Washington State Health Care Authority

Take Charge Application for Family Planning Services

Fax Completed Application to 1-866-841-2267

If you already have health insurance that covers family planning services, you are not eligible for Take Charge, **UNLESS you are a** (check if yes):

☐ Minor child age 18 or younger, covered under your parent's health insurance and you do not want your parents to know you are seeking family planning services.

☐ Victim of domestic violence and covered under the perpetrator's health insurance.

If you checked one of the boxes above, what is the name of your insurance? ☐ Medicare ☐ Tricare ☐ Indian Health Services ☐ Long-Term Care Insurance ☐ Other health insurance: _____

PROVIDER NAME	PROVIDER TELEPHONE NUMBER

1. FIRST NAME | MIDDLE INITIAL | LAST NAME

2. ADDRESS WHERE YOU LIVE | STREET | CITY | STATE | ZIP CODE

3. MAILING ADDRESS (if different from above): | STREET | CITY | STATE | ZIP CODE

4. TELEPHONE NUMBER(S)	HOME, CELL, PREFERRED NUMBER	WORK/MESSAGE NUMBER	E-MAIL ADDRESS

5. Do you have trouble speaking, reading, or writing English? ☐ Yes ☐ No	Do you need an interpreter? ☐ Yes ☐ No	What language do you speak?

General Information

SEX ☐ Male ☐ Female	DATE OF BIRTH	Do you intend to use a birth control method to prevent unintended pregnancy? ☐ Yes ☐ No
SOCIAL SECURITY NUMBER	U.S. CITIZEN OR NATIONAL? ☐ Yes ☐ No	If not a U.S. citizen or national, are you in the country legally? (Provide a copy of immigration documents) ☐ Yes ☐ No

6. To determine eligibility for this program, we need to know your family size (spouse and/or dependent children living with you). Including yourself, what is your family size?

7. If you are married and living with your spouse, enter spouse's name and Social Security Number (SSN) :

(First, Middle, Last): SSN

Race/Ethnic Background

8. We ask you to voluntarily tell us your race or ethnic background. This information will not be used in considering your eligibility for services.

☐ Caucasian ☐ Black or African American ☐ Vietnamese/Laotian/Cambodian ☐ Other Asian or Pacific Islander

☐ Hispanic ☐ American Indian or Alaskan Native; tribe name: _____

☐ Other: _____

Optional Authorized Representative (AREP)

(An AREP is someone you allow the department to talk with about your benefits, and/or receive Take Charge mail for you). To name an AREP, complete the information below.

NAME / ORGANIZATION | TELEPHONE NUMBER

MAILING ADDRESS | STREET | CITY | STATE | ZIP CODE

☐ Send my Take Charge mail to my address. ☐ Send my Take Charge mail to this AREP's address.

13781

CLIENT NAME	SOCIAL SECURITY NUMBER

Income

Have you quit or lost a job in the last 90 days? ☐ Yes ☐ No Date last worked	Has your spouse quit or lost a job in the last 90 days? ☐ Yes ☐ No Date last worked
Your income from employment / self-employment	**Spouse's income from employment / self-employment**
EMPLOYER NAME / TELEPHONE NUMBER	EMPLOYER NAME / TELEPHONE NUMBER
Gross income before taxes or expenses: $ _____ ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly Hours worked each week:	Gross income before taxes or expenses: $ _____ ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly Hours worked each week:

OTHER INCOME	AMOUNT	HOW OFTEN DO YOU GET THIS INCOME?	WHICH FAMILY MEMBER GETS THIS INCOME?
9. Child support or alimony			
10. Social Security payment			
11. Unemployment services			
12. Veterans services/military allotments			
13. Labor and Industries			
14. Investment Income			
15. Other Income (Examples: supported by parents, student loans)			

Expenses

	YES	NO	IF YES, AMOUNT
16. Do you pay for child care or adult dependent care while you work?	☐	☐	
17. Do you pay child support for a child who is not living in your home?	☐	☐	

Read Carefully Before Signing Below

I understand that:

- HCA may ask me to prove the information I provide. HCA may help me get the proof or contact other agencies or persons for it.
- My information may be reviewed by other state or federal agencies. This information will NOT be shared with U.S. Customs and immigration Services (USCIS).
- By asking for and receiving medical care benefits, I assign to the state of Washington all rights to any medical support, and to any third party payments for medical care.
- I understand this application is for family planning services to prevent pregnancy only. If my family needs other medical services, financial assistance, or food stamps, we must apply through a DSHS Community Services Office.

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	DATE