



Apple Health for Kids



What is Apple Health for Kids?

Apple Health for Kids is a state sponsored health insurance program available to all qualifying children in Washington State. This program offers medical, dental and vision coverage for all income eligible children regardless of immigration status.

Who qualifies for Apple Health for Kids?

- Children under age 19.
- Families who's gross monthly income is at or below the income limit (See chart below)
- If you have current health insurance, and your family's gross monthly income is at or below the income limit for free coverage. You may be eligible for secondary coverage through the state of Washington.

Total Number in Family Including yourself	Monthly income limit for Free coverage	Monthly Income limit for Low cost coverage* Cost: \$20 per child/ \$40 per family max.	Monthly Income limit for Low cost coverage* Cost: \$30 per child/ \$60 per family max.
1	\$1,815	\$2,269	\$2,723
2	\$2,452	\$3,065	\$3,678
3	\$3,089	\$3,861	\$4,633
4	\$3,725	\$4,657	\$5,588
5	\$4,362	\$5,453	\$6,543
	+ \$637 per person	+ \$796 per person	+ \$955 per person

What you need to do if you qualify for Apple Health for Kids:

- Fill out the attached application.
- Attach copies of birth certificates for all qualifying children.
- Proof of income for the last 30 days (pay stubs, letter from employer, etc.)
- Photo ID for children age 15 or older (school ID, driving permit, ID, etc.)
- Mail your completed application with copies of all your proof to:

Department of Social & Health Services
 PO Box 45531
 Olympia, WA 98504-5531

If you need assistance or have questions, please contact:
 Long Vue, MPH (360) 397-8214
 (se habla español)



 For other formats
 Clark County ADA Office, Voice (360) 397-2000
 Relay (800) 833-6384, E-mail ADA@clark.wa.gov



APPLICATION FOR CHILDREN'S MEDICAL BENEFITS



This application is for medical coverage only for children and teens under 19. Anyone can apply on behalf of a child. Children may apply on their own behalf. **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 in black or blue ink. Do not use pencil. **(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)			CITY	STATE ZIP CODE
4. TELEPHONE NUMBERS		5. Do you have trouble speaking, reading or writing English? <input type="checkbox"/> Yes <input type="checkbox"/> No		
HOME ()		What language or alternative format do you need? _____		
WORK ()		Do you need an interpreter? (If yes, we will help you through an interpreter). <input type="checkbox"/> Yes <input type="checkbox"/> No		
MESSAGE ()		What language do you speak? _____		
		6. Does a child under 19 have a medical condition that needs attention right away? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		Is anyone in your home pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		If "yes", who? _____		

General Information

7. List family members **living together**. (If needed, attach a separate sheet of paper to list more family members).

NAME (FIRST, MIDDLE, LAST)	SEX M or F	RELATION TO YOU	BIRTH DATE (MO/DA/YR)	SOCIAL SECURITY NUMBER *=-OPTIONAL	U.S. CITIZEN YES NO	PLACE OF BIRTH (CITY/STATE)	COMPLETE IF CHILD IS NOT A U.S. CITIZEN	
A. Parent, Guardian or Self				*	<input type="checkbox"/> <input type="checkbox"/>		LIST DATE CHILD ARRIVED IN U.S.	DOES CHILD HAVE A SPONSOR? YES NO
B. Spouse or Other Parent (If living in the home)				*	<input type="checkbox"/> <input type="checkbox"/>			
C. List Children & Teens Under 19 Years of Age (who want medical benefits)					<input type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/> <input type="checkbox"/>
D.					<input type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/> <input type="checkbox"/>
E.					<input type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/> <input type="checkbox"/>
F.					<input type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/> <input type="checkbox"/>
G. List Other Adults/Children in the Home (who do not want medical benefits)				*		Note: Please attach any documents showing children's status.		
				*				

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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes", how much per month? \$
Do you pay someone to take care of a disabled dependent adult while you work?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes", how much per month? \$

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Income Enter GROSS pay (before taxes or expenses).

(Please attach proof of income)

11. PARENT'S EMPLOYER NAME AND TELEPHONE NUMBER () START DATE:	OTHER HOUSEHOLD INCOME	AMOUNT RECEIVED IN LAST 30 DAYS	WHICH FAMILY MEMBER EARNS THIS INCOME?
	15. CHILD SUPPORT	\$	
12. Amount you received in the last 30 days before taxes and expenses were taken out: \$ How much of this income is from self-employment?* \$	16. ALIMONY	\$	
	17. SOCIAL SECURITY PAYMENT	\$	
	18. UNEMPLOYMENT BENEFITS	\$	
13. SPOUSE'S (OR OTHER PARENT LIVING IN THE HOME) EMPLOYER NAME AND TELEPHONE NUMBER () START DATE:	19. INVESTMENT INCOME/ INTEREST/DIVIDENDS	\$	
	20. VETERANS BENEFITS	\$	
14. Amount your spouse (or other parent living in the home) received in the last 30 days before taxes and expenses were taken out: \$ How much of this income is from self-employment?* \$	21. LABOR & INDUSTRIES	\$	
	22. MILITARY ALLOTMENTS	\$	
	23. OTHER (Please Explain):	\$	
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.	24. Do you need help paying for unpaid medical bills – within the last 3 months – for any of the children you are applying for? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please send copies of all household income for the months you would like us to review.		

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

25A. Do any of the children you are applying for already have health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	25B. If "Yes", does that health insurance cover doctor, hospital, x-ray (radiology) and laboratory services? <input type="checkbox"/> Yes <input type="checkbox"/> No	26A. Have your children been covered by job-related health insurance in the last 4 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	26B. If "Yes", did the premium cost less than \$50 per month for dependents? <input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black or African American
	<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	
	<input type="checkbox"/> White	<input type="checkbox"/> Other:	
Discrimination is prohibited in all programs and activities administered by the Department of Social and Health Services. No one shall be excluded from these programs and activities on the basis of race, color, creed, political beliefs, national origin, religion, age, sex or disability.			

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, basic food 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 Services (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	DATE

How to Submit

MAIL TO: **Department of Social and Health Services**
PO Box 45531
Olympia, WA 98504-5531



FOR HELP: If you need help or have questions, please call 1-877-543-7669

