



Health For All

HELPING PEOPLE FIND HEALTHCARE

Maternity Medical

To speed up the application be sure check off and provide the following:

- Signed and dated Health For All release form so that Health For All can act as your advocate.
- Signed and dated Application. Answer all questions, using N/A if not applicable.
- Include **PROOF OF INCOME** such as pay stubs etc. If you are self employed, your last year's tax forms (including all schedules) may be used as proof of income.
- Include **SOCIAL SECURITY NUMBER** for the pregnant woman. DO NOT put in a false or made-up one.
- Include **PROOF OF PREGNANCY** from a licensed medical provider if you have it, such as a doctor, nurse, or lab technician. DO NOT submit a home test as proof of pregnancy.

IMPORTANT - Keep a copy of entire application packet for your records and date when mailed to State.

If you have any questions, Call Health For All at **444-3066 or 1-866-444-3066** (outside of Spokane calling area)

As your advocate and DSHS contractors, you may send your application to us to check for completeness, keep a copy for future reference and forward it on to DSHS at:

Health For All Community-Minded Enterprises
25 W Main Ave Suite 300
Spokane, WA 99201

Or

Send your application directly to your local DSHS office.

Application for Pregnancy Medical Benefits

1. FIRST NAME	MIDDLE INITIAL	LAST NAME
2. ADDRESS WHERE YOU LIVE	STREET	CITY STATE ZIP CODE
3. MAILING ADDRESS (IF DIFFERENT)	STREET	CITY STATE ZIP CODE
4. PHONE NUMBERS / E-MAIL ADDRESS	5. YES NO	
HOME / CELL / PREFERRED NUMBER	Do you have trouble speaking, reading or writing English? <input type="checkbox"/> YES <input type="checkbox"/> NO	
WORK / MESSAGE	Do you need an interpreter? (If yes, we will communicate through an interpreter.)..... <input type="checkbox"/> YES <input type="checkbox"/> NO	
E-MAIL ADDRESS	What language do you speak?	

6. Expected date of delivery: _____ If unknown, please estimate: _____
 How was pregnancy verified: Home pregnancy test Doctor Health department
 Other: _____

7. Does the pregnant woman have a medical condition which needs medical attention right away? Yes No

General Information

8. List yourself and everyone living at your address. Use legal names. Do not use nicknames. If you do not know a Social Security Number, leave it blank.

NAME (FIRST, MIDDLE, LAST)	SEX M or F	RELATIO N TO YOU	BIRTH DATE (MO/DA/YR)	SOCIAL SECURITY NUMBER	U.S. CITIZEN YES NO	PLACE OF BIRTH (CITY/STATE)	COMPLETE IF <u>NOT</u> A U.S. CITIZEN	
							LIST DATE ARRIVED IN U.S.	DO YOU HAVE A SPONSOR? YES NO
A.		SELF			<input type="checkbox"/> YES <input type="checkbox"/> NO			<input type="checkbox"/> YES <input type="checkbox"/> NO
B.					<input type="checkbox"/> YES <input type="checkbox"/> NO			<input type="checkbox"/> YES <input type="checkbox"/> NO
C.					<input type="checkbox"/> YES <input type="checkbox"/> NO			<input type="checkbox"/> YES <input type="checkbox"/> NO
D.					<input type="checkbox"/> YES <input type="checkbox"/> NO			<input type="checkbox"/> YES <input type="checkbox"/> NO
E.					<input type="checkbox"/> YES <input type="checkbox"/> NO			<input type="checkbox"/> YES <input type="checkbox"/> NO
F.					<input type="checkbox"/> YES <input type="checkbox"/> NO			<input type="checkbox"/> YES <input type="checkbox"/> NO

Please attach any documents showing immigration status.

Health Insurance and Medical Information

9. Do you already have health insurance? Yes No If yes, we may be able to pay the premium.
 If you checked "yes", list the name of your insurance company or employer, the policy number and the policy holder's name and social security number. Even if you already have health insurance, you can still qualify for medical benefits.

INSURANCE COMPANY OR EMPLOYER	POLICY NUMBER	POLICY HOLDER'S NAME	POLICY HOLDER'S SSN

10. Did anyone in the home receive medical services in the past three (3) months including Maternity Support Services and/or Maternity Case Management? Yes No



Income

Your income from employment / self-employment		Spouse's income from employment / self-employment	
11. Employer name and phone number		13. Employer name and phone number	
12. Gross income before taxes or expenses: _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Every two weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly Hours worked each week:		14. Gross income before taxes or expenses: _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Every two weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly Hours worked each week:	
OTHER INCOME	AMOUNT	HOW OFTEN DO YOU GET THIS INCOME?	WHICH FAMILY MEMBER GETS THIS INCOME?
15. Child support or alimony			
16. Social Security payment			
17. Unemployment benefits			
18. Veterans benefits/military allotments			
19. Labor and Industries			
20. Investment Income/other (explain):			

Expenses

	YES	NO	IF YES, AMOUNT
9. Do you pay for child care or adult dependent care while you work?	<input type="checkbox"/>	<input type="checkbox"/>	_____
10. Do you pay child support for a child who is not living in your home?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Race/Ethnic Background

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 Hispanic American Indian or Alaskan Native; tribe name: _____
 Vietnamese/Laotian/Cambodian Other Asian or Pacific Islander Other: _____

Read Carefully Before Signing Below

I understand that:

- I must immediately report to the Department of Social and Health Services (DSHS), in writing or by telephone, any changes in my situation. Late reporting may cause incorrect benefits.
- My situation is subject to verification by DSHS or other state or federal agencies.
- I must provide proof I am eligible for help. DSHS may help me obtain the proof or contact other persons or agencies for it.
- 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.
- DSHS may share my child's immunization history with the Department of Health's Child Profile Immunization Tracking System for purposes directly connected to the administration of medical programs.
- **I understand this application is for medical benefits for the pregnant woman only. If my family needs 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
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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.

CONSENT

NOTICE TO CLIENTS: The Department of Social and Health Services (DSHS) can help you better if we are able to work with other agencies and professionals that know you and your family. By signing this form, you are giving permission for DSHS and the agencies and individuals listed below to use and share confidential information about you. DSHS cannot refuse you benefits if you do not sign this form unless your consent is needed to determine your eligibility. If you do not sign this form, DSHS may still share information about you to the extent allowed by law. If you have questions about how DSHS shares client confidential information or your privacy rights, please consult the DSHS Notice of Privacy Practices or ask the person giving you this form.

CLIENT IDENTIFICATION:

NAME		DATE OF BIRTH	IDENTIFICATION NUMBER	
ADDRESS		CITY	STATE	ZIP CODE
TELEPHONE NUMBER (INCLUDE AREA CODE)	OTHER INFORMATION			

CONSENT:

I consent to the use of confidential information about me within DSHS to plan, provide, and coordinate services, treatment, payments, and benefits for me or for other purposes authorized by law. I further grant permission to DSHS and the below listed agencies, providers, or persons to use my confidential information and disclose it to each other for these purposes. Information may be shared verbally or by computer data transfer, mail, or hand delivery.

Please check all below who are included in this consent in addition to DSHS and identify them by name and address:

- Health care providers: _____
- Mental health care providers: _____
- Chemical dependency service providers: _____
- Other DSHS contracted providers: _____
- Housing programs: _____
- School districts or colleges: _____
- Department of Corrections: _____
- Employment Security Department and its employment partners: _____
- Social Security Administration or other federal agency: _____
- See attached list
- Other: **Health For All (AREP) - 25 W Main, Ste 310, Spokane, WA 99201**

I authorize and consent to sharing the following records and information (check all that apply):

- All my client records
- Records on attached list
- Only the following records

<input type="checkbox"/> Family, social and employment history	<input type="checkbox"/> Health care information	<input type="checkbox"/> Treatment or care plans
<input type="checkbox"/> Payment records	<input type="checkbox"/> Individual assessments	<input type="checkbox"/> School, education, and training
<input type="checkbox"/> Other (list): _____		

PLEASE NOTE: If your client records include any of the following information, you must also complete this section to include these records.

I give my permission to disclose the following records (check all that apply):

- Mental health
- HIV/AIDS and STD test results, diagnosis, or treatment
- Chemical Dependency (CD) services

- This consent is valid for one year as long as DSHS needs records, or until _____ (date or event).
- I may revoke or withdraw this consent at any time in writing, but that will not affect any information already shared.
- I understand that records shared under this consent may no longer be protected under the laws that apply to DSHS.
- A copy of this form is valid to give my permission to share records.

SIGNATURE	DATE	AGENCY CONTACT/WITNESS SIGNATURE	DATE
PARENT OR OTHER REPRESENTATIVE'S SIGNATURE (IF APPLICABLE)		TELEPHONE NUMBER (INCLUDE AREA CODE)	DATE
		509-444-3066	

If I am not the subject of the records, I am authorized to sign because I am the: (attach proof of authority)

- Parent
- Legal Guardian (attach court order)
- Personal representative
- Other:

NOTICE TO RECIPIENTS OF INFORMATION: If these records contain information about HIV, STDs, or AIDS, you may not further disclose that information without the client's specific permission. If you have received information related to drug or alcohol abuse by the client, you must include the following statement when further disclosing information as required by 42 CFR 2.32:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

INSTRUCTIONS FOR COMPLETION OF CONSENT FORM

Purpose: Use this form when you need consent to use confidential information on a continuing basis about a client within DSHS or to disclose that information to other agencies to coordinate services or for treatment, payment or agency operations or for other purposes recognized by law. Clients are persons receiving benefits or services from DSHS.

Use: Fill out this form electronically if possible for ease of reading, **A separate form must be completed for each person, including children.** "You" in the instructions refers to the DSHS employee and "you" on the form refers to the client. Sharing of records includes the use and disclosure of confidential information about a client.

Parts of Form:

IDENTIFICATION:

- **Name:** Provide the name of one client only on each form. Include any former names that client may have used when receiving services.
- **Date of Birth:** Needed to identify client from persons with similar names.
- **Identification Number:** Provide a client identification number or other identifier such as a social security number (not required) to assist in identifying records and tracking history and services received.
- **Address and telephone:** Additional information that will help in locating and identifying or contacting the client.
- **Other:** Include in this box any additional information that may help to locate records that may include parts of DSHS involved with services, names of family members, or other relevant information.

CONSENT (AUTHORIZATION):

- **Agencies or persons exchanging records:** The client's completion of this form allows the use and sharing of confidential information within all of DSHS. DSHS will be able to disclose to and receive confidential information from the outside agencies or persons listed. Provide identifying information about the agencies or providers, including name, address or location if possible. You may also attach a list of agencies allowed to share information which the client must also sign.
- **Information included:** Clients must indicate what records are covered by the consent. Clients may make all records available or may limit the included records by date, type or source of record. If a client does not sign a consent or does not specify a particular record, sharing of that record will still be allowed if permitted by law. You may attach a list of covered records that the client must also sign. If any records include information relating to mental health (RCW 71.05.620), HIV/AIDS or STD testing or treatment (RCW 70.24.105), or drug and alcohol services (42 CFR 2.31(a)(5)), the client must mark these areas specifically to give permission to share these records. This form is not valid to include psychotherapy notes under 45 CFR 164.508(b)(3)(ii) and a separate form must be completed to include those records.
- **Duration:** Include an expiration date for the consent that serves your program purposes or as provided by law.
- **Understanding:** Be sure the client understands what permission is being granted and how and why information will be shared. If needed, use a translated form and interpreter or read the form aloud. If the client needs more information, provide an additional copy of the DSHS Notice of Privacy Practices or refer the client to the public disclosure officer for your unit

SIGNATURES:

- **Client:** Have client or a child over age of consent (13 for mental health and drug and alcohol services; 14 for HIV/AIDS and other STDs; any age for birth control and abortions; 18 for health care and other records) sign this box and insert the date of signature. The client may substitute a mark in this box that you witness.
- **Agency Contact or Witness:** You will sign in this box if you are the one presenting and explaining the form to the client. Please include your telephone number. If the client will be signing the form away from a business site, instruct the client to have a witness sign in this block and provide a telephone number. A notary public may serve as a witness to a client signature.
- **Parent or Other Representative:** If the client is a child under the age of consent, a parent or guardian must sign. If the child does not meet the age of consent for all records to be shared, both the child and the parent must sign. If the client has been declared legally incompetent, the court appointed guardian must sign and provide a copy of the order of appointment. If someone is signing in another capacity (including a person with a power of attorney or an estate representative), mark "other" and obtain a copy of the legal authority to act. The person signing must date the signature and give a telephone number or contact information.