Department of Corrections
WASHINGTON STATE

COMMUNITY HEALTH CARE COVERAGE WORKSHEET

APPLICANT NAME AND CONTACT INFORMATION				
Name (First, MI, Last, & Suffix):		DOC Number:		ERD:
Are you without a fixed address? ☐ Yes ☐ 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	Zip Code
Mailing address (if different)	City	County	State	Zip Code
Primary Phone Number ☐ Cell ☐ Home ☐ Work ( )	Secondary Phone Number ☐ Cell ☐ Home ☐ 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: ☐ Married ☐ Divorced ☐ Separated ☐ Single

Do you have dependent children? ☐ Yes ☐ No

Citizen or Non-Citizen Status (Check one): ☐ U.S. Citizen ☐ Non-Citizen lawfully present in the U.S. ☐ Other

Do you plan on residing with your dependents (spouse and/or children) when you release? ☐ Yes ☐ 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? ☐ Yes ☐ No

(For individuals in Work Release) - **if yes, please complete:**

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?

☐ Yes ☐ No **If yes, please complete the following**: ☐ Earned income or ☐ Self-employment

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

☐ SSI Disability Who _____ $ _____ How often _____

☐ Social Security Who _____ $ _____ How often _____

☐ Other Who _____ $ _____ How often _____

DEDUCTIONS

☐ Spousal Maintenance $ _____ How often _____

☐ 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