



Is this for renewal? Yes No

HEALTH INSURANCE PARTNERSHIP

Subsidy Application

NOTE Use blue or black ink to complete this application. Your Social Security number (SSN) is voluntary. If you do not provide your SSN, we will assign an ID number to you. We depend on your SSN for verifying income with certain sources, and for coordinating benefits with your carrier.

Section 1: Employee Information					If you need an interpreter call 1-800-377-0926					
Applicant's last name			First name			MI				
Residential address required; must attach proof			Apt. #	City		County		State	ZIP Code	
Mailing address or P.O. Box (if different from above)			City		County		State	ZIP Code		
Home phone number () ()		Other phone number () ()		Marital status (check one) <input type="checkbox"/> Single <input type="checkbox"/> Divorced/Legally Separated <input type="checkbox"/> Legally Married - Date of marriage:						
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Social Security number (optional)				Birth date / /				
E-mail address										
If the document you are submitting for proof of residence has a different address than the address on this application, please explain why.										

Section 2: Spouse Information			Complete this section for legal spouse, even if not requesting subsidy.							
Spouse's last name			First name			MI				
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Social Security number (optional)				Birth date / /				

Section 3: Legal Dependents			Complete this section for legal dependents, even if not requesting subsidy.								
List all of your legal dependents, under age 19, even if you do not want a HIP subsidy for them or they are not living in your home. Do not list foster children. If you are applying for subsidy for your unmarried, legal dependents between the ages of 19-25, you must list them below. (If more than four, list on a separate sheet or copy this page.)											
1	Last name, first name, MI				Relationship to applicant <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other:						
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Social Security number (optional)				Birth date / /					
Applying for a HIP subsidy? <input type="checkbox"/> Yes <input type="checkbox"/> No			Does dependent have a disability? <input type="checkbox"/> Yes <input type="checkbox"/> No								
2	Last name, first name, MI				Relationship to applicant <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other:						
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Social Security number (optional)				Birth date / /					
Applying for a HIP subsidy? <input type="checkbox"/> Yes <input type="checkbox"/> No			Does dependent have a disability? <input type="checkbox"/> Yes <input type="checkbox"/> No								
3	Last name, first name, MI				Relationship to applicant <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other:						
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Social Security number (optional)				Birth date / /					
Applying for a HIP subsidy? <input type="checkbox"/> Yes <input type="checkbox"/> No			Does dependent have a disability? <input type="checkbox"/> Yes <input type="checkbox"/> No								
4	Last name, first name, MI				Relationship to applicant <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other:						
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Social Security number (optional)				Birth date / /					
Applying for a HIP subsidy? <input type="checkbox"/> Yes <input type="checkbox"/> No			Does dependent have a disability? <input type="checkbox"/> Yes <input type="checkbox"/> No								

CHILDREN'S MEDICAL COVERAGE: Your children may qualify for the new Apple Health for Kids program or other low-cost health care coverage, including programs that can help pay for health insurance premiums. For more information, please call the toll-free phone numbers below.

DSHS Apple Health for Kids Program:
1-877-543-7669 (www.applehealthforkids.wa.gov)

DSHS Premium Payment Programs:
1-800-794-4360 Option 3

Section 4: Employment Information

Fill in the following information for all current employers for yourself and your spouse, if legally married.
If you need more room, use a separate sheet and include your full name and address.

Applicant	Employer/company name		
	Employer address		
	Employer phone number ()	Date you started working for this employer	
	Have you changed employers in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has your income changed in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Briefly explain why you had a change in employers and/or income in the last 12 months.		
Spouse	Employer/company name		
	Employer address		
	Employer phone number ()	Date started working for this employer	
	Changed employers in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	Income changed in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Briefly explain why there was a change in employers and/or income in the last 12 months.		
Legal Dependent, age 19-25	Employer/company name		
	Employer address		
	Employer phone number ()	Date started working for this employer	
	Changed employers in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	Income changed in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Briefly explain why there was a change in employers and/or income in the last 12 months.		

Section 5: Family Gross Income

How is Family Income Calculated?

The HIP requires proof of income from all sources to get the best picture of your family gross income. "Family Gross Income" means total cash receipts, before taxes, received by an applicant, spouse, and adult dependent. Some income received by dependent children is also counted. All income documents must show:

- Recipient's name;
- The time period for which the income was paid or earned;
- The date the income was paid;
- Gross income amounts

Required Documentation:

- Your IRS Form 1040 (or an IRS transcript of your federal income tax form) for the most recent tax year.
- If you, your spouse, or dependent didn't file a tax return, you must submit a **Declaration of Non-filing** with the subsidy application. In these cases, the HIP will require income documentation listed in Section 7. The HIP will also require pay stubs for the past 90 days and will average the wages over three months.

When pay stubs cannot be provided, the HIP may accept:

- A signed, dated statement from the employer (the statement must include the employee's name, pay period(s), pay date(s), and amount of gross income.

Do not mail originals to the HIP; they will not be returned to you.

To request a transcript of your federal income tax form, call the IRS at 1-800-829-1040.

Section 6: Declaration of Non-filing

Please explain why you or your family members did not file a tax return with the Internal Revenue Service (IRS) for the most recent tax year:

My signature below certifies that I have provided all available family income documentation as requested by the HIP. I did not file an income tax return with the Internal Revenue Service for the most recent tax year for the reason stated above.

X _____ Date _____
Applicant's Signature

X _____ Date _____
Spouse's Signature

X _____ Date _____
Legal Dependent's Signature (age 19-25)

Section 7: Acceptable Income Documentation

Please provide Income documentation if you did not file a tax return. Only items specifically identified below will be counted as Income.

Do not mail originals to the HIP; they will not be returned to you.

Income type	Documentation
Wages, salary, tips, commissions <ul style="list-style-type: none"> • Overtime • Housing/travel allowance, if included in net pay • Bonuses, strike benefits 	<ul style="list-style-type: none"> • Copy of pay stub(s) • Signed and dated letter from the employer
Self-employment Income (Non-farm and Farm)	<ul style="list-style-type: none"> • <i>HIP Self-employment/Rental Income Reporting Form</i> (see Section 8)
Rental Income	<ul style="list-style-type: none"> • <i>HIP Self-employment/Rental Income Reporting Form</i> (see Section 8)
Stipend, Work Study, Assistantship	<ul style="list-style-type: none"> • Copy of pay stub(s) • Award letter • Signed and dated statement from an institution of higher education
Personal Care Worker Wages	<ul style="list-style-type: none"> • <i>DSHS SSPS Invoice and Remittance Advice Form</i>
Periodic payments from: <ul style="list-style-type: none"> • Social Security • Railroad Retirement • Military Pension or Retirement • Military Disability(VA) Payment • Government Employee Pension • Private Company Pension • Unemployment Compensation • Private Insurance Disability Payments 	<ul style="list-style-type: none"> • Award letter or Benefits statement • Signed and dated statement from payer • L&I payment order • Computer print-out from agency/payer (Employment Security Department, Social Security Administration, etc.)
Periodic Annuity payments	<ul style="list-style-type: none"> • Statement from institution
Alimony	<ul style="list-style-type: none"> • Signed and dated statement or copy of personal check from the person paying alimony • Signed and dated statement from person receiving alimony
Dividends & Interest	<ul style="list-style-type: none"> • Statement from investment firm, bank or financial institution • 1099 INT/DIV Form
Royalties	<ul style="list-style-type: none"> • Copy of contract • Copy of check
Inheritances, Estates, Trusts	<ul style="list-style-type: none"> • Court document(s) • Statement from trustee, attorney, bank or financial institution • Copy of check • 1099R
Punitive Damages	<ul style="list-style-type: none"> • Court documents

Section 8: Self-Employment or Rental Income Reporting Form

Complete this section if you are self-employed or have rental income and did not file a 1040 tax form with the IRS.

Name		Social Security Number (optional)	
Mailing address			
If you filed an income tax return for your business, provide a copy of the IRS 1040 forms. If you have more than one business, copy this form, or print from www.hip.hca.wa.gov . Complete a separate form for each business.			
Name of business			
Names(s) of business owner(s)			
Washington State Unified Business identifier (UBI) # (not required)		Check box of no UBI # <input type="checkbox"/>	
Date business began / /	Months you are reporting From / / through / /		Total number of months in business
Type of business	<input type="checkbox"/> Rental(s)	<input type="checkbox"/> C-Corporation	Percent of business owned by you and your spouse, if married %
	<input type="checkbox"/> Sole proprietor	<input type="checkbox"/> S-Corporation	
	<input type="checkbox"/> LLC	<input type="checkbox"/> Partnership	

Income	Total for this period
Gross receipts, sales, or rental income	

Expenses (business-related only)	Total for this period
Merchandise and materials	
Gross wages paid to employees (less employment credits)	
Employer's payroll-related taxes	
Advertising/other promotional	
Car and truck	
Commissions/management fees	
Insurance (other than HIP group offering)	
Interest—Mortgage	
Interest—Other	
Legal and professional fees	
Rent or lease of vehicles, machinery, equipment	
Rent or lease of other business property	
Repairs and maintenance	
Supplies	
Taxes and licenses	
Travel, meals, and entertainment	
Utilities	
Business use of the home	
Total business expenses	
Total net profit (or loss)	

Section 9: Voluntary Information

Completing this section is voluntary and will not affect your eligibility for subsidy, but may help us to better assist you.

ETHNIC BACKGROUND	WHERE DID YOU GET YOUR HIP APPLICATION?	WHERE DID YOU HEAR ABOUT HIP?
<input type="checkbox"/> Black/African-American <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Indian (Native American) <input type="checkbox"/> Eskimo <input type="checkbox"/> Aleutian Islander/Aleut <input type="checkbox"/> Asian or Pacific Islander (API) <input type="checkbox"/> Hispanic/Latin American <input type="checkbox"/> Other or mixed ethnic background	<input type="checkbox"/> Employer <input type="checkbox"/> Local, nonprofit organization <input type="checkbox"/> Website <input type="checkbox"/> Medical office/hospital/clinic <input type="checkbox"/> Insurance Agent/Broker <input type="checkbox"/> Government office, such as DSHS or health department <input type="checkbox"/> Called HIP and received it by mail <input type="checkbox"/> Other	<input type="checkbox"/> Family/Friend/Website <input type="checkbox"/> Government Agency/Office <input type="checkbox"/> Local, non-profit organization <input type="checkbox"/> Employer <input type="checkbox"/> Insurance Agent/Broker <input type="checkbox"/> Other

Section 10: Permission Form (optional)

If you want someone else to be given information about your HIP subsidy account, or to help with your application and future changes to your account, please complete, sign, and date this form.

This form is for the HIP only. It will not be used for medical information, or shared with your health plan. This permission will be in effect until you are disenrolled from the HIP or tell us to cancel it.

To the Health Insurance Partnership:

The person(s) named below is authorized to act as my or my family's representative(s) in the preparation and submission of the Health Insurance Partnership (HIP) Subsidy application and future changes to my HIP account.

The person(s) listed below may provide information necessary for processing my application, enrollment, and future changes to my HIP subsidy account.

I understand that by signing this form I have not authorized the release or sharing of my health information.

This permission will continue as long as I am enrolled in the HIP unless I notify the HIP that it is cancelled.

Applicant's name (please print) _____

Name(s) of person(s) / representative(s)
given permission to access account

Relationship to applicant OR name of
organization (list phone or fax number)

Must be signed by you and your spouse (if legally married)

X _____
 Your signature Date

X _____
 Spouse signature Date

Signature of all legal dependents age 18 and over who are applying for HIP subsidy

X _____
 Legal dependent signature Date

X _____
 Legal dependent signature Date

Washington State law may require disclosure of any information you submit as a public record. The HIP is administered by the Health Care Authority. Our Privacy Notice is available upon request by calling 360-923-2822 or online at www.hca.wa.gov.

Section 11: Agreement and Signature

I understand that:

- I must provide proof of my family's gross income (before taxes and deductions).
- By signing this form, I have authorized the HIP to verify my eligibility information and family income with other state or federal agencies or other third-party sources.
- I must report address changes within 30 days.
- I must report family changes requiring new enrollment in the HIP, within 30 days. For example, a marriage, and/or the birth or adoption of a child.
- I must report any HIP participant disenrollment within 30 days. For example, a divorce, or when a child leaves home and is no longer a dependent or is no longer a full-time student.
- My application and the documents I send to the HIP will be used to determine eligibility for the HIP subsidy according to HIP program requirements.
- HIP subsidies are not an entitlement. Subsidy payments will end for the following reasons:
 1. Failure of employer's group premium payment to be paid within the timeline set forth in the Employer Agreement.
 2. Participant moves out of Washington State.
- The HIP will not disclose income information, but will disclose subsidy eligibility and amount of subsidy to my employer and my employer's health insurance broker. They need to know how much to deduct from my paycheck each month to pay my share of the group insurance premium.

I have read and understand the information provided to me with the HIP application. I declare that the information I have given in this application is true, correct, and complete to the best of my knowledge. I understand that incorrect information may delay or prevent my enrollment in the HIP.

Agreement must be signed by you and your spouse, if legally married.

X _____ X _____
Signature of applicant Date Signature of spouse Date

Signature of all dependents age 18 and over

X _____ X _____
Signature Date Signature Date

X _____ X _____
Signature Date Signature Date

Use the checklist below to make sure you include the required documents with your application:

- Your IRS Form 1040, or IRS transcript for the most recent tax year.
- If you, your spouse, or dependent didn't file a tax return, you must submit a *Declaration of Non-filing* with the subsidy application (see Section 6). In these cases, the HIP will require documentation of income in Section 7.
- Proof of Washington State residence (i.e., utility bill with your name and street address).

When pay stubs cannot be provided, the HIP may accept a signed, dated statement from the employer. The statement must include the employee's name, pay period(s), pay dates, and amount of gross income.

**Do not send original documents; they will not be returned to you.
All required forms and documentation must be mailed to:**

Health Insurance Partnership
Administration Office
20021 120th Ave. NE, Suite 200 • Bothell, WA 98011
(800) 377-0976 • (425) 686-1370 • Fax: (425) 686-1396

**Questions? Call (800) 377-0976
On the Internet, go to www.hip.hca.wa.gov**



HEALTH INSURANCE
PARTNERSHIP

Privacy statement We will keep your information private as allowed by law.

The Washington State Health Care Authority manages the Health Insurance Partnership. To see our Privacy Notice, call 360-923-2822 or go to www.hca.wa.gov.