Washington State Health Care Authority

Retroactive Health Care Coverage Request form – MAGI Medicaid

Use this form only if the applicant has completed an application for health care coverage.

Primary Applicant / Head of Household Information	
First Name, Middle Initial, Last Name	Date of Birth
DSHS ACES Client ID or ProviderOne ID number	Healthplanfinder Application ID number (if known)

Household Members Needing Retroactive Coverage	
Name	Name
Name	Name

Retroactive Months Needed, Household Income, and Deductions

List the month(s) coverage is needed and the household's gross income and deductions for each month. If the household had no income or deductions for the month, write "none."

***Income we count includes**:* Money from employment, self-employment, unemployment, Social Security, dividend payments, renting out a property, railroad retirement benefits, annuity/pension payments, alimony/spousal support, and per capita distributions from gaming.

Deductions include: Tuition or school-related fees, health savings account contributions, alimony/spousal support, student loan interest, educator expenses, moving costs since January, domestic production activities, penalty on early withdrawal of savings, pre-tax retirement account payments (excluding Roth IRA contributions), or certain claimable business expenses of reservists, performing artists, or fee-basis government officials.

Month 1:	Total Gross Household Income: $	Total Deductions: $
Month 2:	Total Gross Household Income: $	Total Deductions: $
Month 3:	Total Gross Household Income: $	Total Deductions: $

Declaration and Signature

By signing below, I certify under penalty and false swearing that my answers are correct and complete to the best of my knowledge. I also understand the penalties for giving false information or breaking the law.

Signature of Applicant	Date
Signature of Authorized Representative (if applicable)	Date
Authorized Representative (AREP) Name	AREP Organization
AREP Email Address	AREP Phone Number

Return the completed form to the Health Care Authority:

- By fax to 1-866-841-2267; or
- By mail to MEDS, PO Box 45531, Olympia WA 98504-5531.