

Basic Health *Plus* Application

Questions? Call 1-800-660-9840

Note: Children enrolled in Basic Health *Plus* must use the same health plan as other family members on Basic Health.

Complete this information for each family member. Make a copy of this form if you need more room.		Gender	Does dependent live in your home?	Relationship to you	U.S. citizen?	Applying for Basic Health <i>Plus</i> ?
Subscriber's name	Social Security number	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Subscriber's birth date	Subscriber's place of birth: City/State					
Subscriber's employer						
Employer's address				Employer's phone number		
Spouse's name (must be legally married)	Social Security number	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse's birth date	Spouse's place of birth: City/State					
Spouse's employer						
Employer's address				Employer's phone number		
Dependent	Social Security number	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent birth date	Dependent's place of birth: City/State					
Dependent	Social Security number	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent birth date	Dependent's place of birth: City/State					
Dependent	Social Security number	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent birth date	Dependent's place of birth: City/State					
Dependent	Social Security number	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent birth date	Dependent's place of birth: City/State					

- If you checked "no" to "U.S. citizen" for any family member applying for Basic Health *Plus*, please provide a copy (front and back) of that person's U.S. Citizenship and Immigration Services (USCIS) documentation, and indicate their date of arrival into the U.S. _____
- What was the amount of your gross (before taxes) household income for the most recent full calendar month? \$ _____
 You must send proof of your household income for the most recent full calendar month (copies of pay stubs, unemployment insurance, child support, etc.).
 What days were you paid on during that month? _____
 If you are self-employed or have rental income, you can provide your most recent tax return and all schedules for proof of income.
 If you have had no income in the last 30 days, attach a signed and dated note telling us how you support yourself.
- Do you pay court-ordered support? Yes No
 If yes, how much do you pay each month? _____
 You must provide proof, such as a court order, of what you pay each month.
- Are you applying for Basic Health *Plus* coverage for a dependent whose other biological parent is not legally married to you, but is living in your home? (This information is used to determine Basic Health *Plus* eligibility only. If the other biological parent wants Basic Health coverage, he or she must submit a separate application.) Yes No
If yes, you must fill in the information about that parent on the next page, and attach proof of that person's monthly income.

Name of other biological parent	Social Security number (required)	Birth date	Gross monthly income (before taxes)	Daytime phone number ()
Employer/Company name			Employer phone number	
Employer address				

List the names of this parent's children shown on your application:

5. Home phone number: () Other phone number: ()

email address: _____

6. Have you had a recent change in address? Yes No

If yes, please write your current address: _____

7. List yourself and any family members who have other health insurance or are covered under a health program such as Tri-Care, Medicare, or Medicaid.

Last name	First name	M.I.	Health insurance company or health program	Phone number of health insurance company or program	Policy or group number	Policy end date
(List yourself first.) 1.				()		/ /
2.				()		/ /
3.				()		/ /

8. Completing this information is voluntary and will not affect your ability to enroll in Basic Health *Plus*.

Please indicate your ethnic background:

- Black/African-American White/Caucasian Indian (Native American)
 Eskimo Aleutian Islander/Aleut Asian or Pacific Islander (API)
 Hispanic/Latin American Other or mixed ethnic background

9. What language and dialect do you speak? _____
Do you need an interpreter? Yes No

10. Are you applying for Basic Health coverage for a child with an urgent medical need? Yes No
If yes, give the child's name here: _____

11. Do you have any unpaid medical bills, or have you received medical services in the past three months for any of the children above (Basic Health *Plus* applicants) that are NOT covered by other insurance? Yes No
If yes, attach proof of income for those three months.

AGREEMENT AND SIGNATURE

I understand that:

- I must provide proof of my gross family income (before taxes and deductions) and report income changes that would change my premium or eligibility to Basic Health/Department of Social and Health Services (DSHS) within 30 days after the end of the month my income changed.
- By signing this form, I have authorized Basic Health and DSHS to verify my eligibility information and family income with other state or federal agencies or other third-party sources.
- I must report address changes and changes in my family. I must report, for example, my marriage or divorce, or the marriage or divorce of any family member on my account, the birth or adoption of a child, or the date when a child leaves home or is no longer a dependent or is no longer a full-time student.
- My application and the documents I send to Basic Health will be used to determine eligibility for DSHS programs (Basic Health *Plus* or the Maternity Benefits Program), according to DSHS program requirements.
- By asking for and receiving DSHS benefits, my family and I assign to the state of Washington our rights to any third-party payment for medical care of covered medical services while receiving medical benefits.
- Basic Health's deposit of my premium payment does not guarantee coverage. The payment will be refunded if I am determined ineligible for coverage.

I authorize my health plan or medical provider to give medical records for me or my children to Basic Health, for purposes of participation in Basic Health/DSHS programs.

I have read and I understand the information provided to me with the Basic Health application. I declare, under penalty of perjury, that the information I have given in this application and the documents I send to Basic Health are true, correct, and complete to the best of my knowledge. I understand that if I or any member of my family, or any person on my behalf, submits false information, my family or I may lose coverage, may be held financially responsible for services obtained under Basic Health or additional or past premium amounts due, and may face other penalties and prosecution. Any debt owed to the state may be sent to a collection agency for recovery.

Signature of parent or guardian _____

Date _____

Explanation of income types and what to send with your *Family Income Reporting Form*

You must provide copies from the Internal Revenue Service (IRS) of the following:

- Your IRS Form 1040, federal income tax form, and all schedules
- Schedule K-1 for each family member for each S-Corporation, partnership, or trust beneficiary
- A complete IRS transcript, if you do not have a copy of your IRS Form 1040
- Verification of non-filing status from the IRS if you did not file a tax return

To request a transcript or letter of non-filing status, call the IRS at 1-800-829-1040.

Proof of income must include the name of the person paid, the **gross** amount(s) paid, and the dates paid. Send a full 30 days' proof for each income source. On a separate sheet, explain any gaps in income. **(Always send current documents.)** If you need another copy of this form, or would like more information about Basic Health, visit our Web site (www.basichealth.hca.wa.gov).

Do not mail originals to Basic Health; they will not be returned to you.

Explanation of income type	Examples of copies you might send
Wages, salary, tips, assistantships, commissions	<ul style="list-style-type: none"> • Pay stubs for four consecutive weeks or one month • Signed and dated statement from employer(s)
Self-employment or rental income	<ul style="list-style-type: none"> • IRS 1040 and all applicable schedules • Schedule K-1(s), if applicable • Statement of income and expenses (any business not shown on 1040) • Washington State Unified Business Identifier (UBI) number
Unemployment compensation, strike benefits	<ul style="list-style-type: none"> • Unemployment stubs for four consecutive weeks or one month • Strike benefit statement • Computer print-out from agency/payer
Social security benefits	<ul style="list-style-type: none"> • Initial notice of award letter • Statement showing monthly benefit amount • Computer print-out from agency/payer
Retirements, pensions, annuity benefits	<ul style="list-style-type: none"> • Award letter or benefit statement • Cost of living allotment statement • Signed and dated statement from payer(s) • Computer print-out from agency/payer
Child support, alimony/spousal maintenance	<ul style="list-style-type: none"> • Payment order • Court documents or Division of Child Support (DCS) statement • Signed and dated statement from payer(s) • Computer print-out from agency/payer • Copy of check or signed statement from recipient
Insurance benefits	<ul style="list-style-type: none"> • Award letter • Court documents • Statement from institution
Interest, dividends, trust, estate, inheritance, capital gains, gambling, lottery, royalties	<ul style="list-style-type: none"> • IRS 1040 and all applicable schedules • Statement from trustee, investment firm, bank, or financial institution • Court documents • Copy of contract
Veterans' benefits, military allotments	<ul style="list-style-type: none"> • Award letter or benefit statement • Leave and Earnings Statement (LES)
Workers' compensation	<ul style="list-style-type: none"> • Award letter or benefit statement • Labor & Industries (L & I) payment order for four consecutive weeks (two consecutive orders)
Public assistance cash grants	<ul style="list-style-type: none"> • Award letter or benefit statement • Computer print-out from Department of Social and Health Services (DSHS)
Income from any other source	<ul style="list-style-type: none"> • Signed and dated statement from payer • Signed and dated statement from applicant/member
Personal care workers, independent providers	<ul style="list-style-type: none"> • Social Service Payment System (SSPS) invoice, and • Remittance Advice, pages 1 and 2

Can dependent care expenses be deducted?

Yes; you may deduct work- or school-related dependent care expenses (work- or school-related means the dependent spends time in dependent care so that adults in the home can go to work or school). You must provide copies of receipts that include the amount you paid, the dates of care, and the dependent care provider's name, address, and phone number.