APPLICATION FOR WASHINGTON STATE
TAKE CHARGE PRE-APPLICATION WORKSHEET

APPLICANT'S NAME LAST	FIRST	MIDDLE INITIAL	DATE

SECTION I - MEDICAL NEED FOR FAMILY PLANNING

	Yes	No
1. I need Family Planning Services.	☐	☐

If "no", you are ineligible for T AKE CHARGE (Stop here, discuss payment for services with your provider).

SECTION II - RESIDENCY AND CITIZENSHIP REQUIREMENTS

	Yes	No
1. Are you a Washington State resident?	☐	☐
If "no", you are ineligible for TAKE CHARGE (Stop here, discuss payment options).		
2. Are you a US citizen or US nationalist? (If "yes" skip to Section III, Health Insurance).	☐	☐
3. Are you a permanent legal resident who arrived in the US prior to 5 years before this application?	☐	☐
If "no", you are ineligible for TAKE CHARGE (Stop here, discuss payment options).		
4. Are you visiting friends or relatives, a tourist, foreign student or in the US temporarily?	☐	☐
If "yes", you are ineligible for TAKE CHARGE (Stop here, discuss payment options).		

See Chart in Billing Instructions.

SECTION III - HEALTH INSURANCE

	Yes	No
1. Do you have a DSHS Medical ID card?	☐	☐
If "yes", you are ineligible for TAKE CHARGE, have your provider bill MAA (exception Medically Indigent (MI)).		
2. Do you have health insurance that fully covers family planning?	☐	☐
If "yes" you are ineligible for TAKE CHARGE. (Stop here, discuss payment options).		

See Chart in Billing Instructions.

SECTION IV - INCOME REQUIREMENTS FOR FAMILY SIZE

Monthly Earned Income

1.	Enter your GROSS wages, tips for the last monthly pay period. (Enter zero (0) if unemployed.)	$ 0.00
2.	If you are married, enter spouse's gross monthly wages.	(plus) + 0.00
3.	Subtotal earned monthly wages.	(subtotal) = 0.00
4.	Subtract $90 if you work and $90 if your spouse works.	(minus) - 0.00
5.	Subtract any monthly work-related child or adult care expenses paid.	(minus) - 0.00
6.	Subtract all monthly court ordered Child Support payments made for a child living outside the home.	(minus) - 0.00
7.	Total earned income.	**(Earned Income Sub Total)** $ 0.00

8. You and Your Spouse's Monthly Unearned Income

	Amount		Amount
Child Support or Alimony	$ 0.00	Veterans Benefits	$ 0.00
Social Security Benefits	$ 0.00	Labor & Industries Benefits	$ 0.00
Unemployment Benefits	$ 0.00	Military Allotments	$ 0.00
Interest from bank account	$ 0.00	Other	$ 0.00

9.	Total unearned income:	**(Unearned Income Sub Total)** $ 0.00
10.	Total Monthly Income: (Use this amount on your application)	(Total of #7 and #9) $ 0.00
11.	Family size: (Include all family members living together and dependent on this income. Use this number on your application)	_____

IF YOU MEET THESE REQUIREMENTS, COMPLETE THE ATTACHED APPLICATION.
If you do not qualify for the TAKE CHARGE program, ask about other payment options.

APPLICATION FOR WASHINGTON STATE TAKE CHARGE FAMILY PLANNING SERVICES

Please print.

LAST NAME	FIRST NAME	MIDDLE INITIAL

DATE OF BIRTH (m/d/yyyy)	☐ Male ☐ Female	SOCIAL SECURITY NUMBER

ADDRESS WHERE YOU LIVE	STREET	CITY	STATE	ZIP CODE

MAILING ADDRESS (IF DIFFERENT)	STREET/PO BOX	CITY	STATE	ZIP CODE

HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER	MESSAGE TELEPHONE NUMBER

If we need to contact you about your application, where may we contact you?	PLACE	TELEPHONE NUMBER

What language do you need for written information?

My total monthly income is: (Use the amount entered in Item #10 of the worksheet) _____

My family size is: (Use the number entered in Item #11 of the worksheet). _____

DECLARATION AND SIGNATURE

I have read and understood the information in this application. I declare, under penalty of perjury,

- that I need family planning services,
- that I am a Washington resident,
- I am a US citizen, US nationalist, or a lawful permanent resident who arrived in the US 5 years prior to the date of this application.
- I do not have any health insurance that fully covers family planning services.
- I have reported all my total monthly income.

All information I gave in this application is true, correct, and complete to the best of my knowledge.

I also understand that if I am not eligible for the TAKE CHARGE program to pay for my family planning services, I need to make other arrangements to pay.

SIGNATURE OF APPLICANT	DATE

☐ I would like information about other medical programs.

FOR DEPARTMENT USE ONLY

NAME OF CLINIC/PROVIDER WHERE CLIENT IS APPLYING:

NAME OF STAFF PERSON ASSISTING CLIENT WITH APPLICATION:	TELEPHONE NUMBER	FAX NUMBER