Washington State Department of Social & Health Services
HRSA Health & Recovery Services Administration

Family and Children's Medical Benefits Renewal

This form is for renewal of medical benefits only. To apply for financial or food assistance contact your local DSHS Community Services Office (CSO).

To continue medical coverage you must complete a yearly renewal by doing one of the following:

- **Call the number on the attached letter to complete your renewal by telephone; or**
- **Complete this form and mail it to us with current proof of income.**

Please Print.

CLIENT ID NUMBER			
FIRST NAME	LAST NAME	MIDDLE INITIAL	DATE OF BIRTH
ADDRESS	CITY	STATE	ZIP CODE
MAILING ADDRESS (IF DIFFERENT)	CITY	STATE	ZIP CODE
HOME PHONE NUMBER INCLUDE AREA CODE	CELL PHONE NUMBER INCLUDE AREA CODE	EMAIL ADDRESS	

HOUSEHOLD

Has anyone moved **into** your home in the past 12 months? Yes ☐ No ☐

NAME	DATE OF BIRTH	GENDER	SSN
		Female ☐ Male ☐	

U.S. Citizen Yes ☐ No ☐ Relationship to you

Has anyone moved **out** of your home in the past 12 months? ☐ Yes ☐ No

NAME	DATE MOVED OUT

Did anyone in the household begin receiving private health insurance in the past 12 months? ☐ Yes ☐ No

If yes, who _____

Name of private health insurance _____

All Monthly Earned or Unearned Income for your household.

Name of person with Income	Employer (Name/Phone) or Income Source	Monthly Income (before taxes or expenses)

Note: Provide proof of your current income. Proof of earned income is copies of wage stubs, or a statement from your employer. If you are self-employed, you can provide a copy of last year's income tax return. Don't wait to call or return this renewal form because you don't have proof of income.

Expenses paid by your household

Total monthly child care cost you pay so you can work $

Total court ordered child support you pay each month $