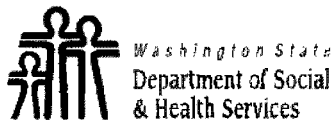


For help in your community call:



### Application For Children's Medical Benefits

This application is for medical coverage only for children and teens under 19. Anyone can apply on behalf of a child. Children may apply on their own behalf. **We will send the person listed in box 1 all follow-up information.** If you have questions or would like help filling out this form, just call 1-877-543-7669. We'll be happy to help you!

Please print in black or blue ink. Do not use pencil. **(List parent, guardian or contact person who will receive follow-up information)**

FIRST NAME		MIDDLE INITIAL		LAST NAME		
ADDRESS WHERE YOU LIVE		STREET		CITY STATE ZIP CODE		
MAILING ADDRESS (IF DIFFERENT)		STREET		CITY STATE ZIP CODE		
TELEPHONE NUMBERS	Do you have trouble speaking, reading or writing English?				Yes <input type="checkbox"/> No <input type="checkbox"/>	
HOME ( )	What language or alternative format do you need?				_____	
WORK ( )	Do you need an interpreter? (If yes, we will help you through an interpreter.)				Yes <input type="checkbox"/> No <input type="checkbox"/>	
MESSAGE ( )	What language do you speak?				_____	
		Does a child under 19 have a medical condition that needs attention right away?				Yes <input type="checkbox"/> No <input type="checkbox"/>
		Is anyone in your home pregnant?				Yes <input type="checkbox"/> No <input type="checkbox"/>
		If "yes," who?				_____

### General Information

List family members **living together.**  
(If needed, attach a separate sheet of paper to list more family members.)

NAME (FIRST, MIDDLE, LAST)	SEX M or F	RELATION TO YOU	BIRTH DATE (MO/DA/YR)	SOCIAL SECURITY NUMBER * = OPTIONAL	U.S. CITIZEN YES NO	PLACE OF BIRTH (CITY/STATE)	COMPLETE IF CHILD IS <b>NOT</b> A U.S. CITIZEN	
							LIST DATE CHILD ARRIVED IN U.S.	DOES CHILD HAVE A SPONSOR?  YES NO
A. PARENT, GUARDIAN OR SELF				*	<input type="checkbox"/> <input type="checkbox"/>			
B. SPOUSE OR OTHER PARENT (if living in the home)				*	<input type="checkbox"/> <input type="checkbox"/>			
C. LIST CHILDREN & TEENS UNDER 19 YEARS OF AGE (who want medical benefits)					<input type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/> <input type="checkbox"/>
D.					<input type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/> <input type="checkbox"/>
E.					<input type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/> <input type="checkbox"/>
F.					<input type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/> <input type="checkbox"/>
G. LIST OTHER ADULTS/CHILDREN IN THE HOME (who do not want medical benefits)				*			Note: Please attach any documents showing children's status.	
				*				

Is a child under age 19 in your household disabled? Yes  No   
If "Yes," who? \_\_\_\_\_

### Expenses

This information can help your children qualify.

Do you pay for childcare while you work?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If "Yes," how much per month? \$ _____
Do you pay someone to take care of a disabled dependent adult while you work?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If "Yes," how much per month? \$ _____
Do you pay court ordered child support for a child who is not living in your home?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If "Yes," how much per month? \$ _____

## Income

Enter GROSS pay (before taxes or expenses).

(Please attach proof of income for last 30 days)

PARENT'S EMPLOYER NAME AND PHONE _____ ( ) _____		OTHER HOUSEHOLD INCOME 15 CHILD SUPPORT \$	AMOUNT RECEIVED IN LAST 30 DAYS	WHICH FAMILY MEMBER EARNS THIS INCOME?
Amount you received in the last 30 days before taxes or expenses were taken out: \$ _____ How much of this income is from self employment? * \$ _____		16 ALIMONY \$		
SPOUSE'S (OR OTHER PARENT LIVING IN THE HOME) EMPLOYER NAME AND PHONE NUMBER: _____ ( ) _____		17 SOCIAL SECURITY PAYMENT \$		
Amount your spouse (or other parent living in the home) received in the last 30 days before taxes or expenses were taken out: \$ _____ How much of this income is from self employment? * \$ _____		18 UNEMPLOYMENT BENEFITS \$		
		19 INVESTMENT INCOME/INTEREST/DIVIDENDS \$		
		20 VETERANS BENEFITS \$		
		LABOR & INDUSTRIES \$		
		MILITARY ALLOTMENTS \$		
		OTHER (Please explain) \$		
*IF YOU OR YOUR SPOUSE (OR OTHER PARENT LIVING IN THE HOME) ARE SELF-EMPLOYED, YOU MAY GET OTHER DEDUCTIONS. PLEASE CALL 1-877-KIDS-NOW FOR MORE INFORMATION OR APPLICATION ASSISTANCE.		Do you need help paying for unpaid medical bills – within the last 3 months – for any of the children you are applying for? Yes <input type="checkbox"/> No <input type="checkbox"/>  If "Yes," please send copies of all household income for the months you would like us to review.		

## Health Insurance Information

Tell us about any health insurance your **children** already have.

21 Do any of the <b>children</b> you are applying for already have health insurance? Yes <input type="checkbox"/> No <input type="checkbox"/>	25 If "Yes," does that health insurance cover doctor, hospital, x-ray (radiology) and laboratory services? Yes <input type="checkbox"/> No <input type="checkbox"/>	23 Have your <b>children</b> been covered by job-related health insurance in the last 4 months? Yes <input type="checkbox"/> No <input type="checkbox"/>	24 If "Yes," did the premium cost less than \$50 per month for dependents? Yes <input type="checkbox"/> No <input type="checkbox"/>
22 If you checked "Yes" to any of the above questions (25 a or b or 26 a or b), please list the name of the insurance company or employer providing health insurance for your children.			
INSURANCE COMPANY OR EMPLOYER	POLICY NUMBER	POLICY HOLDER'S NAME	POLICY HOLDER'S SOCIAL SECURITY NUMBER (OPTIONAL)

## Children's Race/Ethnic Background (Voluntary Information)

We ask you to voluntarily tell us your children's race or ethnic background. This information will not be used in considering your eligibility for benefits.	<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black or African American	<input type="checkbox"/> Hispanic or Latino
	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	<input type="checkbox"/> White	<input type="checkbox"/> Other _____	
Discrimination is prohibited in all programs and activities administered by the Department of Social and Health Services. No one shall be excluded from these programs and activities on the basis of race, color, creed, political beliefs, national origin, religion, age, sex or disability.				

## Read Carefully Before Signing

This application is for medical benefits for children only. If anyone in your family already receives, or would like to apply for cash benefits, basic food or other benefits, please contact your local DSHS Community Services Office (CSO).

- DSHS may ask you to prove the information you are giving them to tell if you are eligible. You can ask DSHS for help in getting proof.
- Your information may be reviewed by other state or federal agencies. This information will NOT be shared with Immigration and Naturalization Service (INS).
- By asking for and getting health care benefits, you give the state of Washington all rights to any medical support and to any third party payments for health care.
- DSHS may share your child's immunization history with the Child Profile Immunization Tracking System.

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  X _____  Date _____
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## How to Submit

MAIL TO: <b>Dept. of Social and Health Services</b> <b>P.O. Box 45449</b> <b>Olympia, WA 98504-5449</b>	FOR HELP: If you need help or have questions, please call <b>1-877-KIDS-NOW.</b> (1-877-543-7669)
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