to avoid a gap in coverage, complete your renewal by** doing one of the following:

- Online http://www.wahealthplanfinder.org
  - From your dashboard under “Quick Links,” click on “Update My Application and Renew My Coverage” to make any necessary changes to your application.
- Call 1-855-WAFINDER (855-923-4633)
- You can also make changes on the attached application, sign, and return:
  - By Mail: Washington Healthplanfinder
PO Box 946
Olympia WA 98507
  - By Fax: 1-855-867-4467

Please be aware, completing any changes by mail or fax may delay processing.

If your income has increased or you believe you no longer qualify for Washington Apple Health, you may be eligible for other coverage. To see if you qualify, you must complete your renewal.

Washington Apple Health

If you are enrolled in a managed care plan, you will continue coverage under the same plan. You can change your plan at any time.

You have several options to change your managed care plan online:

- www.wahealthplanfinder.org
- https://www.WAProviderOne.org/client
- https://fortress.wa.gov/hca/p1contactus/Client_WebForm

Or, you can call the Health Care Authority at 1-800-562-3022.

Hearing Rights

If you disagree with the decisions above you have the right to request an administrative hearing. See the attached information about your hearing rights. There are deadlines to request a hearing, so you should act quickly.

Administrative Hearing Rights and Deadlines

You have the right to appeal a decision about Washington Apple Health coverage or Qualified Health Plan tax credits, cost-sharing reductions, and special enrollment periods. This is called an administrative hearing, which is a legal process where a judge reviews an agency decision. Contact us as we may be able to help you before you file an appeal.

To appeal your **Washington Apple Health** decision, contact the Health Care Authority:

- Send a written request or download and complete the form found at: http://www.hca.wa.gov/sites/default/files/free-or-low-cost/12-511.pdf.
  - Fax: 1-855-867-4467
  - Email: askmagi@hca.wa.gov
  - Mail: Health Care Authority
PO Box 45531
Olympia, WA 98504-5531
- Call and request an appeal at 1-800-562-3022

For more information, see Washington Administrative Code (WAC) chapter 182-526.

To appeal your **Qualified Health Plan** decision, contact the Washington Health Benefit Exchange:

- Send a written request or download and complete the form found at: www.wahbexchange.org/appeals
  - Fax: 360-841-7653

- Email: appeals@wahbexchange.org
- Mail: Washington Health Benefit Exchange Appeals
  PO Box 1757
  Olympia, WA 98507

- Call and request an appeal at 1-855-859-2512

Interpreter services and other help is available to help you complete an appeal. You can appoint an attorney or a personal representative to help with your appeal. For free legal assistance, contact Coordinated Legal Education Advice and Referral (CLEAR) at 1-888-201-1014 (1-888-387-7111 if you are age 60 and over).

Important Information

- You have 90 days from the date of this notice to request an appeal.
- You may be able to keep your Washington Apple Health coverage during the appeal process, if you request an appeal within 10 days from the date of this notice or by the end of the month, whichever is later.
- If you receive continued Washington Apple Health coverage and lose your appeal, you may have to pay back up to 60 days of the continued coverage.
- If you were denied Washington Apple Health coverage, you cannot receive coverage while waiting for an appeal.
- If you have an urgent health care need, you may request an expedited hearing and must submit medical evidence of the need. The judge will decide if you can have one.
- If you are receiving continued Washington Apple Health coverage, you may not receive an expedited hearing.

The outcome of an appeal could change the eligibility of other members of your household even if they did not ask for an appeal.

Discrimination is Against the Law

The Washington Health Benefit Exchange/Health Care Authority complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Washington Health Benefit Exchange/Health Care Authority does not exclude people or treat them differently because of their race, color, national origin, age, disability, or sex.

The Washington Health Benefit Exchange/Health Care Authority also complies with applicable state laws and does not discriminate on the basis of creed, gender, gender expression or identity, sexual orientation, marital status, religion, honorably discharged veteran or military status, or the use of a trained dog guide or service animal by a person with a disability.

The Washington Health Benefit Exchange/Health Care Authority:

- Provides free aids and services to people with disabilities so they can communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact 1-855-923-4633.

If you believe that the Washington Health Benefit Exchange/Health Care Authority has failed to provide these services or

discriminated in another way, you can file a grievance with:

Washington Health Benefit Exchange Legal Department ATTN: Legal Division Equal Access/Equal Opportunity Coordinator PO Box 1757 Olympia, WA 98507-1757 1-855-859-2512 Fax: 360-841-7653 appeals@wahbexchange.org	Health Care Authority Division of Legal Services ATTN: Compliance Officer PO Box 42704 Olympia. WA 98504-2704 1-855-682-0787 Fax: 360-507-9234 Compliance@hca.wa.gov

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Washington Health Benefit Exchange Legal Department/Health Care Authority Division of Legal Services is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

ATTENTION: If you speak [insert language], language assistance services, free of charge, are available to you. Call 1-855-923-4633 (TTY: 1-855-627-9604).

Spanish - ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-923-4633 (TTY: 1-855-627-9604).

Chinese - 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-923-4633（TTY：1-855-627-9604）。

Vietnamese - CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-923-4633 (TTY: 1-855-627-9604).

Korean - 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-923-4633 (TTY: 1-855-627-9604) 번으로 전화해 주십시오.

Russian - ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-923-4633 (телетайп: TTY: 1-855-627-9604).

Tagalog - PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-923-4633 (TTY: 1-855-627-9604).

Ukrainian - УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-855-923-4633 (телетайп: TTY: 1-855-627-9604).

Cambodian (Khmer)- ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ ជំនួយផ្នែកភាសា
ឥតគិតឈ្នួល , ទូរស័ព្ទអាច មានទស់រ៉ប់ បន់បំរើអ្នកៗចូរ1-855-923-4633(TTY:1-855-627-9604)។

Japanese - 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-923-4633（TTY: 1-855-627-9604）まで、お電話にてご連絡ください。

Amharic - ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-855-923-4633

(ማስማት ለተሳናቸው: TTY: 1-855-627-9604).

Oromo - XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-855-923-4633 (TTY: 1-855-627-9604).

Somali - MUHIIM AH: Haddii aad ku hadashid Af-soomaali, adeegaha caawimaada luuqada, ee lacag la'aanta ah, ayaad heli kartaa. Wac 1-855-923-4633 (TTY: 1-855-627-9604).

Arabic - ملحوظة: إذا كنت تتحدث اللغة اليوغلل تتاحة لك بالمجان. اتصل بقرب 1-855-923-4633
(رقم هاتف الصم والبكم: 1-855-627-9604:TTY).

Punjabi - ਧਿਆਨ ਿਦਓ: ਜੇ ਤੁਸ਼ ਪ ੰਜਾਬੀ ਬੋਲਦੇ ਹ , ਤ ਭਾਸ਼ਾ ਿਵ ੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-855-923-4633 (TTY: 1-855-627-9604) 'ਤੇ ਕਾਲ ਕਰੋ।

German - ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-923-4633 (TTY: 1-855-627-9604).

Lao - □□□□□□: □□□□□□

Current Application Information **Application ID: 0001**

Review your information below and report any changes you have. **For faster processing, complete your renewal online.** If you would like to return this form by mail or fax, write your updates in the form below and send it to us.

Primary Applicant's Information - Provide updates in the space provided.			
Primary applicant Name Jane Doe			
Physical address GENERAL DELIVERY TACOMA WA 98409 PIERCE		**Mailing address** GENERAL DELIVERY TACOMA WA 98409 PIERCE	
Preferred written language English		**Preferred spoken language** English	
Phone number (206) 555-5555		**Alternative phone**	
Email address janedoe@email.com		**Go paperless?** Y	

Household Members - Verify information and provide updates in the space provided.					
Name	**DOB**	**SSN**	**Requesting coverage?**	**Relationship to primary applicant**	**Living with primary applicant**
Jane Doe	01/01/1970	***-**-1111	Yes	N/A	Y
Updates for Jane Doe?					

Tax filing status - Verify information and provide updates in the space provided.			
Name	**2019**		**Primary tax filer**
Jane Doe	Head of household	n/a	Self
Updates for Jane Doe?			

Household Members Continued - Verify information and provide updates in the space provided.						
Name	**Gender**	**Race**	**U.S. citizen**	**WA resident**	**Affiliated with a tribe?**	**If so, what tribe?***
Jane Doe	FEMALE	American Indian/Alaska Native	YES	YES	YES	Eastern Band of Cherokee Indians
Updates for Jane Doe?						

New Household Members - Add new members (If you need more room, attach additional pieces of paper)

Name _____ Date of birth _____ Gender _____	Social Security number _____ Race _____	Relationship to primary applicant _____
Tax filing status for: 2018 _____ 2019 _____ _____ Primary tax filer _____ Reason for addition _____ Date of event _____ Has unpaid medical expenses incurred within the last three months? Circle one: Yes No	**Is this individual** (circle one): Living with primary applicant? Yes No Requesting coverage? Yes No A Washington resident? Yes No Affiliated with a tribe? Yes No If yes, what tribe* _____	
Citizenship status (check one): ☐ U.S. citizen ☐ Non-citizen lawfully present ☐ Other _____	Immigration document type: _ "A" number: _____ Receipt number or other number: _____ Foreign passport number: _____ Country of issuance: ___ Date of entry: _____ Document expiry date: _____	

Additional Questions - Verify information and provide updates in the space provided.		
Is anyone in the household currently:	**Yes/No**	**Household Member with Change**

Incarcerated? If yes, is the member pending disposition of charges? _____ Date of incarceration: _____	N	
Regularly using tobacco products? If yes, who?* _____	N	
Pregnant? If yes, who?_____Due date: _____ Number of babies expected: _____	N	
Have other health insurance (not including Washington Apple Health/Medicaid) or other coverage selected through Washington Healthplanfinder? If yes, provide the following: Name of insurance company: ____ Policy holder name: _____ Policy number: _____ Who is covered: _____	N	

Additional Screening Questions - Does anyone in the household need any of the following services? Check the box for "Yes" and list who in the household.

☐ Long-term care services because someone is currently living in a medical facility. Type of facility: _____	_____
☐ In-home care-giver	_____
☐ Assisted living services	_____
☐ Services through the Division of Developmental Disabilities	_____
☐ Hospice care	_____
☐ A disability determination because of a disabling condition expected to last at least 12 months or result in death	_____
☐ Needs emergency hospitalization, cancer treatment, or kidney dialysis	_____
☐ Has an adult child who is a disabled dependent aged 26 or older?	_____

Reported Income - This is the information we currently have on your application:

Jane Doe reports Income from a job of $1182.00 per month

Report all your current gross household income in the spaces provided below, even if it is same amount reported above. (If you need more room, attach additional pieces of paper).

Does anyone have income from a job? ☐ No ☐ Yes	If yes, who?	Name of employer Employer address	Amount: $_____ How often: ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly
Does anyone have self-employment income? ☐ No ☐ Yes	If yes, who?	Name of company Type of business	Amount: $_____ How often: ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly
Does anyone have Social Security income? ☐ No ☐ Yes	If yes, who?	Type of income	Amount: $_____ How often: ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly
Does anyone have rental income? ☐ No ☐ Yes	If yes, who?	Name of property (if applicable)	Amount: $_____ How often: ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly
Does anyone have one of these income types? ☐ No ☐ Yes	- **Alimony or spousal support** - **Farming income** - **Royalty income** - **Unemployment benefits** - **Capital gains**	- **Taxable tribal income** - **Income from a trust** - **Dividends, stocks or shares income** - **Interest income** - **Foreign income**	- **IRA income** - **Railroad Retirement benefits** - **Annuity or pension income** - **Other taxable income**

If yes, who?	Type of income	Amount: $_____ How often: ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly

Will the members under 19 or tax dependents on this application meet the threshold requirement to file a federal tax return this year?		
Name	**Yes/No**	**Update**

Reported Deductions - Deductions allowed per the Internal Revenue Service each year for adjusted gross income include:			
- **School tuition and related fees** - **Health savings account contributions** - **Student loan interest**	- **Alimony/spousal support paid** - **Self-employment tax** - **Self-employment retirement**	- **Self-employment health insurance** - **Penalty on early withdrawal of savings** - **Moving costs for a job this year**	- **Domestic production activities** - **Educator expenses** - **Certain claimable business expenses**
This is the information we currently have on your application:			
Jane Doe reports School tuition and fees of $100.00 per month			
Report all your household deductions in the space below, even if it is same amount reported above. (If you need more room, attach additional pieces of paper).			
Does anyone have deductions? ☐ No ☐ Yes	If yes, who?	Type of deduction	Amount: $_____ How often: ☐ Monthly ☐ Quarterly ☐ Annualy

**Questions are not necessary to determine eligibility for Washington Apple Health*

READ CAREFULLY

☐ I authorize Washington Healthplanfinder to electronically verify my tax return information during the annual renewal process for up to 5 years. I understand that I am able to change my consent at any time. By checking this box, I permit tax credits to be applied to my annual renewal without my taking further action.

I have read and understand the information in this review. I declare, under penalty of perjury, the information I gave in this review is true, correct, and complete to the best of my knowledge.

Primary Applicant's Name: Jane Doe

Primary Applicant's Signature: _____ Date: _____