

FOR OFFICE USE ONLY



Basic Health™ Application

NOTE:

Use blue or black ink to complete this application.

Your social security number (SSN) is voluntary, unless you answer "yes" to any of the questions under "Are you applying for" in Section 3. If you do not provide your SSN, we will assign an I.D. number to you. Since we depend on your SSN for verifying income with certain sources, you will also have to prove your eligibility for Basic Health more often.

Questions? www.basicehealth.hca.wa.gov or call 1-800-660-9840

Section 1: APPLICANT AND HOUSEHOLD INFORMATION

If you need help in a language other than English, what language and dialect do you speak? _____

Proof of your street address listed below is required (not a P.O. box).

Applicant's last name		First name			MI	
Street address (attach proof)	Apt. #	City	County	State	ZIP Code	
Mailing address or P.O. box (if different from above)		City			State	ZIP Code
Home phone number	Other phone number		Marital status (check one): <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Legally married - Date of marriage: _____			

Section 2: COVERAGE FOR APPLICANT AND SPOUSE

Complete this section for applicant and legal spouse, even if not requesting coverage.

	Social security number	Birth date	Gender	Requesting coverage?	U.S. citizen?	Receiving DSHS benefits?
For applicant listed above →			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse's last name, first name, M.I.			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Are you or a family member currently receiving social security disability benefits? Yes No

If "yes," list them here with dates benefits started. Attach copies of the original and current award letters for each.

Are you or a family member eligible for Medicare (the federal health program for people over age 65 or people who have been receiving social security disability benefits [SSDB] for more than two years)? Yes No

If "yes," list them here: _____ SSDB entitlement date: _____

Is anyone in your family, including yourself, attending school full-time in the United States on a student visa? Yes No

If "yes," list them here: _____

Section 3: HEALTH PLAN SELECTION AND ADDITIONAL PROGRAM CHOICES

<p>CHOOSE ONE HEALTH PLAN FOR YOUR FAMILY</p> <p>Not all health plans are available in every county. Read the <i>Health Plans and Premiums</i> brochure to see the plans available where you live.</p> <p>CHECK ONE</p> <p><input type="checkbox"/> Columbia United Providers, Inc.</p> <p><input type="checkbox"/> Community Health Plan of Washington</p> <p><input type="checkbox"/> Group Health Cooperative</p> <p><input type="checkbox"/> Kaiser Foundation Health Plan of the Northwest</p> <p><input type="checkbox"/> Molina Healthcare of Washington, Inc.</p>	<p>ARE YOU APPLYING FOR:</p> <ul style="list-style-type: none"> Basic Health Plus for a family member under 19 on this application? <input type="checkbox"/> Yes <input type="checkbox"/> No Basic Health Plus for a child with an urgent medical need? <input type="checkbox"/> Yes <input type="checkbox"/> No Coverage for someone who is currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <p>If "yes," has this woman received a positive result from a pregnancy test? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Pregnant woman's name (print): _____</p> <p>Signature: _____</p> <ul style="list-style-type: none"> Basic Health Plus or the Maternity Benefits Program, and want to be referred to DSHS for help with unpaid medical bills from the last three months? <input type="checkbox"/> Yes <input type="checkbox"/> No <p>If yes, attach proof of income for those three months.</p> <p>Social security numbers are required if you answered "yes" to any of these questions.</p> <p>TYPE OF COVERAGE (CHECK ONE):</p> <p><input type="checkbox"/> Individual/family coverage OR</p> <p><input type="checkbox"/> Coverage through an employer, home care agency, or financial sponsor (Complete the information below, and return the completed application to your organization's contact.)</p> <p>Employer/organization _____ Group I.D. number _____ Daytime phone number _____ () _____</p> <p>If employer coverage, are you a full-time (30 or more hours per week) or part-time employee? <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time</p>
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Please detach at perforation.

Section 4: LEGAL DEPENDENTS *(If more than four, list on a separate sheet or copy this page.)*

List all of your legal dependents, even if you do not want coverage for them and/or they are not living in your home. Do not list foster children. Dependents ages 19-22 must be enrolled full time in an accredited school (verification must be included) or have a documented disability to be listed on your application.

1	Last name, first name, middle initial		Relationship to applicant <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other: _____	Social security number	Birth date
	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Applying for Basic Health? <input type="checkbox"/> Yes <input type="checkbox"/> No	Applying for Basic Health <i>Plus</i> ? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is dependent, age 19-22, a full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, send proof of registration.	
	Is dependent a U.S. citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is dependent receiving DSHS medical assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is dependent living in the home full-time? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does dependent have a disability? <input type="checkbox"/> Yes <input type="checkbox"/> No	

2	Last name, first name, middle initial		Relationship to applicant <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other: _____	Social security number	Birth date
	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Applying for Basic Health? <input type="checkbox"/> Yes <input type="checkbox"/> No	Applying for Basic Health <i>Plus</i> ? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is dependent, age 19-22, a full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, send proof of registration.	
	Is dependent a U.S. citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is dependent receiving DSHS medical assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is dependent living in the home full-time? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does dependent have a disability? <input type="checkbox"/> Yes <input type="checkbox"/> No	

3	Last name, first name, middle initial		Relationship to applicant <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other: _____	Social security number	Birth date
	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Applying for Basic Health? <input type="checkbox"/> Yes <input type="checkbox"/> No	Applying for Basic Health <i>Plus</i> ? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is dependent, age 19-22, a full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, send proof of registration.	
	Is dependent a U.S. citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is dependent receiving DSHS medical assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is dependent living in the home full-time? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does dependent have a disability? <input type="checkbox"/> Yes <input type="checkbox"/> No	

4	Last name, first name, middle initial		Relationship to applicant <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other: _____	Social security number	Birth date
	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Applying for Basic Health? <input type="checkbox"/> Yes <input type="checkbox"/> No	Applying for Basic Health <i>Plus</i> ? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is dependent, age 19-22, a full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, send proof of registration.	
	Is dependent a U.S. citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is dependent receiving DSHS medical assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is dependent living in the home full-time? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does dependent have a disability? <input type="checkbox"/> Yes <input type="checkbox"/> No	

▲ Please detach at perforation. ▼

Are you applying for any dependents who don't live in your home full time? **If so, complete the following for those dependents.**

Dependent's name	Address	City	County	State	ZIP Code

Do you pay court-ordered child support? If so, how much per month do you pay? \$ _____ Yes No
(This may help you qualify for Basic Health *Plus* or the Maternity Benefits Program.)

Have you checked "no" to "U.S. citizen?" for any family member applying for Basic Health *Plus* or the Maternity Benefits Program? **If so, please send a copy (front and back) of that person's INS documentation, and indicate the date of arrival into the United States:** _____ Yes No

Are any of your dependents (age 19 or over) disabled or otherwise under your legal guardianship? Yes No
If so, attach a copy of legal guardianship papers. If your dependent child (through birth or adoption) has a disability, you only need to provide proof that (s)he cannot support himself or herself due to disability.

Are any dependents with a disability receiving social security disability? **If so, attach a copy of the eligibility award letter for each.** Yes No

Section 5: OTHER BIOLOGICAL PARENT (IF LIVING IN THE HOME)

Are you applying for Basic Health *Plus* coverage for a child whose other biological parent is not legally married to you, but is living in your home? (This information is used to determine Basic Health *Plus* eligibility only. If the other biological parent wants coverage, (s)he must submit a separate application.)

Yes No

If you checked "yes," you must fill in the following information about that parent.

Attach proof of this person's income. If self-employed, complete FORM B (page 7) for this person's income.

Name of other biological parent	Social security number (required)	Birth date	Gross monthly income	Daytime phone number
				()

List the names of this parent's children shown on your application:

Section 6: OTHER HEALTH INSURANCE INFORMATION

Complete this section **only** if you are applying for Basic Health *Plus* or the Maternity Benefits Program.

List yourself and any family members who have other health insurance or are covered under a health program (such as Tri-Care, Medicare, or Medicaid), even if they're not applying for Basic Health coverage.

Last Name (List yourself first.)	First Name	M.I.	Health insurance company or health program	Phone number of health insurance company or health program	Policy or group number	Policy end date
1.				()		
2.				()		

Section 7: FAMILY INCOME

Applicant's name: _____

LIST NAME(S) OF ALL CURRENT EMPLOYERS FOR:

Self: _____

Spouse: _____

If you have not received a full 30 current/consecutive days of income or benefits from any source of income you list on the *Family Income Reporting Form* (page 4), please explain why here. Also explain any periods for which you don't have documentation.

Your signature

Date

Spouse's signature

Date

Please detach at perforation.

Section 7: FAMILY INCOME (continued)

Family Income Reporting Form

Have you changed employers in the last 12 months? Yes No Has your income changed in the last 12 months? Yes No

Briefly explain change(s) _____

Basic Health may average or use your last 30 days' income to get the most accurate picture of your income.			
You must check "yes" or "no" for each family member on every income line item. Show gross amounts. If more dependents, list on a separate sheet or copy this form.	Self	Spouse	Child
Wages, salary, tips, assistantships, commissions Employer name (self) _____ Employer name (spouse) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No \$	<input type="checkbox"/> Yes <input type="checkbox"/> No \$	
Self-employment or rental income Provide Washington State Unified Business Identifier (UBI) # _____ Check box if no UBI # <input type="checkbox"/> (For details on what to send us, see the next page.)	<input type="checkbox"/> Yes <input type="checkbox"/> No \$	<input type="checkbox"/> Yes <input type="checkbox"/> No \$	<input type="checkbox"/> Yes <input type="checkbox"/> No \$
Unemployment compensation, strike benefits	<input type="checkbox"/> Yes <input type="checkbox"/> No \$	<input type="checkbox"/> Yes <input type="checkbox"/> No \$	
Social security benefits - circle types received Retirement Survivor Supplemental security (SSI) Disability If social security disability, date of entitlement _____	<input type="checkbox"/> Yes <input type="checkbox"/> No \$	<input type="checkbox"/> Yes <input type="checkbox"/> No \$	<input type="checkbox"/> Yes <input type="checkbox"/> No \$
Retirements, pensions, annuity benefits Is the amount received due to an early withdrawal? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No \$	<input type="checkbox"/> Yes <input type="checkbox"/> No \$	<input type="checkbox"/> Yes <input type="checkbox"/> No \$
Child support, alimony/spousal maintenance	<input type="checkbox"/> Yes <input type="checkbox"/> No \$	<input type="checkbox"/> Yes <input type="checkbox"/> No \$	<input type="checkbox"/> Yes <input type="checkbox"/> No \$
Insurance benefits, whether private or through employment, such as life, accident, long- or short-term disability	<input type="checkbox"/> Yes <input type="checkbox"/> No \$	<input type="checkbox"/> Yes <input type="checkbox"/> No \$	<input type="checkbox"/> Yes <input type="checkbox"/> No \$
Interest, dividends, trust, estate, inheritance, capital gains, gambling, lottery, royalties	<input type="checkbox"/> Yes <input type="checkbox"/> No \$	<input type="checkbox"/> Yes <input type="checkbox"/> No \$	<input type="checkbox"/> Yes <input type="checkbox"/> No \$
Veterans benefits, military allotments	<input type="checkbox"/> Yes <input type="checkbox"/> No \$	<input type="checkbox"/> Yes <input type="checkbox"/> No \$	<input type="checkbox"/> Yes <input type="checkbox"/> No \$
Workers' compensation, crime victims' compensation	<input type="checkbox"/> Yes <input type="checkbox"/> No \$	<input type="checkbox"/> Yes <input type="checkbox"/> No \$	<input type="checkbox"/> Yes <input type="checkbox"/> No \$
Public assistance cash grants DO NOT INCLUDE FOOD STAMPS	<input type="checkbox"/> Yes <input type="checkbox"/> No \$	<input type="checkbox"/> Yes <input type="checkbox"/> No \$	<input type="checkbox"/> Yes <input type="checkbox"/> No \$
Income from any other source Explain _____	<input type="checkbox"/> Yes <input type="checkbox"/> No \$	<input type="checkbox"/> Yes <input type="checkbox"/> No \$	<input type="checkbox"/> Yes <input type="checkbox"/> No \$
No income from any source If both you and your spouse report no income, how do you support yourselves? _____	<input type="checkbox"/> No income	<input type="checkbox"/> No income	

▲ Please detach at perforation. ▼

Must be signed by both you and your spouse, if married

Your printed name

Your signature

Date

Spouse's printed name

Spouse's signature

Date

Explanation of income types and what to send with your *Family Income Reporting Form*

Current documentation from the Internal Revenue Service (IRS) is required if not already on file with Basic Health:

- Your IRS Form 1040, federal income tax form, and all schedules
- Schedule K-1 for each family member for each S-Corporation, partnership, or trust beneficiary
- A complete IRS transcript, if you do not have a copy of your IRS Form 1040
- Verification of non-filing status from the IRS if you did not file a tax return

To request a transcript or letter of non-filing status, call the IRS at 1-800-829-1040.

Income documentation must include the name of the person paid, the **gross** amount(s) paid, and the dates paid. Send a full 30 days' documentation for each income source. **Always send current documents.** On a separate sheet, explain any gaps in income. If you need another copy of this form, or would like more information about Basic Health, visit our Web site (www.basichealth.hca.wa.gov).

Do not mail originals to Basic Health; they will not be returned to you.

Explanation of income type	Examples of copies you might send
Wages, salary, tips, assistantships, commissions	<ul style="list-style-type: none"> • Pay stubs • Signed and dated statement from employer(s)
Self-employment or rental income	<ul style="list-style-type: none"> • IRS 1040 and all applicable schedules • K-1(s), if applicable • Basic Health <i>Self-Employment/Rental Income Reporting Form</i> • Statement of income and expenses (any business not shown on 1040) • Washington State Unified Business Identifier (UBI) number
Unemployment compensation, strike benefits	<ul style="list-style-type: none"> • Unemployment stubs • Strike benefit statement • Computer print-out from agency/payer
Social security benefits	<ul style="list-style-type: none"> • Initial notice of award letter • Statement showing monthly benefit amount • Computer print-out from agency/payer
Retirements, pensions, annuity benefits	<ul style="list-style-type: none"> • Award letter or benefit statement • Cost of living allotment statement • Signed and dated statement from payer(s) • Computer print-out from agency/payer
Child support, alimony/spousal maintenance	<ul style="list-style-type: none"> • Award letter • Court documents or Division of Child Support (DCS) statement • Signed and dated statement from payer(s) • Computer print-out from agency/payer • Copy of check
Insurance benefits	<ul style="list-style-type: none"> • Award letter • Court documents • Statement from institution
Interest, dividends, trust, estate, inheritance, capital gains, gambling, lottery, royalties	<ul style="list-style-type: none"> • IRS 1040 and all applicable schedules • Statement from trustee, investment firm, bank, or financial institution • Court documents • Copy of contract • Copy of check
Veterans benefits, military allotments	<ul style="list-style-type: none"> • Award letter or benefit statement • Leave and Earnings Statement (LES)
Workers' compensation, crime victims' compensation	<ul style="list-style-type: none"> • Award letter or benefit statement • Labor & Industries (L&I) payment order
Public assistance cash grants	<ul style="list-style-type: none"> • Award letter or benefit statement • Computer print-out from Department of Social and Health Services (DSHS)
Income from any other source	<ul style="list-style-type: none"> • Signed and dated statement from payer • Signed and dated statement from applicant/member
Personal care workers, independent providers	<ul style="list-style-type: none"> • Social Service Payment System (SSPS) invoice, and • Remittance Advice, pages 1 and 2

Can dependent care expenses be deducted?

Yes; you may deduct work- or school-related dependent care expenses (work- or school-related means the dependent spends time in dependent care so that adults in the home can go to work or school). You must provide copies of receipts that include the amount you paid, the dates of care, and the dependent care provider's name, address, and phone number.

Please detach at perforation.

Section 7: FAMILY INCOME (continued)

**FORM A: Self-Employment or
Rental Income Reporting Form**

Basic Health I.D. # (usually your social security number): _____

If you filed an income tax return for your business, provide a copy of all forms, schedules, and K-1s, if applicable. If you have more than one business, copy this form, or print from our Web site (www.basichealth.hca.wa.gov). Complete a separate form for each business.

If you have owned the business(es) or rental property less than 12 months, fill in the income and expenses for the number of months you have been in business or owned the property.

Do not mail originals to Basic Health; they will not be returned to you.

Name of business				
Name(s) of business owner(s)				
Washington State Unified Business Identifier (UBI) #				Check box if no UBI # <input type="checkbox"/>
Date business began	Months you are reporting			Total number of months in business
/ /	From / /	through / /		
Type of business	<input type="checkbox"/> Rental(s)	<input type="checkbox"/> C-Corporation	<input type="checkbox"/> LLC	Percent of business owned by you and your spouse, if married %
	<input type="checkbox"/> Sole proprietor	<input type="checkbox"/> S-Corporation	<input type="checkbox"/> Partnership	

Income	Total for this period
Gross receipts, sales, or rental income	

Expenses: Business-related only	Total for this period
Merchandise and materials	
Gross wages paid to employees (less employment credits)	
Employer's payroll-related taxes	
Advertising/other promotional	
Car and truck	
Commissions/management fees	
Insurance (not Basic Health)	
Interest—Mortgage	
Interest—Other	
Legal and professional fees	
Rent or lease of vehicles, machinery, equipment	
Rent or lease of other business property	
Repairs and maintenance	
Supplies	
Taxes and licenses	
Travel, meals, and entertainment	
Utilities	
Total business expenses (Basic Health does not allow depreciation, amortization, or business use of the home.)	
Total net profit (or loss)	

▲ Please detach at perforation. ▼

Section 7: FAMILY INCOME (continued)

FORM B: DSHS Programs' Self-Employment or Rental Income Worksheet

Use this form only if you're applying for Basic Health Plus and/or the Maternity Benefits Program. Complete this form in addition to other applicable forms.

- For this form, report the dollar amounts of your most current complete calendar month. Do not total and do not transfer this page to the Family Income Reporting Form. This form is to help DSHS determine your eligibility for Basic Health Plus and/or the Maternity Benefits Program.
- You must provide proof of all your gross receipts and expenses for the last complete calendar month.
- If you are requesting DSHS help with unpaid medical bills from the last three months, you must copy and complete this form for each of those months.

Applicant's name: _____		Month of: _____
1. Name of business:	Type of business:	
2. Business street address:		
<input type="checkbox"/> PARTNERSHIP <input type="checkbox"/> INCORPORATED <input type="checkbox"/> SOLE PROPRIETORSHIP		
For partnerships and corporations, list members' names and relationships: _____		
If incorporated, monthly amount paid to you by corporation: \$ _____		
Check and complete if no longer self-employed.		
<input type="checkbox"/> I am no longer self-employed		Date of last pay: _____
Last day worked: _____		Amount of last pay: \$ _____

YOU MUST PROVIDE PROOF FOR ALL INCOME AND EXPENSES LISTED BELOW.

Gross business income (month of report only)	\$
Employees (not including yourself, your spouse, or your children): _____	
Wages and commissions paid in month of report	\$
Employer share of social security taxes paid in month of report	\$
Business expenses (month of report only)	
Printing	\$
Postage/shipping	\$
Supplies/materials	\$
Advertising/accounting	\$
Insurance (business-related only)	\$
Business licenses, trade dues, etc.	\$
Business loan (interest paid only)	\$
Business tax (sales, UI, L&I, B&O, etc.)	\$
Other (list and describe):	
	\$
	\$
	\$
	\$

Business location	
Is business in your home?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes , is the room/area used for business purposes only ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes: Total square footage in your home:	
Square footage used for business:	
Rent (for business address or home business only)	\$
Mortgage	\$
Utilities (including telephone, electricity, water, etc.)	\$
Business transportation costs	
Is your vehicle used for business only?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Total miles driven for month of report:	
Total miles driven on the job for month of report:	
Vehicle repairs for vehicle used for business (paid in month of report only)	\$
Registration and license fees for vehicle used for business (paid in month of report only)	\$
Interest only from payments on vehicles used for business (paid in month of report only)	\$
Check and complete one :	
<input type="checkbox"/> I want to deduct \$.485 per mile for gas, oil, and fluids	
<input type="checkbox"/> I want to deduct actual expenses for gas, oil, and fluids	\$

DSHS WILL TOTAL ALLOWABLE EXPENSES.

Please detach at perforation.

Section 8: VOLUNTARY INFORMATION

Completing this section is voluntary and will not affect your ability to enroll, but may help us to better assist you.

ETHNIC BACKGROUND

- | | |
|---|---|
| <input type="checkbox"/> Black/African-American | <input type="checkbox"/> Aleutian Islander/Aleut |
| <input type="checkbox"/> White/Caucasian | <input type="checkbox"/> Asian or Pacific Islander (API) |
| <input type="checkbox"/> Indian (Native American) | <input type="checkbox"/> Hispanic/Latin American |
| <input type="checkbox"/> Eskimo | <input type="checkbox"/> Other or mixed ethnic background |

WHERE DID YOU GET YOUR APPLICATION?

- | | |
|---|---|
| <input type="checkbox"/> Family/friend | <input type="checkbox"/> Local, nonprofit organization |
| <input type="checkbox"/> Web site | <input type="checkbox"/> Medical office/hospital/clinic |
| <input type="checkbox"/> Government office, such as DSHS or health department | |
| <input type="checkbox"/> Called Basic Health and received it by mail | |
| <input type="checkbox"/> Other | |

Section 9: AGREEMENT AND SIGNATURE

I understand that:

- I must provide proof of my gross family income (before taxes and deductions) and report income changes that would change my premium or eligibility to Basic Health/Department of Social and Health Services (DSHS) within 30 days after the end of the month my income changed.
- By signing this form, I have authorized Basic Health and DSHS to verify my eligibility information and family income with other state or federal agencies or other third-party sources.
- I must report address changes and changes in my family. I must report, for example, my marriage or divorce, or the marriage or divorce of any family member on my account, the birth or adoption of a child, or the date when a child leaves home or is no longer a dependent or is no longer a full-time student.
- My application and the documents I send to Basic Health will be used to determine eligibility for DSHS programs (Basic Health *Plus* or the Maternity Benefits Program).
- By asking for and receiving DSHS benefits, my family and I assign to the state of Washington our rights to any third-party payment for medical care of covered medical services while receiving medical benefits.
- Basic Health's deposit of my premium payment does not guarantee coverage. The payment will be refunded if I am determined ineligible for coverage.

I authorize my health plan or medical provider to give medical records for me or my children to Basic Health, for purposes of participation in Basic Health/DSHS programs.

I have read and I understand the information provided to me with the Basic Health application. I declare, under penalty of perjury, that the information I have given in this application and the documents I send to Basic Health are true, correct, and complete to the best of my knowledge. I understand that if I or any member of my family, or any person on my behalf, submits false information, my family or I may lose coverage, may be held financially responsible for services obtained under Basic Health or additional premium amounts due, and may face other penalties and prosecution. Any debt owed to the state may be sent to a collection agency for recovery.

AGREEMENT MUST BE SIGNED BY YOU AND YOUR SPOUSE

X _____	Date	X _____	Date
Signature of applicant		Signature of spouse	

Signature of all dependents age 18 and over			
X _____	Date	X _____	Date
Signature		Signature	
X _____	Date	X _____	Date
Signature		Signature	

Use this checklist below to make sure you include:

- Documentation of full 30 days' income from all types of income.
- Current tax year 1040 form, including all schedules and K-1 form, if you received one, or proof of nonfiling if not required to file. If you did not file a Form 1040, call the Internal Revenue Service and ask for a letter of nonfiling status.
- Documents showing your name and current street address.
- Court order showing required child support you are paying, if applying for Basic Health *Plus* or the Maternity Benefits Program.
- Application signed by all family members over age 18 asking for coverage.
- Your health plan choice on the first page of this application.
- The Permission Form (included in this packet), if you'd like someone else to be able to access your account information.

**Please enclose all required forms and documentation,
and return in the envelope provided.**
Mail to: Basic Health, P.O. Box 94213, Seattle WA 98124-6513



Questions? Call 1-800-660-9840
On the Internet, go to: www.basichealth.hca.wa.gov



Privacy statement: Washington State law may require disclosure of any information you submit as a public record. The Health Care Authority's (the agency that administers Basic Health) Privacy Notice is available upon request by calling 360-923-2822 or online at www.hca.wa.gov.

Please detach at perforation.