



## COMMUNITY HEALTH CARE COVERAGE WORKSHEET

APPLICANT NAME AND CONTACT INFORMATION				
Name (First, MI, Last, & Suffix):		DOC Number:	ERD:	
Are you without a fixed address? <input type="checkbox"/> Yes <input type="checkbox"/> No Check yes, if you do not have a home address. You still need to provide a mailing address.				
Address where you will live		City	County	State
Mailing address (if different)		City	County	State
Primary Phone Number <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work (    )		Secondary Phone Number <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work (    )		E-mail Address

Washington HealthPlanFinder may need to contact you regarding the status of your application and/or request additional information.

What is your preferred method of contact?     Phone     E-mail     USPS Mail

APPLICANT	
Marital Status: Citizen or Non-Citizen Status (Check one):	<input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Non-Citizen lawfully present in the U.S. <input type="checkbox"/> Other
Do you have dependent children? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you plan on residing with your dependents (spouse and/or children) when you release? <input type="checkbox"/> Yes <input type="checkbox"/> No	

AMERICAN INDIAN & ALASKAN NATIVE INFORMATION	
Name:	Tribe Name:

Member of a Federally Recognized Tribe, Band, Pueblo, or Rancheria; Shareholder in an Alaska Native Regional or Village Corporation  
 Yes     No

Descendant of a Federally recognized Tribe, Band, Pueblo, or Rancheria; Shareholder in an Alaska Native Regional or Village Corporation  
 Yes     No

Eligible for Indian Health Services, Tribal Health Services, or Urban Indian Health Services, including as a California Indian, Eskimo, Aleut, or other Alaska Native  
 Yes     No

INCOME INFORMATION - EARNED AND SELF-EMPLOYMENT
Do you currently have a job in the community? <input type="checkbox"/> Yes <input type="checkbox"/> No (For individuals in Work Release) - <b>if yes, please complete:</b>

Name of Employer or Company	Gross (before taxes are taken out) monthly income (wages, salaries, tips, corporation, S-corporation)

When you are released, will you have a job?     Earned income    or     Self-employment  
 Yes     No    **If yes, please complete the following:**

Name of Employer or Company	Anticipated Gross Income			
Employer Street Address	City	County	State	Zip Code

Does your employer offer Health Insurance coverage?     Yes     No

**OTHER INCOME - SUCH AS DIVIDENDS, PER CAPITA, ANNUITIES, SOCIAL SECURITY**

<input type="checkbox"/> SSI Disability	Who _____	\$ _____	How often _____
<input type="checkbox"/> Social Security	Who _____	\$ _____	How often _____
<input type="checkbox"/> Other	Who _____	\$ _____	How often _____

**DEDUCTIONS**

<input type="checkbox"/> Spousal Maintenance	\$ _____	How often _____
<input type="checkbox"/> Child Support Payments	\$ _____	How often _____

**READ CAREFULLY BEFORE SIGNING**

Disclosure of information to other state and federal agencies:  
 In order to simplify the application/redetermination process, I authorize Washington Healthplanfinder to obtain my updated federal tax information for period of no more than five years.  Yes  No I can change my consent at any time through the Washington Healthplanfinder.

I have read or had explained to me my rights and responsibilities and received a copy of *Client Rights and Responsibilities*.

**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. Additional, if I am eligible I wish to receive Washington Apple Health benefits.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Distribution: **ORIGINAL** - Scan and send to [MedicaidApplications@DOC.WA.GOV](mailto:MedicaidApplications@DOC.WA.GOV)