Washington State Health Care Authority

Apple Health Request for Children in Tribal Foster Care

Complete this form to request Apple Health (Medicaid) coverage, report changes, or request disenrollment for children in Tribal Foster Care.

Type of request

☐ New coverage ☐ Change of placement ☐ Report a change (i.e., demographic updates)

Requirements

A child aged 18 or younger is eligible for Apple Health Foster Care Medical if the child meets the requirements in Section 4 below. This program requires:

- Initial confirmation from the Tribal placement agency that the child meets the program requirements; and
- Timely notification from the Tribal placement agency of changes in placement or if the child no longer meets program requirements.

Individuals who were in foster care placement and received Apple Health on their 18th birthday remain eligible for health care coverage until their 26th birthday through the Foster Care Alumni program. This eligibility remains regardless of changes in income, household composition, or marital status, if they remain a Washington resident. See requirements in Section 4 below.

Placement information

Date of placement/change: _____

☐ Under age 18 out of home placement
☐ Trial Return Home
☐ Out of state placement with relative
☐ Out of state placement in a facility
☐ Tribal adoption support
☐ Guardianship (Tribal supported)
☐ Guardianship (case closed)
☐ Exit care at age 18 (eligible for Foster Care Alumni coverage)
☐ Age 18 up to 21 (eligible for Extended Foster Care coverage)

1 Children's Information (Please print)

Name _____ Date of birth _____ Gender _____

Social Security number _____ Tribal Affiliation _____

2 Tribal Information (Please print)

Tribe _____ Send additional service card ___ Yes ___ No Phone _____

Tribe mailing address _____ City _____ State _____ Zip code _____

Case worker name _____ Email _____

3 Placement Status (Please print)

☐ **Placement:** If the youth is in the care and custody of the tribe, provide the contact information for the placement family below.

☐ **Placement closed:** If the placement has closed and the youth/alumni is no longer in the care and custody of the tribe, provide the current contact information for the youth/alumni below.

Adult name(s)

Relationship(s) to child | Email | Phone

Address | City | State | Zip code

4 Tribe Attestation for Coverage

(Please check the appropriate box, sign and complete)

The child named above is under the care and placement authority of the placement agency (e.g., Indian Child Welfare agency) of the Tribe named above, for whom one of the following applies:

☐ Receiving foster care/adoption support payments under Title IV-E of the Social Security Act (42 CFR 435.145);

☐ Receiving full or partial financial support through the Tribe's Placement Agency (42 CFR 435.222);

☐ A non-Title IV-E Adoption Assistance agreement or tribal guardianship is in place (42 CFR 435.227).

☐ The youth named above was enrolled in Apple Health and is under the care and placement authority of the Tribe upon attaining age 18.

Signature | Date

Name (Please print) | Email | Phone

5 Type of Coverage

As the placement agency with authority over this child's care, we are choosing enrollment in (please select one):

Learn more about each coverage option by clicking the link below:

☐ Apple Health coverage without a managed care plan (also referred to as fee-for-service).

☐ Apple Health Core Connections through Coordinated Care, Inc. (CC) . This form will be shared with CC to allow for health care coordination.

☐ Apple Health coverage without a managed care plan with Behavioral Health Services Only (BHSO)
Select which health plan:

- ☐ Commuity Health Plan of Washington
- ☐ Coordinated Care
- ☐ Molina Healthcare
- ☐ UnitedHealthcare
- ☐ Wellpoint

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Please submit the completed form to:

Mail: Health Care Authority - Foster Care Adoption Support
P.O. Box 45534
Olympia, WA 98504

Fax: (360) 725-1158

Email: **hcatribalfostercaremedical@hca.wa.gov**

Questions? Call 1 (800) 562-3022 Ext. 15480