

Apple Health Request for Children in Tribal Foster Care

Complete this form to request Apple Health (Medicaid) coverage, report changes, or request disenrollment for children in Tribal Foster Care.

Type of request

New coverage

Change of placement

Report a change (i.e., demographic updates)

Requirements

A child aged 18 or younger is eligible for Apple Health Foster Care Medical if the child meets the requirements in Section 4 below. This program requires:

- Initial confirmation from the Tribal placement agency that the child meets the program requirements; and
- Timely notification from the Tribal placement agency of changes in placement or if the child no longer meets program requirements.

Individuals who were in foster care placement and received Apple Health on their 18th birthday remain eligible for health care coverage until their 26th birthday through the Foster Care Alumni program. This eligibility remains regardless of changes in income, household composition, or marital status, if they remain a Washington resident. See requirements in Section 4 below.

Placement information

Date of placement/change:

Under age 18 out of home placement

Guardianship (Tribal supported)

Trial Return Home

Guardianship (case closed)

Out of state placement with relative

Exit care at age 18 (eligible for Foster Care Alumni coverage)

Out of state placement in a facility

Age 18 up to 21 (eligible for Extended Foster Care coverage)

Tribal adoption support

1

Children's Information (Please print)

Name

Date of birth

Gender

Social Security number

Tribal Affiliation

2

Tribal Information (Please print)

Tribe

Send additional service card

Yes

No

Phone

Tribe mailing address

City

State

Zip code

Case worker name

Email

3**Placement Status (Please print)**

Placement: If the youth is in the care and custody of the tribe, provide the contact information for the placement family below.

Placement closed: If the placement has closed and the youth/alumni is no longer in the care and custody of the tribe, provide the current contact information for the youth/alumni below.

Adult name(s)

Relationship(s) to child

Email

Phone

Address

City

State

Zip code

4**Tribe Attestation for Coverage**

(Please check the appropriate box, sign and complete)

The child named above is under the care and placement authority of the placement agency (e.g., Indian Child Welfare agency) of the Tribe named above, for whom one of the following applies:

Receiving foster care/adoption support payments under Title IV-E of the Social Security Act (42 CFR 435.145);

Receiving full or partial financial support through the Tribe's Placement Agency (42 CFR 435.222);

A non-Title IV-E Adoption Assistance agreement or tribal guardianship is in place (42 CFR 435.227).

The youth named above was enrolled in Apple Health and is under the care and placement authority of the Tribe upon attaining age 18.

Signature

Date

Name (Please print)

Email

Phone

5**Type of Coverage**

As the placement agency with authority over this child's care, we are choosing enrollment in (please select one):

Learn more about each coverage option by clicking the link below:

Apple Health coverage without a managed care plan (also referred to as fee-for-service).

Apple Health Core Connections through Coordinated Care, Inc. (CC) . This form will be shared with CC to allow for health care coordination.

Apple Health coverage without a managed care plan with Behavioral Health Services Only (BHSO)

Select which health plan:

Community Health Plan of Washington

Coordinated Care

Molina Healthcare

UnitedHealthcare

Wellpoint



19027

Please submit the completed form to:

Mail: Health Care Authority - Foster Care Adoption Support
P.O. Box 45534
Olympia, WA 98504

Fax: (360) 725-1158

Email: hcatribalfostercaremedical@hca.wa.gov

Questions? Call 1 (800) 562-3022 Ext. 15480