

Application for Family Planning Only services

<p>Are you eligible for the Family Planning Only (FPO) programs?</p>	<p>FPO programs are available to Washington residents with income at or below 260% of the federal poverty level (FPL), regardless of gender and immigration status, who are not eligible for full scope Apple Health programs and do not have other health coverage. Insured clients who are seeking confidential family planning services may apply for FPO programs.</p>
<p>What benefits are covered?</p>	<p>Benefits include, but are not limited to:</p> <ul style="list-style-type: none"> • Comprehensive family planning preventive visit • Counseling, education, initiation and management of birth control and contraceptive methods • Cervical cancer screening • Some sexually transmitted disease (STD) and sexually transmitted infection (STI) testing and treatment • Prescription and non-prescription contraceptives • Sterilization procedures
<p>How do you apply?</p>	<p>You can apply for FPO programs anytime, with a provider who accepts Apple Health.</p>
<p>How should you complete section 1?</p>	<p>This section should be completed in full, to the applicant’s best knowledge. More information on specific questions contained in section 1 of the application is provided later in this document.</p>
<p>Are there language or disability services available when applying?</p>	<p>To get free help in another language (including an interpreter or translation of printed materials) or a disability accommodation, call 1-800-562-3022.</p>
<p>Can you use an Authorized Representative (AREP) to apply?</p>	<p>An AREP is any adult who is sufficiently aware of the household circumstances and is authorized by the household to act on behalf of the household for eligibility purposes. This is different from partnering with a Navigator or Broker.</p>
<p>What are income requirements?</p>	<p>Income must be at or below 260% of the FPL. Visit hca.wa.gov/family-planning for more information.</p>
<p>How is household size determined?</p>	<p>Household size is determined based on tax filing status. A household member is a spouse or dependent for whom the applicant files taxes with or claims as a tax dependent. If you do not file taxes, a household member is a spouse or dependent living in the same home.</p>
<p>Are you considered a Washington State resident?</p>	<p>Washington state residents currently live and intend to reside in Washington, or entered the state looking for a job or entered the state with a job commitment.</p>
<p>What if you need confidential services?</p>	<p>Insured individuals may be eligible for confidential family planning services, if you meet one of these exceptions: seeking confidential family planning services and are 18 years old or younger; OR you are a victim of domestic violence and covered under your abuser’s health insurance.</p>
<p>What if you have other insurance?</p>	<p>You are not eligible for FPO services if you have other insurance, unless you are seeking confidential family planning services.</p>

<p>How will Health Care Authority (HCA) use your Social Security Number (SSN) or immigration status information?</p>	<p>HCA uses this information to determine your eligibility by confirming your identity, citizenship, immigration status, date of birth, and availability of other health care coverage. HCA does not share this information with any immigration agency.</p> <p>If you do not have a SSN or immigration document number, leave those fields blank.</p>
<p>What is full-scope Apple Health (Medicaid) and should you waive your right to apply for it?</p>	<p>If you are eligible for full-scope Apple Health, you are eligible for all mandatory benefits such as inpatient and outpatient hospital, home health, and physician services, among others and optional benefits such as prescription drugs, dental services, and physical therapy. It is in your best interest to apply for full-scope Apple Health (Medicaid) in order to receive the maximum health benefits coverage you may be eligible for. For more information on full-scope Apple Health, visit https://www.hca.wa.gov/health-care-services-supports/apple-health-medicaid-coverage.</p>
<p>Is voter registration information available?</p>	<p>The National Voter Registration Act of 1973 requires all states to provide voter registration through their public assistance offices.</p> <p>Applying or declining to register to vote will not affect the services or benefits provided by this agency. You can register to vote at vote.wa.gov or order a voter registration form by calling 1-800-448-4881.</p>
<p>How and when will you know the status of your application?</p>	<p>Applications are processed in the order received within 45 days. If additional information is required, applicants will be contacted by phone and/or mail. Once processed, an approval or denial letter will be sent by mail. Some providers may provide services while you wait for the submission and processing of your application.</p>
<p>Can you appeal an eligibility determination?</p>	<p>Yes, you can appeal within 90 days if you disagree with a determination made by HCA, Washington Healthplanfinder or the Department of Social and Health Services (DSHS) that affects your eligibility for health coverage. For more information about the appeals process, visit hca.wa.gov/about-hca/file-appeal-apple-health-medicaid.</p>
<p>What other family planning services are available in Washington State?</p>	<p>Washington State Department of Health’s Family Planning Network offers a full range of family planning services. Get more information, by visiting doh.wa.gov/YouandYourFamily/FamilyPlanning/FullRangeofServices.</p>
<p>What other health coverage options are available in Washington State?</p>	<p>View other Washington Apple Health programs available, including services for non-qualified and undocumented immigrants, and pregnancy-related care at hca.wa.gov/apple-health.</p>
<p>Where can you find additional information?</p>	<p>Additional information can be found at hca.wa.gov/family-planning.</p>

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Are you currently pregnant? Yes No If you answered Yes, you are not eligible for family planning services, but may be eligible for health coverage. Apply online at wahealthplanfinder.org

By filling out this application, you acknowledge you are applying for family planning services only.

1. Applicant and Contact Information

First Name (use your full legal name)		Middle Initial	Last Name		
Male	Female	Date of birth	Social Security Number	Resident of Washington? Yes No	
Address where you live		Apt. #	City	State	Zip Code
Mailing address		Apt. #	City	State	Zip Code
Home/cell/preferred number	Work/message number	Can we contact you at the phone numbers provided? Yes No			
E-mail address					
Do you have trouble speaking, reading, or writing English? Yes No					
Do you need an interpreter? Yes No What language do you speak? _____					

Do you have Private health insurance or Apple Health (Medicaid) coverage? Yes No

If you answered Yes, you are not eligible for family planning services unless you meet one of the exceptions below:

I am seeking confidential family planning services and I am 18 years old or younger;

OR

I am a victim of domestic violence and I am covered under my abuser's health insurance.

(proceed to section (2) if you have checked either of the boxes above)

Within the last 30 days, have you been denied Apple Health (Medicaid) full-scope coverage through

wahealthplanfinder.org? Yes No

If Yes, stop here and move to section (9). If your household has experienced any changes, since you were denied Apple Health (Medicaid), proceed to section (2) to complete your application.

If No, you must apply for coverage at **wahealthplanfinder.org** *(unless you meet one of the two exceptions above or are making an informed choice to not apply for full-scope Apple Health (Medicaid))*.

I choose to apply for family planning only coverage and am making an informed choice to not apply for full-scope Apple Health (Medicaid).

2. Citizenship and Immigration Status

Citizen or Non-citizen status: (check one):

U.S. citizen or U.S.National

Non-citizen lawfully present in the U.S.

Other

If you are a lawfully present non-citizen, enter the following information:

Immigration document type

"A" number

Receipt number or other number

Foreign passport number

Country of residence

Date of entry

Document expiry date

3. Income From Employment / Self-Employment

Earned by you

Earned by other household members

Name of current employer (1st Job)

Telephone Number

Name of current employer (1st Job)

Telephone Number

Gross monthly income before taxes

Self-Employed?
Yes No

Gross monthly income before taxes

Self-Employed?
Yes No

(and/or net monthly income for self-employment)

(and/or net monthly income for self-employment)

Name of current employer (2nd Job)

Telephone Number

Name of current employer (2nd Job)

Telephone Number

Gross monthly income before taxes

Self-Employed?
Yes No

Gross monthly income before taxes

Self-Employed?
Yes No

(and/or net monthly income for self-employment)

(and/or net monthly income for self-employment)

If a household member currently has more than two employers, attach on a separate sheet of paper.
For more information about how to report income, visit wahbexchange.org/how-to-report-income.

4. Other Household Income

Monthly amount: Who receives this:

Alimony/spousal support

Rental, and/or royalty income (net)

Social Security/Railroad Retirement benefits

Unemployment

Retirement income, including: pension, annuity, and/or IRA distribution

Dividend, stocks, shares, capital gains,
foreign, trust/ other investment income

Taxable tribal income

Farming and fishing income (net)

Other taxable income

5. Household Deductions

Monthly amount: Who pays this:

Alimony/spousal support <u>PAID</u>	_____	_____
Contribution/IRA or pre-tax retirement account contributions	_____	_____
Student loan interest payments	_____	_____
Moving costs for members of the armed forces	_____	_____
Educator expenses	_____	_____
Health savings account contributions	_____	_____
Penalty on early withdrawal of savings	_____	_____
Certain claimable business expenses	_____	_____

6. Tax Filing Status

What will your tax filing status be for this year? Single Filer Married Filing Separately Married Filing Jointly
Tax Dependent of Someone from Household Tax Dependent of Someone Outside Household Non-Tax Filer

Are you legally married? If yes, your spouse's full legal name _____
Yes No first, middle, last name

If you file a tax return, how many tax dependents do you claim? _____ If not, how many children do you have? _____

7. Recent Job Loss

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 Yes No
If yes, the business's name: _____ If yes, the business's name: _____
Employment end date: _____ Employment end date: _____

8. Race/Ethnic Background

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
Hispanic American Indian or Alaskan Native Other Asian or Pacific Islander
Other: _____ Tribe name: _____

9. 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 coverage assistance, 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 I need other medical coverage assistance, I can apply at Washington Healthplanfinder (**wahealthplanfinder.org**). If I need financial assistance or food stamps, I can apply at a DSHS Community Services Office or Washington Connection (**washingtonconnection.org**).
- **I must respond** to any requests for additional information within 15 business days or my application will be denied and I may be responsible for all charges incurred through my family planning provider's office.

10. Optional Authorized Representative (AREP)

Name / Organization

Telephone number

Mailing address

Apt. #

City

State

Zip Code

11. 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

Return the completed form to the Health Care Authority using one of the following:

- Mail: HCA MEDS, PO Box 45531, Olympia WA 98504-5531
- Fax: **1-866-841-2267**
- Phone: **1-800-562-3022**
- Email: **apple@hca.wa.gov**