



# Maternity Benefits Application

Questions? Call 1-800-660-9840



The pregnant family member must answer the following questions, then print and sign her name.

Are you pregnant?  Yes  No If yes, have you received a positive result from a pregnancy test?  Yes  No

Expected date of delivery \_\_\_\_\_ email address: \_\_\_\_\_

Printed name: \_\_\_\_\_ Signature: \_\_\_\_\_

Complete this information for each family member. Make a copy of this form if you need more room.		Gender	Relationship to you	U.S. citizen?
Subscriber's name	Social Security number	<input type="checkbox"/> M <input type="checkbox"/> F		<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
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"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other	<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"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other	<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"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other	<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"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent birth date	Dependent's place of birth: City/State			

1. If the pregnant woman is not a U.S. citizen, is she lawfully admitted for permanent residence?  Yes  No

2. If the pregnant woman checked "no" to "U.S. citizen," please provide a copy (front and back) of that person's U.S. Citizenship and Immigration Services (USCIS) documentation, and indicate her date of arrival into the U.S. \_\_\_\_\_

3. 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.

4. 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.

5. Do you want help with unpaid medical bills from the last three months?  Yes  No  
If yes, attach proof of income for those three months.
6. Are both parents of the unborn child living in the same household?  Yes  No
7. Home phone number: ( ) \_\_\_\_\_ Other phone number: ( ) \_\_\_\_\_
8. Have you had a recent change in address?  Yes  No  
If yes, please write your current address: \_\_\_\_\_

9. 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.				( )		/ /

10. Completing this information is voluntary and will not affect your ability to enroll in the Maternity Benefits Program. 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
11. What language and dialect do you speak? \_\_\_\_\_  
Do you need an interpreter?  Yes  No
12. Please check the box that applies to your situation:
- There is no change in my family's income, and we have no self-employment income.
- I am self-employed, and have included proof of gross household income received in the most recent full calendar month for Department of Social and Health Services (DSHS) eligibility purposes. I provided proof of my tax return and all schedules. My income has not changed since last reported to Basic Health.
- My income has changed since last reported to Basic Health. I have enclosed income documentation from all sources for the most recent full calendar month, along with the *Family Income Reporting Form*.

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

### 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.