Washington State Department of CHILDREN, YOUTH & FAMILIES

Enrollment Application Medical and Dental Benefits

Participation Rules

You may be eligible for this health insurance benefit if you are a WA State licensed family child care provider that provides care for at least one child whose participation in care was funded by the Working Connections Child Care, Seasonal Child Care, or Child Welfare subsidy program and was paid through the Social Service Payment System (SSPS).

Initial Eligibility

You may submit your application after you have claimed your SSPS service invoice for licensed family child care provided in one of the past three months.

This coverage is for the family child care license holder only, (in the case of co-owners, one licensee may apply for benefits), and is linked to their SSPS number. Benefits do not cover other family members such as spouses or dependents, or employees of the child care program.

IF YOU HAVE QUESTIONS ABOUT THIS APPLICATION FORM, OR ELIGIBILITY FOR HEALTH CARE BENEFITS, EMAIL dcyf.healthcare@dcyf.wa.gov or you may call 1-866-201-8343. Additional information and resources are located on the Child Care Health Benefits program website.

MAIL TO:
Department of Children, Youth, and Families
Child Care Health Benefits Program
PO Box 40970
Olympia, WA 98504-0970

EMAIL TO:
dcyf.healthcare@dcyf.wa.gov

PERSONAL INFORMATION – *All Fields are required			
*FIRST NAME	*MIDDLE INITIAL	*LAST NAME	
*SOCIAL SECURITY NUMBER OR INDIVIDUAL TAX IDENTIFICATION #	*SSPS NUMBER *(6-digits, found on your SSPS invoice include zeros)*	*DATE OF BIRTH *Month/Day/Year*	
*HOME ADDRESS MAILING ADDRESS (*if different*):	*CITY	*STATE	*ZIP
*PHONE NUMBER ☐ MOBILE ☐ HOME ☐ WORK	*EMAIL ADDRESS (*DCYF will contact you using the email address you provide here)*		
*GENDER ☐ MALE ☐ FEMALE ☐ PREFER NOT TO DISCLOSE			
DENTAL CARE PROVIDER PREFERENCE ☐ DELTA ☐ WILLAMETTE *If you do not check a box, Delta Dental will be chosen for you.*			

Please note: Medical care provider is determined based upon applicants zip code.

I am applying for medical and dental benefits as indicated on this application. I understand that DCYF is responsible for determining eligibility for benefits and that at any time I do not meet eligibility requirements, my benefits will be terminated. By signing below, I attest that I am not eligible for other medical coverage, including Medicaid, while enrolled in DCYF's health benefit program and that the information in this application is true to the best of my knowledge. I further agree to a deduction of the required monthly health benefit co-share premium from my SSPS payment for these health benefits.

*Signature _____ *Print Name _____ *Date _____