Washington State Department of Social & Health Services
MPA Medicaid Purchasing Administration

Take Charge Application for Family Planning Benefits

Fax Completed Application to 1-866-841-2267

PROVIDER NAME	PROVIDER TELEPHONE NUMBER

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.

1. FIRST NAME	MIDDLE INITIAL	LAST NAME

2. ADDRESS WHERE YOU LIVE	STREET	CITY	STATE	ZIP CODE

3. I WANT MY TAKE CHARGE MAIL SENT TO:	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

YOUR NAME	FIRST	MIDDLE	LAST

SEX ☐ Male ☐ Female	DATE OF BIRTH	Do you want Family Planning Benefits? ☐ 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 (First, Middle, Last):

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 benefits.

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

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

☐ Other: ______________________

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 benefits			
12. Veterans benefits/military allotments			
13 Labor and Industries			
14. Investment Income			
15. Other Income (explain):			

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:

- DSHS may ask me to prove the information I give is correct. I can ask DSHS for help in getting proof.
- 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 benefits to prevent pregnancy only. If my family needs other medical benefits, 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