



## Application For Washington State Take Charge Family Planning Services

**Note: This application can ONLY be completed at a TAKE CHARGE Provider's office. All information provided will be verified. Please Print**

LAST NAME	FIRST NAME	MIDDLE INITIAL
DATE OF BIRTH (MM/DD/YYYY)	<input type="checkbox"/> Male <input type="checkbox"/> Female	SOCIAL SECURITY NUMBER
I have no access to my Social Security Number. I have been given SSN "Referral" Form Number 13-823 to take to the Social Security Office and obtain my Social Security Number. I understand that I must do this within 60 days of applying for TAKE CHARGE.		
STAFF INITIALS _____	CLIENT INITIALS _____	
STREET ADDRESS WHERE YOU LIVE	CITY	STATE ZIP CODE
CONFIDENTIAL OR MAILING ADDRESS (IF DIFFERENT FROM ABOVE)	CITY	STATE ZIP CODE
If the clinic needs to contact you about your application, where or how may they contact you?		
<b>MEDICAL NEED FOR FAMILY PLANNING</b>		
1. <b><u>Male or Female Applicant</u></b> Do you intend to use a birth control method to prevent an unintended pregnancy? <b>If "no", you are not eligible for TAKE CHARGE. (Stop here – discuss payment for services with your provider).</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2. <b><u>Female Applicant</u></b> Do you have <b>any</b> reason to believe you could be pregnant now? <b>If "yes" or "don't know", stop here and ask for a pregnancy test. If pregnancy test is negative, continue. If you are pregnant you are not eligible for Take Charge. You may be eligible for other medical coverage. Contact your local Community Services Office (CSO).</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/> Don't Know <input type="checkbox"/>
<b>HEALTH INSURANCE</b>		
1. Do you have a DSHS Medical ID card? If "yes", you are not eligible for TAKE CHARGE. Your Provider will bill the state using your coupon.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2. Do you have health insurance that covers family planning services? If "yes", you are not eligible for TAKE CHARGE. Exception:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
a. I am 18 years old or younger and covered under my parents'/guardians' health insurance but do not want to use my parent's/guardian's insurance in order to keep my use of family planning services confidential. I have entered a confidential address in the above section so please send mail to that address.	<input type="checkbox"/>	<input type="checkbox"/>
b. I am a domestic violence victim who is covered under my perpetrator's health insurance and do not want him/her to know that I am receiving family planning services. I have entered a confidential address in the above section so please send mail to that address.	<input type="checkbox"/>	<input type="checkbox"/>
<b>I am 18 years old or younger and <u>do not</u> have health insurance coverage under my parents'/guardians' health insurance but do not want my use of services shared with my parents/guardians. I have entered a confidential address in the above section so please send mail to that address.</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>CITIZENSHIP VERIFICATION</b>		
All Take Charge applicants must prove that they are a US Citizen or a Legal Permanent Resident (LPR) and provide photo identification before they can be enrolled in TAKE CHARGE or any other Medicaid program.		

Are you a U.S. citizen or U.S. National?  Yes  No

If you answered “NO” to this question, please skip to #2

1. If “YES”, do you have a copy with you today of your

- Birth Certificate,  Yes  No
- Passport, or,  Yes  No
- Certificate of Naturalization  Yes  No

Note: A US Passport verifies both citizenship and identity.

**If you do not have access to any of the above documents, AND, you were born in Washington State, DSHS can help to verify your citizenship. You must provide all of the following information for us to prove your birth in Washington State. Please check to see that the information is complete, accurate and correctly spelled.**

CITY, COUNTY AND STATE OF BIRTH

FULL NAME AT BIRTH: (First, Middle, Last)

FATHER's NAME

MOTHER's MAIDEN NAME: (First, Middle, Maiden)

If you were NOT born in Washington, DSHS will request a copy of your birth certificate from the state where you were born. Complete, date and sign the Citizenship Documentation and Identity Declaration Form. Include full First, Middle, and Last birth names and your Mother's Maiden Last name. Please be sure that the information is complete, accurate and correctly spelled.

Note: For minors under the age of 18 some states require the signature of a parent or guardian on the Citizenship Documentation and Identity Declaration Form.

2. If “NO”, please give a copy of your U.S. Citizenship and Immigration Services (USCIS) paperwork and date you permanently entered the U.S. to the provider. Please provide the clinic a photo ID to copy.

**Note: If you are not a Legal Permanent Resident, U.S. Citizen or U.S. National, you do not qualify for TAKE CHARGE.**

**FOR CLINIC USE ONLY:**

Note to clinic assisting with applications:

For all clients born out of state, fax Citizenship and Identity Declaration to the TAKE CHARGE Eligibility Unit.

For Legal Permanents Resident, fax USCIS documents to TAKE CHARGE Eligibility Unit.

You must put the clients TAKE CHARGE Confirmation number on all faxes.

The fax number for the TAKE CHARGE Eligibility Unit is: 866-841-2267.

**RESIDENCY**

Are you a Washington State resident or a college student that intends to remain in Washington after school?  Yes  No

**If “no”, you are not eligible for TAKE CHARGE. (Stop here – discuss payment for services with your provider).**

**ETHNICITY/RACE**

Are you Hispanic or Latino?  Yes  No  Don't Know  Prefer not to answer

Which one or more of the following would you say is your race? (Check or write any or all that apply)

- White
- African American/Black
- Asian
- Pacific Islander
- American Indian or Alaska Native
- Other (Please specify): \_\_\_\_\_
- Prefer not to answer

**INCOME REQUIREMENTS AND FAMILY SIZE**

**Monthly Earned Income**

1. Enter your GROSS wages and tips (before taxes and deductions are taken out) for the last **monthly** pay period. \_\_\_\_\_
2. If self-employed, estimate your anticipated net monthly income after business expenses. \_\_\_\_\_
3. Are you married?  Yes  No **If yes, and your spouse works, enter your spouses' gross monthly wages.** (plus) + \_\_\_\_\_
4. Subtotal earned monthly wages. (subtotal) = \_\_\_\_\_
5. Subtract \$90 if you work and another \$90 if your spouse works. (minus) - \_\_\_\_\_  
*(Note: If you make less than \$90 a month, just subtract amount you make)*
6. Subtract any monthly work-related child or adult care payments. (minus) - \_\_\_\_\_
7. Subtract all monthly court-ordered Child Support payments for a child living outside the home. \_\_\_\_\_
8. Total earned income **(Earned Income Subtotal)** \_\_\_\_\_

9. You and your Spouse's Monthly Unearned Income

	Amount Per Month		Amount Per Month
Child Support or Alimony	<input type="text"/>	Veteran's Benefits	<input type="text"/>
Social Security Benefits	<input type="text"/>	Labor & Industries Benefits	<input type="text"/>
Unemployment Benefits	<input type="text"/>	Military Allotments	<input type="text"/>
Interest from Bank Account	<input type="text"/>	Other	<input type="text"/>

10. Total Unearned Income: **(Unearned Income Subtotal )** \_\_\_\_\_

11. Total Monthly Income: **Total of #8 #10)** \_\_\_\_\_

12. To determine family size, only count you, your spouse and any legally dependent children **under** 18 years of age. Family size:

13. If you are reporting zero income, explain how you are meeting your needs.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**I have been told that:**

**I may qualify for other Medicaid programs which could offer me and my family access to many more medical services besides family planning. All I need to do is go to the local Community Services Office to find out more information. I have been told where the Community Services Office is located and how to get more information on these services.**

**I have read and understand the information in this application. I declare, under penalty of perjury all information I gave in this application is true, correct and complete to the best of my knowledge. I give DSHS permission to verify any of the information given on this application. If I am not eligible for TAKE CHARGE all family planning services costs are my responsibility.**

**I understand that I may be asked to participate in voluntary surveys and that my health care information may be used by DSHS to evaluate DSHS programs, I understand that my service providers and DSHS will ensure confidentiality of my protected health information as required by federal law.**

SIGNATURE OF APPLICANT

DATE

CONTINUES ON NEXT PAGE

**FOR CLINIC USE – MUST BE COMPLETED**

NAME OF CLINIC/PROVIDER WHERE CLIENT IS APPLYING

NAME OF STAFF PERSON ASSISTING CLIENT WITH APPLICATION

TELEPHONE NUMBER

FAX NUMBER

Yes No

I have retained a copy of the client's:

- Proof of citizenship documentation

Write in type of document copied (passport, birth certificate, etc) \_\_\_\_\_

- Citizenship Documentation and Identity Declaration Form if born outside of Washington
- USCIS documentation for legal permanent residents
- Photo ID.
- SSN Referral form (if client does not have SSN on date of application).