

Washington Apple Health Application for Long-Term Care/Aged, Blind, Disabled Coverage

<p>Use this application to see what health care coverage you qualify for if:</p>	<ul style="list-style-type: none"> • You need to apply for Long-Term Care Services (nursing home care, assisted living facility, adult family home or in-home care programs) • You or someone in your household is age 65 or older • You or someone in your household has Medicare • You need help paying Medicare premiums or coinsurance costs • You or someone in your household has a disability <p>Note: If you need to apply for family, children’s, pregnancy or new adult medical contact Healthplanfinder at: www.wahealthplanfinder.org or call 1-855-923-4633</p>
<p>Apply faster online</p>	<p>You can submit this application online at www.washingtonconnection.org</p>
<p>Information you will need to apply:</p>	<ul style="list-style-type: none"> • Social security numbers • Birthdates • Immigration status • Income information • Resource information (such as bank account balances, stocks, bonds, trusts, retirement accounts)
<p>Why do we ask for so much information?</p>	<p>We ask for information in order to determine what health care coverage you qualify for. We keep the information you provide private as required by law.</p>
<p>Send your complete and signed application to:</p>	<p>For disability-based Washington Apple Health, Refugee coverage and coverage for seniors 65+, and programs that help pay for Medicare premiums and expenses</p> <ul style="list-style-type: none"> • Mail your application to: DSHS Community Services Division - Customer Service Center PO Box 11699, Tacoma, WA 98411-6699 • Fax your application to 1-888-338-7410 • Take your application to a local Community Services Office (CSO). See www.dshs.wa.gov/onlinecso/findservice.shtml for locations. • Apply online at www.washingtonconnection.org • Questions? Call 1-877-501-2233 <p>For long-term care coverage such as nursing home care, in-home personal care, assisted living facility and adult family home programs</p> <ul style="list-style-type: none"> • Mail your application to: DSHS Home and Community Services – Long Term Care Services PO Box 45826, Olympia, WA 98504-5826 • Fax your application to 1-855-635-8305 • Take your application to a local Home and Community Services (HCS) office. See http://www.alsa.dshs.wa.gov/Resources/clickmap.htm for locations. • Apply online at www.washingtonconnection.org • Questions? To locate a local HCS office see http://www.alsa.dshs.wa.gov/Resources/clickmap.htm

Health Care Coverage Rights and Responsibilities

Your rights (we must)

for all health care coverage programs

Help you read and fill out all requested forms. You can contact Washington Healthplanfinder for assistance.

Provide interpreter or translator services at no cost to you and without delay when communicating with Washington Healthplanfinder.

Keep your personal information private but we may share some information with other state and federal agencies for purposes of eligibility and enrollment.

Give you the opportunity to appeal if you disagree with a determination made during your use of Washington Healthplanfinder that affects your eligibility for a health plan, health insurance premium tax credits, or cost-sharing reductions through Healthplanfinder. By asking for an appeal, your case will be reviewed. You can find more information about the Healthplanfinder appeals process by visiting the Healthplanfinder Appeals Page at <http://wahbexchange.org/appeals/> or contacting the Healthplanfinder Customer Support Center at 1-855-923-4633.

If the appeal is for a decision on Washington Apple Health coverage, which is unresolved by a case review, you will be scheduled an Administrative Hearing.

Treat you fairly without regard to your race, color, political beliefs, national origin, religion, age, gender (including gender identity and sex stereotyping), sexual orientation, disability, honorably discharged veteran or military status, or birthplace. To file a complaint of discrimination, you contact the U.S. Department of Health and Human Services at:

- <http://www.hhs.gov/ocr/civilrights/complaints>; or
- Regional Manager, Office for Civil Rights
U.S. Department of Health and Human Services,
2201 Sixth Ave. – M/S: RX-11
Seattle, WA 98121-1831
Voice phone 800-368-1019
Fax 206-615-2297
TDD 800-537-7697

Your responsibilities (you must)

for all health care coverage programs

SSN and Immigration Status Disclosure. With some exceptions, you must provide a Social Security Number (SSN) or immigration document number of yourself or anyone else in your household who wants to apply for health care coverage. An SSN is required to apply for health insurance premium tax credits. We use this information to determine your eligibility by confirming your identity, citizenship, immigration status, date of birth, and availability of other health care coverage. We do not share this information with any immigration agency.

It is possible to apply for coverage for some members of your household, but not others. If you do not have a SSN or immigration document number for all household members, others can still apply for and get coverage. There are also some Washington Apple Health programs for people who cannot show they are in the country legally. But if you choose not to provide a SSN or immigrant document number for someone in your household, we will need to follow up with you to get information about the non-applicant's income.

If requested by the agency, provide any information or proof needed to decide if you are eligible.

Things you should know

for all health care coverage programs

There are certain state and federal laws that govern the operation of Washington Healthplanfinder, your rights and responsibilities as a user of Washington Healthplanfinder, and the coverage obtained through Washington Healthplanfinder. By using Washington Healthplanfinder, you agree to comply with these laws as they may apply to users of this website and coverage obtained hereunder.

The National Voter Registration Act of 1973 requires all states to provide voter registration assistance through their public assistance offices. Applying to register or declining to register to vote will not affect the services or benefits that you will be provided by this agency. You can register to vote at www.vote.wa.gov or order voter registration forms by calling 1-800-448-4881. **Health Insurance Portability and Accountability Act (HIPAA)** restrictions prevent the Health Care Authority (Washington Apple Health) from discussing the health information of you or any

member of your household with anyone, including an authorized representative, unless that individual has power of attorney or you have signed a consent form authorizing the disclosure of this information. This includes disclosure of mental health information, HIV, AIDS, STD test results, or treatment and chemical dependency services.

The Affordable Care Act prevents the Washington Healthplanfinder from giving the personally identifiable information (PII) of you or any member of your household to anyone who is not authorized to receive it, and without your consent.

The information that you give Washington Healthplanfinder is subject to verification by federal and state officials for purposes of determining your eligibility for health care coverage. Verification can include follow-up contacts from agency staff.

If you begin completing an application for health insurance on Healthplanfinder and do not complete the process for any reason, your information will be stored in Healthplanfinder and accessible by you for 90 days. If you do not complete an application after the 90-day period, your information will be deleted from the Healthplanfinder system.

Washington Healthplanfinder is not responsible for administering your health insurance plan. Your health insurance carrier can provide you more information about your benefits. **If you have questions about the terms of your health insurance plan, including what benefits you are eligible for, out of pocket expenses under your plan, and making a benefit claim or appealing a denial of benefits, you should contact your health insurance carrier.** If you are eligible for COBRA following the termination of any health insurance coverage purchased through Healthplanfinder, administering COBRA and providing you the required COBRA notices and election periods is your employer's responsibility.

Do not cancel any current insurance coverage or decline any COBRA benefits until you receive an approval letter and insurance policy, also known as insurance contract or certificate, from the insurance carrier you selected. Make sure you understand and agree with the terms of the policy, pay special attention to the effective date, waiting periods, premium amount, benefits, limitations, exclusions, and riders.

You may apply for support enforcement services through the Division of Child Support (DCS).

To get an application for these services, go to www.childsupportonline.wa.gov or contact your local DCS office.

Your rights (we must) for Washington Apple Health only

Explain to you your rights and responsibilities if you ask.

Allow you to submit a partial application that includes at minimum, your name, address, and signature or the signature of the applicant's authorized representative. The day we get a partial application is your application date, which may affect when your coverage becomes effective. We will not make a final decision about your coverage until after you complete the application.

Allow you to submit an application or partial application using any method listed under WAC 182-503-0010.

Process your application promptly and no later than the timelines described in WAC 182-503-0060.

Give you 10 calendar days to provide information we need to determine eligibility. If you ask for more time, we will give you more time. If you don't give us the information or ask for more time, we may deny, close, or change your healthcare coverage.

Help you if you have trouble getting any information or proof needed for us to decide if you are eligible. If we require a document that will cost you money, we will send for it and pay the cost.

Notify you, in most cases, at least 10 days before we stop your healthcare coverage.

Give you a written decision, in most cases, within 30 days. Health care coverage for some disability cases may take 45 to 60 days. We give a written decision on pregnancy medical within 15 days.

Allow you to refuse to speak to an investigator if we audit your case. You do not have to let an investigator into your home. You may ask the investigator to come back at another time. Such a request will not affect your eligibility for health care coverage.

Continue Washington Apple Health coverage while we decide if you are eligible for another program per WAC 182-504-0125.

Give you equal access services as described in WAC 182-503-0120 if you are eligible.

Your responsibilities (you must) for Washington Apple Health only

Report changes as required in WAC 182-504-0105 and WAC 182-504-0110 within 30 days of the change.

Complete renewals when asked.

Give medical providers information needed to bill us for health care services.

Apply for Medicare if you are entitled to it.

Cooperate with Quality Assurance staff when asked.

Apply for and make a reasonable effort to get potential income from other sources when you ask for or receive Washington Apple Health coverage.

Things you should know for Washington Apple Health only

By asking for and receiving Washington Apple Health, you give the state of Washington all rights to any medical support and to any third party payments for health care.

The Agency may share your child's immunization history with the Child Profile Immunization Tracking System.

Information you report may be provided to the Department of Social and Health Services to determine eligibility and monthly benefits for programs such as health care coverage, cash assistance, food assistance and child care subsidies.

By law (RCW 41.05A.090 and WAC 182-527), if you are age 55 or older AND receive Washington Apple Health services, the Health Care Authority (HCA) may take from your estate (assets you own at the time of death) the amount of costs we paid for certain types of health care assistance, such as nursing home care or long-term care. (HCA may recover the costs for state-only funded long-term care services received at any age.) This is called ESTATE RECOVERY. You can find a full list of the types of health care assistance subject to estate recovery at WAC 182-527-2740 and WAC 182-527-2742.

Estate Recovery does not occur until after death and the death of your surviving spouse, if any. We may also file a pre-death lien for recovery after death, subject to requirements of 42 U.S. Code 1396p. Tribal lands and certain properties belonging to American Indians and Alaskan Natives may be exempt from recovery (WAC 182-527-2754). If you have dependent heirs, estate recovery may be delayed for some hardship reasons.

You may be restricted to one health care provider, pharmacy, and/or hospital if you seek out unnecessary health care services from providers.

Things you should know for qualified health plans only

If you enroll in a qualified health plan through Healthplanfinder and you do not provide enough information for Healthplanfinder to verify your eligibility to purchase a plan or receive a reduced-cost plan, or if any information you provide is not verifiable, you will have 90 days to provide further information to satisfy Washington Healthplanfinder's eligibility requirements. During this time, you should work with Healthplanfinder staff to try to provide any missing information or resolve any inconsistencies so that your coverage and applicable costs may be effective as soon as possible.

If you enroll in a qualified health plan through Healthplanfinder and you have a change in income, you should notify Healthplanfinder as soon as possible. A change in income could change the tax subsidies or cost-sharing reductions for which you are eligible. You could be eligible for a lower-cost plan following a change of income, or you could be required to pay back a portion of a tax subsidy you receive if your income increases and you do not report the change.

Rates shown are subject to change based on the health insurance carrier's underwriting practices and your selection of available optional benefits, if any. Final rates are always determined by the health insurance carrier.

Rates shown are for your requested effective date ONLY. If the actual effective date of your policy is different from your requested effective date, the actual cost of your policy may differ from the rates above, due to rate increases or policy changes from the insurance company and/or one or more family members having a birthday. (Rates are highly dependent on age.) The carrier you selected may not guarantee their rates for any period of time.

You consent to the Washington State Employment Security Department's release of your wage and employment data to Washington Healthplanfinder. You acknowledge that granting this consent will help to simplify the application and redetermination process for Washington Healthplanfinder. Your personal information will be protected as described in the Healthplanfinder Privacy Policy.

Washington Apple Health Application for Long-Term Care/Aged, Blind, Disabled Coverage

Applicant Name and Contact Information			
1. First name	Middle initial	Last name	2. ACES Client ID number
Signature of Applicant or Authorized Representative (Required) _____			
3. Address Where You Live			
County	City	State	Zip Code
4. Mailing Address (if Different)			
County	City	State	Zip Code
5. Primary Phone Number <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work ()			
6. Secondary Phone Number <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work ()			
7. Email Address			
If living in a facility, list the facility name and address, if not the same as above:			
8. Name of Facility			
9. Address of Facility			
County	City	State	Zip Code
Programs Applying for:			
10. I, my spouse, or someone in my household is applying for:			
<input type="checkbox"/> Health Care Coverage for Aged, Blind, or Disabled	<input type="checkbox"/> Help with medical bills (from last three months)		
<input type="checkbox"/> Medicare Savings Program	<input type="checkbox"/> Healthcare for Workers with Disabilities (HWD)		
<input type="checkbox"/> In-Home caregiver services	<input type="checkbox"/> Hospice care		
<input type="checkbox"/> Nursing Home care	<input type="checkbox"/> Assisted Living Facility/Adult Family Home		
Language Information			
11. <input type="checkbox"/> I need an interpreter. I speak: _____ or <input type="checkbox"/> sign; translate my letters into: _____			



Information About Your Family

12. List everyone in your household even if you are not applying for them (attach additional sheets, if necessary).

					Optional for Non-Applicants			
Name (First, Middle, Last)	Sex M or F	How is This Person Related to You?	Date of Birth	Check if You Want Coverage for This Person	Social Security Number	Check if U.S. Citizen	Race (See Examples Below)	Tribe Name (For American Indians, Alaska Natives)
		Myself		<input type="checkbox"/>		<input type="checkbox"/>		
				<input type="checkbox"/>		<input type="checkbox"/>		
				<input type="checkbox"/>		<input type="checkbox"/>		
				<input type="checkbox"/>		<input type="checkbox"/>		
				<input type="checkbox"/>		<input type="checkbox"/>		
				<input type="checkbox"/>		<input type="checkbox"/>		

I. General Information

My ethnic background is Hispanic or Latino: Yes No

Race and Ethnic background information is voluntary. **Race examples:** White, Black or African American, Asian, Native Hawaiian, Pacific Islander, American Indian, Alaska Native, or any combination of races.

- In the past 30 days, I, my spouse, or someone in my household received health care coverage from another state, tribe or other source? Yes No
- I, my spouse, or someone in my household received Supplemental Security Income (SSI) in another state?
 Yes No If yes, who? _____
- I, my spouse, or someone in my household is a sponsored alien?
 Yes No If yes, who? _____
- I, my spouse, or someone in my household served in the military?
 Yes No If yes, who? _____
- I, my spouse, or someone in my household is the dependent or spouse of someone (living or deceased) who served in the military? If yes, who? Yes No
- I have a tax dependent I have not yet included on my application who does not live with me?
 Yes No
If yes, list tax dependent's name(s): _____
- I am: Single Married living with spouse Married living apart from spouse Divorced Widowed
 In a registered Domestic Partnership Legally separated

II. Earned Income (Attach Proof)

1. I, my spouse, or someone I'm applying for has income from work? Yes No If yes, please complete this section.
Note: American Indians/Alaska Natives do not have to report certain income including: Alaska Native Corporations and Settlement Trusts; distributions from property held in trust; distributions and payments from fishing, natural resource extraction and harvests; distributions from ownership of natural resources and improvements; payments from ownership of items that have unique religious, spiritual, traditional, or cultural significance according to Tribal Law or custom; and student financial assistance from Bureau of Indian Affairs education programs.

2. Who earns this Income: _____	Gross amount received (Dollar amount before deductions)
Employer's Name and Phone Number	\$ _____ every: <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Two Weeks <input type="checkbox"/> Twice a Month <input type="checkbox"/> Month
Start Date	Hours per week: _____
Is this job Self-Employment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Pay dates (e.g. 1 st and 15 th , or every Friday): _____

3. Who earns this Income: _____	Gross amount received (Dollar amount before deductions)
Employer's Name and Phone Number	\$ _____ every: <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Two Weeks <input type="checkbox"/> Twice a Month <input type="checkbox"/> Month
Start Date	Hours per week: _____
Is this job Self-Employment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Pay dates (e.g. 1 st and 15 th , or every Friday): _____

III. Other Income (Use for all Household Members) (Attach Proof)

1. Examples of other income are:
- Child Support or Spousal Maintenance
 - Educational benefits (Student Loans, Grants, Work-Study) Gaming Income
 - Gifts (Cash Support/Gift Cards)
 - Interests/Dividends
 - Labor and Industries (L&I)
 - Railroad Benefits
 - Rental Income
 - Retirement or Pension
 - Sales Contracts/Promissory Notes
 - Social Security
 - Supplemental Security Income (SSI)
 - Tribal Income
 - Trusts
 - Unemployment Benefits
 - Veteran Administration (VA) or Military Benefits
 - Other

2. List other income you, your spouse, or anyone you are applying for receives:

Unearned Income Type	Who Gets the Income	Gross Monthly Amount	Who Gets the Income	Gross Monthly Amount
		\$		\$
		\$		\$
		\$		\$
		\$		\$
		\$		\$
		\$		\$

3. I, my spouse, or someone in my household receives income from an annuity investment? Yes No

Who Owns the Annuity	Company or Institution	Amount or Value	Monthly Income	Date Purchased
		\$	\$	

IV. Housing Expenses (Attach proof if applying for LTC services and you are married)

Rent \$	Mortgage \$	Space Rent \$	Homeowners Insurance \$	Property Taxes \$	Other Fees \$
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Another person or agency, such as subsidized housing, helps me pay either all or part of these expenses: Yes No

If yes, who: _____

V. Deductions						
1. I, my spouse, or someone I am applying for pays or is supposed to pay:						
			Monthly Amount	Who Pays		
Child or adult dependent care			\$			
Court ordered child support			\$			
Payee fees			\$			
Guardianship fees			\$			
Court ordered attorney fees			\$			
Recurring medical expenses (include Medicare or other health insurance premiums you pay)			\$			
2. I, my spouse, or someone I am applying for owes medical expenses?						
	Medical Expense Type	Date Incurred	Amount Owed	Who Owes		
			\$			
			\$			
			\$			
3. I, my spouse, or someone I am applying for has a disability and is working and has expenses that support employment? These are called impairment related work expenses (IRWE). <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give IRWE amount \$ _____						
VI. Resources (Attach Proof) (Skip this section if only applying for Healthcare for Workers with Disabilities)						
1. A resource is anything you own or are buying that can be sold, traded, or converted into cash or money held by others. A resource does not include personal property such as furniture, or clothing. Examples of resources are:						
• Cash	• Mutual funds	• Houses, including the one you live in	• Life insurance			
• Checking accounts	• Stocks	• Burial funds	• Prepaid funeral plans			
• Savings accounts	• Annuities	• Condominium	• College funds			
• CDs	• Trusts	• Land	• Time-share			
• Money market account	• IRA	• Sales contracts	• Business equipment			
• Savings bonds	• 401K	• Buildings	• Farm equipment			
• Bonds	• Retirement fund	• Life estate	• Livestock			
2. List the resources you, your spouse, or anyone you are applying for owns or is buying:						
Resource Type	Who Owns	Location	Value	Who Owns	Location	Value
			\$			\$
			\$			\$
			\$			\$
			\$			\$
			\$			\$
			\$			\$
3. I, my spouse, or someone I'm applying for has cars, trucks, vans, boats, RVs, trailers, or other motor vehicles:						
Year (e.g., 2010)	Make (e.g., Ford)	Model (e.g., Escort)	Check if Leased	Check if Used for Medical Purposes	Amount Owed	
			<input type="checkbox"/>	<input type="checkbox"/>	\$	
			<input type="checkbox"/>	<input type="checkbox"/>	\$	

VII. Additional Long-Term Care Resource Questions (Complete only if you are applying for LTC)

1. I, my spouse, or someone I am applying for owns or is buying a home which is a primary residence:

Property Address	Current Value (Per Assessor)	Loan Amounts Owed on the Property
	\$	\$
	\$	\$

2. I, my spouse, or someone I am applying for has sold, traded, given away, or transferred a resource in the last five years (including, property, trusts, vehicles, cash or life estates)? Yes No If yes, complete the following: (attach additional sheets, if necessary)

Type of Resource	Date of Transfer	Value of Resource Transferred	Who Was it Transferred to
		\$	
		\$	

VIII. Long-Term Care Insurance (Not needed for Medicare Savings Program)

I/we have long-term care insurance? Yes No Is this a qualified LTC Partnership (LTCP) policy? Yes No

If yes, please list the name(s) of the insurance company and who the policy covers.

Insurance Company	Policy Number	Policy Holder's Name	Covered Person	Dollar value (if LTCP)
				\$
				\$

IX. Authorized Representative Information

An authorized representative is any adult who is aware of the household circumstances and is authorized by the household to act on behalf of the household for eligibility purposes.

By designating an authorized representative, you are giving permission for your authorized representative to:

- Sign the application on your behalf;
- Receive notices related to your application and account; and
- Act on your behalf for all matters related to the application and account.

1. Are you designating an authorized representative? Yes No
2. Do you want your authorized representative to receive notices related to your application and account? Yes No
3. Does this authorized representative have legal guardianship? Yes No If yes, who: _____
4. Does this authorized representative have power of attorney? Yes No If yes, who: _____

Authorized Representative Name / Organization

Phone Number
()

Mailing Address of Authorized Representative

E-mail Address

X. Read Carefully Before Signing

Repaying the State for Health Care Coverage and Long-Term Care:

By law, if you receive long-term care services, Health Care Authority (HCA) may recover from your estate (assets you own at the time of your death) to repay HCA for the costs of long-term care (including Washington Apple health (Medicaid) personal care services). Medicare cost sharing expenses paid by Medicare Savings Program are exempt. HCA may recover the costs for state-only funded long-term care services received at any age. These are called estate recovery. Tribal lands may be exempt from recovery.

Long-Term Care services include COPES, Washington Apple Health (Medicaid) Personal Care, nursing home services, adult day health, private duty nursing, and Developmental Disabilities Administration (DDA) and Home and Community based Services (HCBS) waivers along with other services provided by Home and Community Services and the Developmental Disabilities Administration. See WAC 182-527-2742.

Estate recovery doesn't occur until after your death and the death of your surviving spouse, if any. If you have dependent heirs, estate recovery may be delayed for some hardship reasons.

If you are permanently living in a nursing home or other medical facility, HCA may file a lien against your property to repay the costs of health care coverage, medical services, and long-term care you received. If you return home, HCA will release the lien. HCA won't file a lien against your home if:

- Your spouse lives there.
- Your child who is blind, disabled, or under 21 lives there.
- Your sibling who has an equity interest in the home lives there and has lived there for at least one year immediately before you entered the facility.
- You receive Supplemental Security Income (SSI) or LTC services under a MAGI-based Washington Apple Health program.

Assignment of Rights and Cooperation:

You understand that you assign third party payments for medical care to the State of Washington when you receive Washington Apple Health coverage. This means that the State of Washington will bill any other insurance plan that is legally obligated to cover any of your medical expenses (this could be the insurance plan of an ex-spouse or a parent that you no longer live with). The subscriber of that insurance plan could receive information about your medical expenses that are paid by that plan. If you are afraid that this could endanger you or your children, you can ask us not to pursue third party payments for medical care.

Annuity Disclosure:

If you or your spouse has an interest in an annuity and you accept Washington Apple Health (Medicaid) Long-Term Care benefits, you must name the State of Washington as a remainder beneficiary of the annuity.

Administrative Hearing Rights:

If you disagree with a decision we have made regarding your health care coverage or long-term care services, you have the right to appeal the decision through the administrative hearing process. You may also ask a supervisor and administrator to review the disputed decision or action without affecting your rights to an administrative hearing.

Declaration and Signature

I have read and understood the information in this application. I declare, under penalty of perjury under the laws of the State of Washington, that the information I have given in this application, including the information concerning citizenship and immigration status of the members applying for benefits, is true, correct, and complete to the best of my knowledge.

Signature of Applicant or Authorized Representative

Date _____

Printed Name of Applicant or Authorized Representative