Washington State Health Care Authority

Take Charge Application for Family Planning Services

Fax Completed Application to 1-866-841-2267

CLINIC NAME	CLINIC TELEPHONE NUMBER
Mt. Baker Planned Parenthood	360-734-9095

1. FIRST NAME	MIDDLE INITIAL	LAST NAME

2. ADDRESS WHERE YOU LIVE	STREET	APT. #	CITY	STATE	ZIPCODE

3. MAILING ADDRESS (if different from above):	STREET	APT. #	CITY	STATE	ZIPCODE

4. HOME, CELL, PREFERRED NUMBER	WORK/MESSAGE NUMBER	E-MAIL ADDRESS

5. Do you have trouble speaking, reading, or writing English?	Do you need an interpreter?	What language do you speak?
☐ Yes ☐ No	☐ Yes ☐ No	

GENERAL INFORMATION

SEX	DATE OF BIRTH	Do you intend to use a birth control method to prevent unintended pregnancy?
☐ Male ☐ Female		☐ Yes ☐ No **If no, you are not eligible.**
SOCIAL SECURITY NUMBER	U.S. Citizen or National? ☐ Yes ☐ No	If not a U.S. citizen or national, and you are a documented alien, provide a copy of your immigration documents.

6. To determine eligibility for this program, we need to know your family size (spouse and/or dependent children 18 years old or younger. living with you. Including yourself, what is your family size? _____

7. If you are married and living with your spouse, enter the spouse's name and Social Security Number (SSN).
(First, Middle, Last Name):_____ SSN:_____

HEALTH INSURANCE INFORMATION

8. Do you have private health insurance? ☐ Yes ☐ No **If yes, provide the following information:**

NAME OF THE INSURANCE COMPANY	
ADDRESS OF THE INSURANCE COMPANY	
POLICY HOLDER'S NAME	
POLICY HOLDER'S INSURANCE ID OR POLICY NUMBER	

I understand the TAKE CHARGE Medicaid program is always the payer of last resort. I understand my insurance will be billed first for the TAKE CHARGE services I receive unless:

☐ I am 18 years old or younger and my parents do **not** know I am seeking family planning services. I want to keep the services that I receive confidential.

OR

☐ I am a victim of domestic violence and I am covered under my perpetrator's health insurance.

RACE/ETHNIC BACKGROUND

9. 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 ☐ Other Asian or pacific Islander
☐ Hispanic ☐ American Indian or Alaskan Native; tribe name:_____
☐ Other:_____

OPTIONAL AUTHORIZED REPRESENTATIVE (AREP)

(An AREP is someone you allow the department to talk with about your benefits, and/or receive Take Charge mail for you.)
To name an AREP, complete the information below.

NAME / ORGANIZATION	TELEPHONE NUMBER

MAILING ADDRESS	STREET	CITY	STATE	ZIP CODE

☐ Send my TAKE CHARGE mail to **my** mailing address ☐ Send my TAKE CHARGE mail to this AREP's address.

CLIENT NAME	SOCIAL SECURITY NUMBER

INCOME

Have **you** quit or lost a job in the last 90 days? ☐ Yes ☐ No If yes, employment end date_____	Has **your spouse** quit or lost a job in the last 90 days? ☐ Yes ☐ No If yes, employment end date_____

YOUR INCOME FROM EMPLOYMENT / SELF-EMPLOYMENT		SPOUSE'S INCOME FROM EMPLOYMENT / SELF-EMPLOYMENT	
CURRENT EMPLOYER	TELEPHONE NUMBER	CURRENT EMPLOYER	TELEPHONE NUMBER
YOUR **GROSS** MONTHLY PAY BEFORE TAXES OR EXPENSES ARE TAKEN OUT		YOUR SPOUSE'S GROSS MONTHLY PAY BEFORE TAXES OR EXPENSES ARE TAKEN OUT	
CURRENT EMPLOYER	TELEPHONE NUMBER	CURRENT EMPLOYER	TELEPHONE NUMBER
YOUR GROSS MONTHLY PAY BEFORE TAXES OR EXPENSES ARE TAKEN OUT		YOUR SPOUSE'S GROSS MONTHLY PAY BEFORE TAXES OR EXPENSES ARE TAKEN OUT	

If you or your spouse currently have more than two employers, please attach additional information on a separate sheet of paper.

OTHER INCOME	AMOUNT	HOW OFTEN DO YOU GET THIS INCOME?	WHICH FAMILY MEMBER GETS THIS INCOME?
10. Support from parents, other relatives, scholarships or loans			
11. Child support or alimony			
12. Social Security payment			
13. Unemployment services			
14. Veteran's services/military allotments			
15. Labor and Industries			
16. Investment income			
17. Any other source of income or financial support			

EXPENSES

18. Do you pay for child care or adult dependent care while you work? ☐ Yes ☐ No If yes, monthly amount:_____

19. Do you pay child support for a child who is not living in your home? ☐ Yes ☐ No If yes, monthly amount:_____

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 care benefits, 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 services, financial assistance, or food stamps, I must apply through a DSHS Community Services Office.

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