Washington State Health Care Authority

Application for Take Charge (Family Planning) Services

Fax Completed Application to 1-866-841-2267

Please read this section carefully before filling out this application

If you are at or below 260% of the Federal Poverty Level for your household size, you must apply and be denied for full-scope Medicaid coverage at www.wahealthplanfinder.org before you can enroll in Take Charge.

Do you have private health insurance or Medicaid (i.e., Apple Health or Healthy Options) coverage? Yes ☐ No ☐

If you answer Yes above, you are not eligible for Take Charge unless one of the following applies:

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

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

Clinic name PPGWNI	Clinic telephone number 1.866.904.7721

1. First name (use your full legal name)	Middle initial	Last name

2. Address where you live	Apt. #	City	State	Zip Code
3. Mailing address (if different from above):	Apt. #	City	State	Zip Code

4. If you would like your mail to be sent to the clinic instead of your mailing address, please initial here: _____________

5. Home/cell/preferred number	Work/message number	E-mail address

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

General Information

☐ Male ☐ Female	Date of birth	Do you intend to use a birth control method to prevent unintended pregnancy? ☐ Yes ☐ No If No, why do you need Take Charge (e.g., IUD removal)?_________________________
Social Security Number	U.S. Citizen? ☐ Yes ☐ No If No, please provide immigration documents. If immigration documents are not provided you may be denied.	

Income From Employment / Self-Employment

Earned by You		Earned by Your Spouse	
Name of business you currently work for (1st Job)	Telephone number	Name of business you currently work for (1st Job)	Telephone number
Gross monthly income before taxes	Self-Employed? ☐ Yes ☐ No	Gross monthly income before taxes	Self-Employed? ☐ Yes ☐ No
Name of business you currently work for (2nd Job)	Telephone number	Name of business you currently work for (2nd Job)	Telephone number
Gross monthly income before taxes	Self-Employed? ☐ Yes ☐ No	Gross monthly income before taxes	Self-Employed? ☐ Yes ☐ No

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

Other Household Income

☐ Spousal support, rental income and/or royalties	Monthly amount:_________	Who receives this:____________________
☐ Social Security/Railroad Retirement income	Monthly amount:_________	Who receives this:____________________
☐ Unemployment	Monthly amount:_________	Who receives this:____________________
☐ Pension, annuity, and/or IRA distribution income	Monthly amount:_________	Who receives this:____________________
☐ Interest/dividend income, capital gains/losses, farm income/losses, other investment income	Monthly amount:_________	Who receives this:____________________
☐ Economic development funds from tribes	Monthly amount:_________	Who receives this:____________________
☐ Other income that is taxable (i.e., included in adjusted gross income on your tax return):_______________	Monthly amount:_________	Who receives this:____________________

Client name	Client Social Security number

Household Deductions

- ☐ Higher education tuition, fees, and books — Monthly amount:________ Who pays this:________
- ☐ Contributions to Health Savings Account/IRA — Monthly amount:________ Who pays this:________
- ☐ Student loan interest and spousal support — Monthly amount:________ Who pays this:________
- ☐ Moving costs since January 1 of this year — Monthly amount:________ Who pays this:________
- ☐ Other AGI deductions (i.e., used to calculate adjusted gross income (AGI) on your tax return):________ — Monthly amount:________ Who pays this:________

Tax Filing Status

What will your tax filing status be for this year? ☐ Single Filer ☐ Married Filing Separately ☐ Married Filing Jointly

☐ Tax Dependent of Someone from Household ☐ Tax Dependent of Someone Outside Household ☐ Non-Tax Filer

Are you legally married? ☐ Yes ☐ No If yes, your spouse's full legal name (first, middle, last name):________

Spouse's SSN:________ If you file a tax return, how many tax dependents do you claim? ________

If you do not file a tax return, how many children do you have? ________

Recent Job Loss

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

If yes, the business's name:________

Employment end date:________

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

If yes, the business's name:________

Employment end date:________

Race/Ethnic Background

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

☐ Hispanic ☐ American Indian or Alaskan Native: ☐ Other Asian or Pacific Islander

☐ Other:________ Tribe name:________

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 (https://www.wahealthplanfinder.org). If I need financial assistance or food stamps, I can apply at a DSHS Community Services Office or Washington Connection (https://www.washingtonconnection.org).
- **I must respond** to any requests for additional information from the Take Charge Eligibility office within 10 business days or my application will be denied and I may be responsible for all charges incurred through my Take Charge Provider's office.

Optional Authorized Representative (AREP)

(An AREP is someone you allow HCA to talk with about your benefits, and/or receive Take Charge mail for you.)

I am naming the person or organization below as my AREP: Client Initial________

Name / Organization			Telephone number	
Mailing address	**Street**	**City**	**State**	**Zip Code**

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