Washington State Health Care Authority

Application for Family Planning Only services

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.
For more information, see the **Frequently Asked Questions section starting on page 6** of this form.

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 _____

Apartment unit _____ City _____ State _____ Zip Code _____

Main phone number _____ Additional phone number _____

Can we contact you at the phone numbers provided? ☐ Yes ☐ No

Email address _____

Do you have trouble speaking, reading, or writing English? ☐ Yes ☐ No

Do you need an interpreter? ☐ Yes ☐ No

What language do you speak? _____

2 Confidential Services

1. **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 26 years old or younger

☐ I am a victim of domestic violence and I am covered under my abuser's health insurance. (Proceed to section 3 if you have checked either of the boxes above)

2. **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 10.

If your household has experienced any changes since you were denied Apple Health (Medicaid), proceed to section 3 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).

3 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

4 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.**

5 Other Household Income

☐ **Alimony/spousal support paid**

Monthly amount: _____ Who receives this: _____

☐ **Rental, and/or royalty income (net)**

Monthly amount: _____ Who receives this: _____

☐ **Social Security/Railroad Retirement benefits**

Monthly amount: _____ Who receives this: _____

☐ **Unemployment**

Monthly amount: _____ Who receives this: _____

☐ **Retirement income, including pension, annuity, and/or IRA distribution**

Monthly amount: _____ Who receives this: _____

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

Monthly amount: _____ Who receives this: _____

☐ **Taxable tribal income**

Monthly amount: _____ Who receives this: _____

☐ **Farming and fishing income (net) Other taxable income**

Monthly amount: _____ Who receives this: _____

☐ **Other taxable income**

Monthly amount: _____ Who receives this: _____

6 Household Deductions

☐ **Alimony/spousal support paid**

Monthly amount: _____ Who pays this: _____

☐ **Contribution/IRA or pre-tax retirement account contributions**

Monthly amount: _____ Who pays this: _____

☐ **Student loan interest payments**

Monthly amount: _____ Who pays this: _____

☐ **Moving costs for members of the armed forces**

Monthly amount: _____ Who pays this: _____

☐ **Educator expenses**

Monthly amount: _____ Who pays this: _____

☐ **Health savings account contributions**

Monthly amount: _____ Who pays this: _____

☐ **Penalty on early withdrawal of savings**

Monthly amount: _____ Who pays this: _____

☐ **Certain claimable business expenses**

Monthly amount: _____ Who pays this: _____

7 Tax Filing Status

3. What will your tax filing status be for this year?

☐ Single filer ☐ Married filing separately ☐ Tax dependent of someone from household

☐ Married filing jointly ☐ Non-tax filer ☐ Tax dependent of someone outside household

4. Are you legally married? ☐ **Yes** ☐ **No**

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

First, Middle, Last Name

5. If you file a tax return, how many tax dependents do you claim? _____

6. If not, how many children do you have? _____

8 Recent Job Loss

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

If yes, the business's name: _____ _____
Employment end date

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

If yes, the business's name: _____ _____
Employment end date

9 Race/Ethnic Background

We use this information to help improve health equity and increase access to health care for all individuals. The information you provide will not prevent your ability to enroll in a health plan.

☐ American Indian or Alaskan Native
☐ Black or African American
☐ Hispanic
☐ Other: _____ Tribe name: _____
☐ Other Asian or Pacific Islander
☐ Caucasian
☐ Vietnamese/Laotian/Cambodian

10 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.

11 Optional Authorized Representative (AREP)

If you choose an AREP, they will receive your mail regarding this application and your FPO coverage.

Name/Organization _____ Telephone number _____

Mailing address _____

Aptartment unit _____ City _____ State _____ Zip Code _____

12 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

13 Return Instructions

Submit completed form to the Health Care Authority using one of the following:
Mail: HCA MEDS, PO Box 45531, Olympia WA 98504-5531
Phone: 1-800-562-3022 ext. 12533
(Translation services available)
Fax: 1-866-841-2267
Email: apple@hca.wa.gov

14 Frequently Asked Questions (FAQ)

1. Are you eligible for the Family Planning Only (FPO) program?
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 the FPO program.

2. What benefits are covered?
Benefits include, but are not limited to:

- Comprehensive family planning preventive visit
- Counseling, education, initiation and management of 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

3. How do you apply?
You can apply for FPO programs anytime, with a provider who accepts Apple Health (Medicaid).

4. How should you complete section 1?
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.

5. 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 disability accommodation, call 1-800-562-3022.

6. Can you use an Authorized Representative (AREP) to apply?
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.

7. What are income requirements?
Income must be at or below 260% of the FPL. Visit **hca.wa.gov/family-planning for more information** for more information.

8. 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.

9. Are you considered a Washington State resident?
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.

10. What if you need confidential services?
Insured individuals may be eligible for confidential family planning services, if you meet one of these exceptions: seeking confidential family planning services and are 26 years old or younger; OR you are a victim of domestic violence and covered under your abuser's health insurance.

11. What if you have other insurance?
You are not eligible for FPO services if you have other insurance, unless you are seeking confidential family planning services.

12. How will Health Care Authority (HCA) use your Social Security Number (SSN) or immigration status information?
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.

If you do not have a SSN or immigration document number, leave those fields blank.

13. What is full-scope Apple Health (Medicaid)?
You may be eligible for full-scope Apple Health, which includes 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. To see if you are eligible for full-scope Apple Health, visit **hca.wa.gov/apply-or-renew-coverage**.

14. Is voter registration information available?
The National Voter Registration Act of 1973 requires all states to provide voter registration through their public assistance offices.

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**.

15. 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, 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.

16. 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**.

17. What other family planning services are available in Washington State?
Washington State Department of Health's Sexual & Reproductive Health Program offers a full range of family planning services. Get more information, by visiting **doh.wa.gov/you-and-your-family/sexual-and-reproductive-health**.

18. What other health coverage options are available in Washington State?
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**.

19. Where can you find additional information?
Additional information can be found at **hca.wa.gov/family-planning**.