Income

Enter GROSS pay (before taxes or expenses). Enter zero "0" if you or your spouse are unemployed or do not live in the home with these children.

11 PARENT'S EMPLOYER NAME AND PHONE

( )

12 Amount you received in the last 30 days before taxes or expenses were taken out:
$_____
How much of this income is from self employment?*
$_____

13 SPOUSE'S (OR OTHER PARENT LIVING IN THE HOME) EMPLOYER NAME AND PHONE NUMBER:

( )

14 Amount your spouse (or other parent living in the home) received in the last 30 days before taxes or expenses were taken out:
$_____
How much of this income is from self employment?*
$_____

*IF YOU OR YOUR SPOUSE (OR OTHER PARENT LIVING IN THE HOME) ARE SELF-EMPLOYED YOU MAY GET OTHER DEDUCTIONS. PLEASE CALL 1-877-KIDS-NOW FOR MORE INFORMATION OR APPLICATION ASSISTANCE.

OTHER HOUSEHOLD INCOME	AMOUNT RECEIVED IN LAST 30 DAYS	WHICH FAMILY MEMBER GETS THIS INCOME?
15 CHILD SUPPORT	$	
16 ALIMONY	$	
17 SOCIAL SECURITY PAYMENT	$	
18 UNEMPLOYMENT BENEFITS	$	
19 INTEREST FROM BANK ACCOUNT	$	
20 VETERANS BENEFITS	$	
21 LABOR & INDUSTRIES	$	
22 MILITARY ALLOTMENTS	$	
23 OTHER (Please explain)	$	

24 In the last 3 months, did any of the children you are applying for have unpaid medical bills or receive medical services NOT covered by other insurance? Yes ☐ No ☐

Health Insurance Information

Tell us about any health insurance your **children** already have.

25 A Do any of the **children** you are applying for already have health insurance? Yes ☐ No ☐

25 B If "Yes," does that health insurance cover doctor, hospital, x-ray (radiology) and laboratory services? Yes ☐ No ☐

26 A Have your **children** been covered by job-related health insurance in the last 4 months? Yes ☐ No ☐

26 B If "Yes," did it cost less than $50 per month for dependents? Yes ☐ No ☐

27 If you checked "Yes" to any of the above questions (25 a or b or 26 a or b), please list the name of the insurance company or employer providing health insurance for your children.

INSURANCE COMPANY OR EMPLOYER	POLICY NUMBER	POLICY HOLDER'S NAME	POLICY HOLDER'S SOCIAL SECURITY NUMBER (OPTIONAL)

Children's Race/Ethnic Background (Voluntary Information)

We ask you to voluntarily tell us your children's race or ethnic background. This information will not be used in considering your eligibility for benefits.

Caucasian ☐ Hispanic ☐ Black ☐ American Indian/Alaska Native ☐
Vietnamese/Laotian/Cambodia ☐ Other Asian or Pacific Islander ☐ Other ☐

Read Carefully Before Signing

This application is for medical benefits for children only. If anyone in your family already receives, or would like to apply for cash benefits, food assistance or other benefits, please contact your local DSHS Community Services Office (CSO).

- DSHS may ask you to prove the information you are giving them to tell if you are eligible. You can ask DSHS for help in getting proof.
- Your information may be reviewed by other state or federal agencies. This information will NOT be shared with Immigration and Naturalization Service (INS).
- By asking for and getting health care benefits, you give the state of Washington all rights to any medical support and to any third party payments for health care.
- DSHS may share your child's immunization history with the Child Profile Immunization Tracking System.

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
X _____ _____ Date

How to Submit

MAIL TO: **Dept. of Social and Health Services**
P.O. Box 45531
Olympia, WA 98599-5531

FAX TO: **(360) 664-0518**

FOR HELP: If you need help or have questions, please call **1-877-KIDS-NOW.** (1-877-543-7669)

Healthy Kids Now!
HEALTHCARE FOR WASHINGTON'S KIDS

1-877-KIDS-NOW

Toll-free (1-877-543-7669)

For information in your community:

Washington State Department of Social & Health Services
DSHS 22-394(X) (4/01)

Free or Low-cost Health Insurance

for Washington's Kids & Teens

1-877-KIDS-NOW
Toll-free (1-877-543-7669)

Healthy Kids Now!

Washington State Has Free and Low-cost Health Insurance for Kids & Teens

Every child deserves to be healthy. Health insurance helps kids stay healthy. Over 100,000 children and teenagers in Washington State don't have health insurance. Now, many families can get free or low-cost health insurance for their kids. Stop worrying about health care expenses. Call toll-free 1-877-KIDS-NOW for information or fill out this easy application to find out if your kids qualify!

This insurance does not affect WorkFirst or citizenship status.

Thousands of Kids Under 19 are Eligible

Infants through teenagers can receive free or low-cost health insurance. Many families in Washington State qualify and don't know it. The programs are flexible and cover kids in many types of households:

- Kids with single parents
- Kids with working parents
- Kids living with grandparents, other family or friends
- Kids with two parents
- Young adults (under 19) living on their own
- Non-citizen kids
- Kids with pre-existing medical conditions

What Kinds of Services are Covered?

The health insurance programs cover a full range of services that all children need to stay healthy. Don't wait until someone in your family is sick or has an accident. Apply today and your kids could have health insurance soon! Once your child is eligible, you will get more information on how to get care. A few services that are covered include:

- Doctor and nurse visits
- Dental care
- Check-ups and immunizations
- Physical and speech therapy
- Transportation for office visits
- Hospital and emergency care
- Prescriptions
- Eyeglasses and hearing aids
- Family planning
- Counseling and more!

How Do I Find Out if My Kids Qualify?

The process is easy and many working families qualify. Income, family size *(be sure to include a pregnancy as a family member)* and some monthly expenses are reviewed for eligibility. To see if your kids might qualify, follow the easy steps below. Then compare your monthly income to the chart.

Step 1

Write Down Your Family's Monthly Income (before tax) $ ________

- Subtract any monthly work-related child or adult care expenses you pay. – ________
- Subtract all monthly court ordered child support payments you pay for a child living outside the home. – ________
- Subtract $90 for each working adult in the household. – ________

Step 2

Compare to See if You Qualify = ________

If your monthly family income is close to the amounts on the chart, your kids may qualify for free or low-cost health insurance!

Many people can make more income and still qualify. If your income is higher than the chart, please call 1-877-KIDS-NOW for more information.

Number of People in Family (includes parents and children)	Medicaid Free Health Insurance Approximate income per month (after deductions from Step 1)	CHIP Low-cost Health Insurance Approximate income per month (after deductions from Step 1)
1	up to $1,432	$1,433 to $1,790
2	up to $1,935	$1,936 to $2,419
3	up to $2,439	$2,440 to $3,048
4	up to $2,942	$2,943 to $3,678
5	up to $3,445	$3,446 to $4,307
More	Add $504 for each additional family member	Add $630 for each additional family member

Income levels are good through March 31, 2002. This chart deals with health insurance for children under 19 only. Other programs with different eligibility requirements are available for families, pregnant women and non-citizens. Call toll-free **1-877-KIDS-NOW** to find out more.

Great Programs for Washington's Kids

Non-Citizen Programs – Free Health Insurance

- Covers non-U.S. citizen kids and teens under 18.
- FREE coverage (no premiums or copays).
- Call 1-877-KIDS-NOW for eligibility and income requirements.

Medicaid – Free Health Insurance

- Covers kids and teens under 19.
- Look at RED box for income guidelines.
- FREE coverage (no premiums or copays).
- Once a child qualifies, that child's unpaid medical bills. for the last three months might be covered.

CHIP – Low-cost Health Insurance

- Covers kids and teens under 19.
- Look at BLUE box for income guidelines.
- Premiums billed monthly:
  - $10 for each child ($30 maximum for three or more children)
- Copays charged at the time of service:
  - $5 for office visits
  - $5 for brand name drugs
- American Indians and Alaska Natives do not pay premiums or copays.

Health insurance helps kids stay healthy—call or apply today!

Call toll-free 1-877-KIDS-NOW (1-877-543-7669)

Operators standing by to help you 8 AM to 8 PM Monday – Friday or mail in your application today!

Information can also be found on our website: http://www.hipspokane.org/HKN/

How Soon Will My Kids Have Health Insurance?

- Health Insurance approved for kids and teens will be effective the first day of the month in which their application is received!
- You will get a letter within 6 weeks letting you know if your kids or teens are eligible.
- When your kids or teens are approved, they can get health care services immediately.
- For faster processing, be sure to fill out the application completely.

Applying is Easy!

1. Fill out the application attached to this brochure.
2. Tear off the application page.
3. Detach the envelope from the application.
4. Fold the application and put it inside the envelope. Drop in any mail box! No stamp is needed.

You can keep the brochure for your records. **Call toll-free 1-877-KIDS-NOW if you have any questions.** When your completed application is received, it will be screened for eligibility.

- Kids are considered for free health insurance first (Medicaid and Non-citizen programs).
- Kids who don't qualify for free insurance are screened for low-cost health insurance (CHIP).

Healthy Kids Now! HEALTHCARE FOR WASHINGTON'S KIDS

Person helping client with application: ________

Organization: ________ Telephone: ( )

Washington State Department of Social & Health Services

Application For Children's Medical Benefits

This application is for medical coverage only for children and teens under 19. A parent, guardian, outreach worker, friend or teen applying for him/her self may fill out the application. **We will send the person listed in box 1 all follow-up information.** If you have questions or would like help filling out this form, just call 1-877-543-7669. We'll be happy to help you!

PLEASE PRINT (List parent, guardian or contact person who will receive follow-up information.)

1 FIRST NAME ________ MIDDLE INITIAL ________ LAST NAME ________

2 ADDRESS WHERE YOU LIVE — STREET ________ CITY ________ STATE ________ ZIP CODE ________

3 MAILING ADDRESS (IF DIFFERENT) — STREET ________ CITY ________ STATE ________ ZIP CODE ________

4 TELEPHONE NUMBERS
HOME ( )
WORK ( )
MESSAGE ( )

5 Do you have trouble speaking, reading or writing English? Yes ☐ No ☐
Do you need materials sent to you in another language? Yes ☐ No ☐
Do you need an interpreter? (If yes, we will help you through an interpreter.) Yes ☐ No ☐
What language do you speak? ________

6 Is anyone in your home pregnant? Yes ☐ No ☐
If "yes," who? ________
Does a child under 19 have a medical condition that needs attention right away? Yes ☐ No ☐

General Information

7 List family members **living together**. (If needed, attach a separate sheet of paper to list more family members.) (This information will not be shared with INS)

NAME (FIRST, MIDDLE, LAST)	RELATION TO YOU	BIRTH DATE (MO/DA/YR)	U.S. CITIZEN	IF NOT A U.S. CITIZEN, WAS YOUR **CHILD** GIVEN A DOCUMENT SHOWING HIS/HER STATUS? PLEASE ATTACH DOCUMENT	LIST DATE THIS CHILD ARRIVED IN U.S.	SOCIAL SECURITY NUMBER * = OPTIONAL	SEX M or F
A. PARENT, GUARDIAN OR SELF						*	
B. SPOUSE OR OTHER PARENT (if living in the home)						*	
C. LIST CHILDREN AND TEENS UNDER 19 YEARS OF AGE (who want medical benefits)			YES ☐ NO ☐	YES ☐ NO ☐			
D.			☐ ☐	☐ ☐			
E.			☐ ☐	☐ ☐			
F.			☐ ☐	☐ ☐			
G. LIST OTHER ADULTS OR CHILDREN IN THE HOME (who do not want medical benefits)						*	
						*	

8 Is a child under age 19 in your household disabled? Yes ☐ No ☐
If "Yes," who? ________

Expenses

This information can help your children qualify.

9 Do you pay for childcare while you work or attend school? Yes ☐ No ☐ If "Yes," how much per month? $ ________
Do you pay someone to take care of a disabled dependent adult while you work or attend school? Yes ☐ No ☐ If "Yes," how much per month? $ ________

10 Do you pay court ordered child support for a child who is not living in your home? Yes ☐ No ☐ If "Yes," how much per month? $ ________

DSHS 14-380

Glue Strip

This application is for medical benefits only. If you want to apply for other benefits (like food stamps), contact your local CSO.

- ☐ Did you sign the application?
- ☐ Did you fill in social security numbers for all children applying?
- ☐ If your children are non-citizens, did you attach a copy of their documentation?

For fastest service, please make sure application is complete.