

Health Coverage Tax Credit (HCTC)-Basic Health Application



Use blue or black ink to complete this application.

Basic Health™

Questions about HCTC? Call the HCTC Customer Contact Center at 1-866-628-4282.

Questions about this application? Call 1-800-660-9840 and say you're interested in HCTC-Basic Health.

APPLICANT AND HOUSEHOLD INFORMATION

If you need help in a language other than English, what language and dialect do you speak?

Applicant's last name		First name		Middle initial
Street address	Apt. #	City	State	ZIP Code
Mailing address or PO box, if different from above		City	State	ZIP Code
Home phone number ()	Other phone number ()	Marital status (check one): <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Legally married		
E-mail address		Do you have access to the internet? <input type="checkbox"/> Yes <input type="checkbox"/> No		

FAMILY MEMBERS (If you need more space, please use a separate sheet or copy this page.)

Complete this section for all family members even if not requesting coverage.			Gender	Requesting coverage?
For applicant listed above →	Social Security number	Birth date	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse's last name, first name, middle initial	Social Security number	Birth date	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No

1	Last name, first name, middle initial		Social Security number	
	Relationship to applicant <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other: _____	Birth date	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Requesting coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
2	Last name, first name, middle initial		Social Security number	
	Relationship to applicant <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other: _____	Birth date	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Requesting coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
3	Last name, first name, middle initial		Social Security number	
	Relationship to applicant <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other: _____	Birth date	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Requesting coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
4	Last name, first name, middle initial		Social Security number	
	Relationship to applicant <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other: _____	Birth date	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Requesting coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No

**Basic Health contracts with private health plans in Washington State.
You must choose a health plan in the section below.**

HEALTH PLAN SELECTION

Choose one health plan for your family. Not all health plans are available in every county. Read *Understanding HCTC-Basic Health* to see the plans available where you live. If you live outside of Washington, you must choose a county where you will receive your HCTC-Basic Health services, and then you must choose a health plan available in that county.

Washington State county where you live, or, if you're not a Washington State resident, the Washington State county where you will receive services: _____

Choose your health plan:

- Columbia United Providers, Inc.
- Community Health Plan of Washington
- Group Health Cooperative
- Kaiser Permanente
- Molina Healthcare of Washington, Inc.

AGREEMENT AND SIGNATURE

I understand that: I must report address changes, changes in my HCTC eligibility, and changes in my family (for example, a marriage or divorce, the birth of a child, or a child who leaves the home or is no longer a dependent).

I authorize any health plan or medical provider to give medical records for me or my children to Basic Health, for purposes of participation in Basic Health. I have read and understood the information in this application. I declare, under penalty of perjury, the information I have given in this application and attachments is true, correct, and complete to the best of my knowledge. I understand that anyone who submits false information may lose coverage, may be held financially responsible for services obtained under Basic Health, and may face other penalties, prosecution, and collection.

**AGREEMENT MUST BE SIGNED BY YOU AND YOUR SPOUSE,
AND DEPENDENTS AGE 18 AND OVER WHO ARE ASKING FOR COVERAGE**

X _____ Signature of applicant	_____ Date	X _____ Signature of spouse	_____ Date
X _____ Signature	_____ Date	X _____ Signature	_____ Date
X _____ Signature	_____ Date	X _____ Signature	_____ Date

IS YOUR APPLICATION COMPLETE?

Use this checklist below to make sure you include:

- Application signed by subscriber and spouse, and any family members over age 18 who are requesting coverage.
- Your health plan choice and county of service at the top of the second page of this application.
- A copy of your "candidate letter" from the Internal Revenue Service/Health Coverage Tax Credit program.

**Please enclose the required forms and documentation, and either fax to (360) 923-2605 (please call us first at 1-800-660-9840 to let us know your fax is coming), or mail it to
Basic Health, PO Box 42703, Olympia, WA 98504-2703.**

Questions? Call 1-800-660-9840. On the Internet, go to www.basichhealth.hca.wa.gov.

Privacy statement: We will keep your information private as allowed by law. The Washington State Health Care Authority runs Basic Health. To see our Privacy Notice, call 360-923-2822 or go to www.hca.wa.gov.