Washington State Health Care Authority

Application for Family Planning Only services for non-citizens

Are you eligible for the FPO services for non-citizens program (state-funded)	The FPO services for non-citizens program (state-funded) is for individuals who do not meet citizenship or immigration status requirements, or for qualified individuals who have not met the 5-year immigration bar. 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. FPO programs are also available to insured individuals who are seeking confidential family planning services. You can apply for FPO programs at any time.
Are you considered a Washington state resident?	You are a Washington state resident if you currently live and intend to reside in Washington, entered the state looking for a job or entered the state with a job commitment
What benefits are covered?	Benefits include, but are not limited to: • Comprehensive family planning preventive visit • Counseling, education, initiation and management of birth control (also called contraception) • Cervical cancer screening • Some sexually transmitted disease (STD) and sexually transmitted infection (STI) testing and treatment • Prescription and non-prescription contraceptives (birth control) • Sterilization procedures
How do you apply?	You can apply for FPO programs anytime, with a provider who accepts Apple Health or on your own by calling 1-800-562-3022 or submitting this application via: • **Mail**: HCA MEDS, PO Box 45531, Olympia WA 98504-5531 • **Fax**: 1-866-841-2267 • **Email**: **apple@hca.wa.gov**
What other health coverage options are available in Washington?	View the Apple Health programs available including for non-qualified and undocumented immigrants: • **hca.wa.gov/apple-health-non-citizens** • **hca.wa.gov/apple-health-pregnant-individuals**
How should you complete section 1?	Complete all that you can. See below for more information on specific questions contained in section 1 of the application.

How will Health Care Authority (HCA) use your Social Security number (SSN)?	HCA uses this information to determine your eligibility by confirming your identity, citizenship, immigration status, date of birth, and availability for other health care coverage. HCA does not share this information with any immigration agency for immigration enforcement purposes. Applying for the FPO services for non-citizens program (state-funded) won't affect your immigration status or chances of becoming a permanent resident or citizen. If you do not have an SSN, leave these items blank.
How will HCA use your immigration status information?	HCA uses this information to determine your eligibility by confirming your identity, citizenship, immigration status, date of birth, and availability for other health coverage. HCA does not share your information with any immigration agency for immigration enforcement purposes. Eligibility for the FPO services for non-citizens program (state-funded) is exempt from the public charge test. If you have questions or concerns about how an application for Apple Health or the FPO services for non-citizens program (state-funded) may impact your immigration status or chances of becoming a permanent resident or citizen, contact an immigration attorney.
Are there language or disability services available when applying?	To get free help in another language (including an interpreter or translation of printed materials) or a disability accommodation, call 1-800-562-3022. Learn more: **hca.wa.gov/interpreter-services**.
Can you use an Authorized Representative (AREP) to apply?	Yes. 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.
What are the FPO program income requirements?	Income must be at or below 260% of the FPL. Visit **hca.wa.gov/family-planning** for more information.
How is household size determined?	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.

What if you have other insurance and need confidential services?	You may be eligible for confidential family planning services even if you have insurance, if you meet one of these exceptions: • You are 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. Call the HCA at 1-800-562-3022 to enroll in confidential services
What if you have other insurance?	You are not eligible for FPO services if you have other insurance that covers family planning services unless you are seeking confidential family planning services.
What is full-scope Apple Health (Medicaid) and should you waive your right to apply for it?	If you are eligible for full-scope Apple Health, you can access benefits such as inpatient and outpatient hospital, home health, physician services, prescription drugs, dental services, and physical therapy. We encourage you to apply for full-scope Apple Health coverage in order to receive the maximum health benefits you may be eligible for. For more information on full-scope Apple Health, visit **hca.wa.gov/apple-health**. You can waive your right to apply for full-scope Apple Health if you are not eligible and still receive FPO services.
How and when will you know the status of your application?	Applications are processed in the order received within 45 days. If additional information is required, you 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.
Can you appeal an eligibility determination?	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**.
Where can you find additional information?	Additional information can be found at **hca.wa.gov/family-planning**.

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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 (if you have one) _____ 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? _____

I am seeking confidential services and I am:

☐ 18 years or younger; or

☐ Victim of domestic violence and I am covered under my abuser's health insurance

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

If **No**, you can make an informed choice to not apply for full-scope Apple Health coverage and still be eligible for the FPO programs **by checking the box below**.

For more information on how you may be eligible for other health care coverage, you can apply at **wahealthplanfinder.org**

☐ **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. Income From Employment / Self-Employment

Earned by you

Name of current employer (1st Job) _____ **Telephone Number** _____

Gross monthly income before taxes _____ Self-Employed? ☐ **Yes** ☐ **No**
(and/or net monthly income for self-employment)

Name of current employer (2nd Job) _____ **Telephone Number** _____

Gross monthly income before taxes _____ Self-Employed? ☐ **Yes** ☐ **No**
(and/or net monthly income for self-employment)

Earned by other household members

Name of current employer (1st Job) _____ **Telephone Number** _____

Gross monthly income before taxes _____ Self-Employed? ☐ **Yes** ☐ **No**
(and/or net monthly income for self-employment)

Name of current employer (2nd Job) _____ **Telephone Number** _____

Gross monthly income before taxes _____ Self-Employed? ☐ **Yes** ☐ **No**
(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**.

3. 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		

4. Household Deductions

	Monthly amount:	**Who pays this:**
☐ Alimony/spousal support PAID		
☐ 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		

5. 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? ☐ Yes ☐ No

If yes, your spouse's full legal name _____
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? _____

6. Recent Job Loss

Have you quit or lost a job in the last 90 days? ☐ **Yes** ☐ **No**

If yes, the business's name: _____

Employment end date: _____

Has your spouse quit or lost a job in the last 90 days? ☐ **Yes** ☐ **No**

If yes, the business's name: _____

Employment end date: _____

7. 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: _____

8. 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.
- 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.

9. Optional Authorized Representative (AREP)

Name / Organization _____ Telephone number _____

Mailing address _____ Apt. # _____ City _____ State _____ Zip Code _____

10. 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**