

How to Register an Unattended Home Birth

An unattended home birth means a child under one (1) year of age, born at home without the assistance of a licensed midwife or medical professional. **Forms must be postmarked prior to the child's first birthday.**

If the child is over one (1) year of age, you must contact the Washington State Department of Health to register a delayed report of live birth.

1. Fill out the [Washington State Birth Filing \(DOH 422-020\) form](#) in black ink.

Complete item numbers 1 through 38. See below for additional details on some items.

- Item 5 – select Home or Other and specify.
- Item 71 – provide exact name and address where birth took place.
- Item 11 – provide name given at birth, also known as maiden name, of mother/person that gave birth.
- Item 29 – select the marital status of the mother/person that gave birth.

Leave items 39-69 and 71 blank. This is page 3 under **Hospital Use Only and Attendant and Certifier Information**.

Complete item 70. The **attendant*** must print their full name, state their relationship to the mother/person who gave birth, and sign the form. This person must be over the age of 18 and be the person who delivered the baby, attended the birth, or has knowledge of the birth facts (father/second parent, friend, unlicensed midwife, etc.).

***Important note: The mother/person who gave birth cannot sign as the attendant.**

2. Fill out [Supporting Affidavit DOH \(422-036\)](#).

Only one original Supporting Affidavit will be accepted. The affidavit must be completed by the mother/person who gave birth or someone with knowledge of the birth facts. **The affidavit must be signed in the presence of a notary public, and cannot be signed by the same person who signed as the attendant on the Washington State Birth Filing form.**

The affidavit must provide the following information:

- Full name of the child (First, Middle, Last Name).
- Child's sex (M for Male or F for female).
- Child's date of birth.
- Place of birth (exact address where the birth occurred).
- Full birth name, also known as maiden name, of the mother/person who gave birth.
- Full current name of the father/second parent (if applicable).

The person completing the affidavit must provide a detailed statement of their personal knowledge about the birth. "*Personal knowledge*" means having seen the child's mother (a.) in an apparent pregnant state within two months before the child's date of birth and in a non-pregnant state after the child's date of birth; or (b.) give birth to the child. Specific details include exact location where the birth took place and list of names of people present at the birth.

3. Submit Copies of Identity Documents.

A copy of identity documents is required from the following individuals:

- Attendant who signed the Washington State Birth Filing form.
- Mother/Person who gave birth.
- Father/Second parent (if listed on the Washington State Birth Filing form).

The [acceptable identity documentation](#) includes:

- One government issued identification document not expired more than 60 days, or
- At least two documents from the alternative list of acceptable identification.

4. Submit Copies of Residence.

Evidence of the mother's/person who gave birth's residence in Washington state within 30 days of the date of live birth. The document(s) submitted must include the mother's/person who gave birth's name and address and the date range on the document must cover the child's date of birth.

Proof documents include, but not limited to:

- An original rent receipt that includes the mother's/person who gave birth's name and address.
- Home utility bill for Washington address (gas, electric, water, garbage, sewer, landline phone, TV, internet, or ISTA) that includes mother's/person who gave birth's name and address.
- Letter attesting residence in alternative housing (e.g. assisted living, college campus, shelter, mission, senior housing, or retirement home) on company letter head with a phone number for use in verification of the facility.
- Proof of home ownership (mortgage documents, property tax documents, deed, title, insurance policy, etc.).
- DSHS benefits letter indicating unexpired benefits (medical, food, etc.).

Other documents or exceptions must be approved by the State Registrar.

5. Submit Acknowledgment of Parentage (if applicable).

If the mother/person who gave birth was not married at any time during the pregnancy, [Acknowledgment of Parentage \(DOH 422-159\)](#) needs to be completed to add the father/second parent to the birth certificate.

For more information and required forms, visit

<https://www.doh.wa.gov/LicensesPermitsandCertificates/VitalRecords/Parentage>.

6. Send completed forms to:

Attention: Birth Registration
Center for Health Statistics
PO Box 47814
Olympia, WA 98504-7814

Washington State Birth Filing Form

Fields with asterisk (*) are required and appear on the Birth Certificate.

For Hospital Use Only			
Mother/Parent's Medical Record #:	Child's Medical Record #:	Prefer Parent / Parent Labels on Birth Certificate <input type="checkbox"/> Yes <input type="checkbox"/> No (Default Labels are Mother / Father)	
Plurality:	<input type="checkbox"/> 1- single birth	<input type="checkbox"/> 2- twin	<input type="checkbox"/> 3- triplet <input type="checkbox"/> Other _____
If multiple, this worksheet is for child:	<input type="checkbox"/> 1- first born	<input type="checkbox"/> 2- second born	<input type="checkbox"/> 3- third born <input type="checkbox"/> Other _____
Child's Information			
*1. Child's Name			
First	Middle	Last	
*2. Child's Date of Birth (MM/DD/YYYY) / /	*3. Time of Birth		*4. Child's Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
5. Type of Birthplace <input type="checkbox"/> Hospital <input type="checkbox"/> Home <input type="checkbox"/> Enroute <input type="checkbox"/> Clinic/Doctor's Office <input type="checkbox"/> Freestanding Birth Center <input type="checkbox"/> Other (specify):		6. Planned Birth Place, if different (specify):	
*7. Name of Facility (If not a facility, enter name of place and address)		*8. County of Birth	*9. City of Birth
Mother/Parent's information			
10. Mother/Parent's Current Legal Name			
First	Middle	Last	
*11. Full name as it appears on your Birth Certificate			
First	Middle	Last	
*12. Date of Birth (MM/DD/YYYY) / /	*13. Birthplace (State, Territory, or Foreign Country)	14. Social Security Number	
15. Do you want to get a Social Security Number for your child? <input type="checkbox"/> Yes <input type="checkbox"/> No			
16a. Residence: Number and Street (e.g., 624 SE 5 th St.)			Apt. No.
16b. If not U.S.; Country	16c. State	16d. County	
16e. If you live on Tribal Reservation, give name		16f. City or Town	16g. Zip Code + 4
16h. Inside City Limits? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	17. How Long at Current Residence? Years: Months:		18. Telephone Number ()
19a. Mailing Address, if different: Number and Street, or PO Box			Apt. No.
19b. If not U.S.; Country	19c. State	19d. City	19e. Zip Code + 4
20. Occupation (type of work done during last year)		21. Kind of Business/Industry (do not use company name)	
22. Mother/Parent Education Level (Check the box that best describes the highest degree or level of school completed at the time of delivery.) 1 <input type="checkbox"/> 8 th grade or less (specify): _____ 2 <input type="checkbox"/> 9 th – 12 th grade; no diploma 3 <input type="checkbox"/> High school graduate or GED 4 <input type="checkbox"/> Some college credit, but no degree 5 <input type="checkbox"/> Associate degree (AA, AS, etc.) 6 <input type="checkbox"/> Bachelor's degree (BA, AB, BS, etc.) 7 <input type="checkbox"/> Master's degree (MA, MS, MEd, MSW, MBA, etc.) 8 <input type="checkbox"/> Doctorate (PhD, EdD, etc.) or professional degree (MD, DDS, DVM, LLB, JD, etc.)		23. Mother/Parent Hispanic Origin? (Check the box that best describes whether the mother is Spanish/Hispanic/Latina or check "No" box if not Spanish/Hispanic/Latina.) 1 <input type="checkbox"/> No, not Spanish/Hispanic/Latina 2 <input type="checkbox"/> Yes, Mexican, Mexican American, Chicana 3 <input type="checkbox"/> Yes, Puerto Rican 4 <input type="checkbox"/> Yes, Cuban 5 <input type="checkbox"/> Yes, Other Spanish/Hispanic/Latina (specify): _____	
24. Mother/Parent Race (check one or more) 1 <input type="checkbox"/> White 2 <input type="checkbox"/> Black or African American 3 <input type="checkbox"/> American Indian or Alaska Native (Name of enrolled or principal tribe) 4 <input type="checkbox"/> Asian Indian 5 <input type="checkbox"/> Chinese 6 <input type="checkbox"/> Filipino 7 <input type="checkbox"/> Japanese 8 <input type="checkbox"/> Korean 9 <input type="checkbox"/> Vietnamese 10 <input type="checkbox"/> Other Asian (specify): _____ 11 <input type="checkbox"/> Native Hawaiian 12 <input type="checkbox"/> Guamanian or Chamorro 13 <input type="checkbox"/> Samoan 14 <input type="checkbox"/> Other Pacific Islander (specify): _____ 15 <input type="checkbox"/> Other (specify): _____			

Continue on next page

Mother/Parent Information	25. Current Height Feet: _____ Inches: _____		26. Pre-Pregnancy Weight (pounds)		27. Were WIC benefits utilized during pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	28. Cigarette Smoking Before and During Pregnancy <input type="checkbox"/> Yes <input type="checkbox"/> No			Average number of cigarettes or packs per day: # of cigarettes # of packs		
			Three months before pregnancy _____ or _____			
			First three months of pregnancy _____ or _____			
			Second three months of pregnancy _____ or _____			
			Last three months of pregnancy _____ or _____			
Marital Status of Mother/Parent						
29. Is Mother/Parent married? (Check only one box)						
Important - Read before responding to marital status question: <i>If you were married at any time during your pregnancy, your spouse or partner is considered the other legal parent unless they complete a denial of parentage and another person acknowledges that they are the father/parent (chapter 26.26A RCW). To add someone other than your spouse or partner to the birth certificate, an Acknowledgment of Parentage form (DOH 422-159) and Denial of Parentage form (DOH 422-158) needs to be completed by all parties. Under Washington State law, a state-registered domestic partnership is considered the same as a marriage (chapter 26.60 RCW).</i>						
<i>If you were not married at any time during the pregnancy, complete an Acknowledgment of Parentage form to add the father/parent to the birth certificate.</i>						
Married - Yes			Married - No			
29a. <input type="checkbox"/> Yes, I am married to the other person identified in box #30.			29d. <input type="checkbox"/> No, I am not married. I am providing information about the father/parent in box #30. I will complete an Acknowledgment of Parentage form at the hospital. <i>Ask hospital staff for an Acknowledgment of Parentage form (DOH 422-159).</i>			
29b. <input type="checkbox"/> Yes, I am married but not to the other person identified in box #30. <i>Ask hospital staff for an Acknowledgment of Parentage form (DOH 422-159). You must complete this form, including the spouse's Denial of Parentage form (DOH 422-158).</i>			29e. <input type="checkbox"/> No, I am not married now, but I was married to the other person identified in box #30 at some time during this pregnancy.			
29c. <input type="checkbox"/> Yes, I am married but not providing the spouse or partner's information. <i>If this box is checked, the other parent will be listed on the birth certificate as "None Named".</i>			29f. <input type="checkbox"/> No, I am not married and not submitting a completed Acknowledgment of Parentage form with the father/parent's information. <i>If this box is checked, the other parent will be listed on the birth certificate as "None Named".</i>			
Father/ Parent's Information						
*30. Father/Parent's Current Legal Name						
First			Middle		Last	
*31. Date of Birth (MM/DD/YYYY) / /			*32. Birthplace (State, Territory, or Foreign Country)		33. Social Security Number	
34. Occupation (type of work done during last year.)				35. Kind of Business/Industry (do not use Company Name)		
36. Father/Parent Education Level (Check the box that best describes the highest degree or level of school completed at the time of delivery.)		37. Father/Parent of Hispanic Origin? (Check the box that best describes whether the father/parent is Spanish/Hispanic/Latino or check "No" box if not Spanish/Hispanic/Latino.)		38. Father/Parent Race (check one or more)		
1 <input type="checkbox"/> 8 th grade or less (specify): _____		1 <input type="checkbox"/> No, not Spanish/Hispanic/Latino		1 <input type="checkbox"/> White		
2 <input type="checkbox"/> 9 th – 12 th grade; no diploma		2 <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano		2 <input type="checkbox"/> Black or African American		
3 <input type="checkbox"/> High school graduate or GED		3 <input type="checkbox"/> Yes, Puerto Rican		3 <input type="checkbox"/> American Indian or Alaska Native (Name of enrolled or principal tribe)		
4 <input type="checkbox"/> Some college credit, but no degree		4 <input type="checkbox"/> Yes, Cuban		4 <input type="checkbox"/> Asian Indian		
5 <input type="checkbox"/> Associate degree (AA, AS, etc.)		5 <input type="checkbox"/> Yes, other Spanish/Hispanic/Latino (specify): _____		5 <input type="checkbox"/> Chinese		
6 <input type="checkbox"/> Bachelor's degree (BA, AB, BS, etc.)				6 <input type="checkbox"/> Filipino		
7 <input type="checkbox"/> Master's degree (MA, MS, MEd, MSW, MBA, etc.)				7 <input type="checkbox"/> Japanese		
8 <input type="checkbox"/> Doctorate (PhD, EdD, etc.) or professional degree (MD, DDS, DVM, LLB, JD, etc.)				8 <input type="checkbox"/> Korean		
				9 <input type="checkbox"/> Vietnamese		
				10 <input type="checkbox"/> Other Asian (specify): _____		
				11 <input type="checkbox"/> Native Hawaiian		
				12 <input type="checkbox"/> Guamanian or Chamorro		
				13 <input type="checkbox"/> Samoan		
				14 <input type="checkbox"/> Other Pacific Islander (specify): _____		
				15 <input type="checkbox"/> Other (specify): _____		

For Hospital Use Only

Mother/Parent's Statistical Information

39. Date of First Prenatal Care Visit (MM/DD/YYYY) / / <input type="checkbox"/> No Prenatal Care	40. Date of Last Prenatal Care Visit (MM/DD/YYYY) / /	41. Total Number of Prenatal Visits for this Pregnancy (If none, enter '0')
42. Number of Previous Live Births (Do not include this child) Number Now Living _____ <input type="checkbox"/> None Number Now Dead _____ <input type="checkbox"/> None	43. Date of Last Live Birth (MM/YYYY) (Do not include this child) / /	44. Number of Other Pregnancy Outcomes (Spontaneous or induced losses or ectopic pregnancies) Number of Other Outcomes _____ <input type="checkbox"/> None
45. Date of Last Other Pregnancy Outcome (MM/YYYY) / /	46. Date Last Normal Menses Began (MM/DD/YYYY) / /	47. Mother'/Parent's Weight at Delivery (pounds)
48. Was mother/parent transferred to higher level care for maternal medical or fetal indications for delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of facility mother/parent was transferred from:		49. Principal Source of Payment for this Delivery <input type="checkbox"/> Medicaid <input type="checkbox"/> Self-Pay <input type="checkbox"/> Private Insurance <input type="checkbox"/> Other Gov't <input type="checkbox"/> Tricare <input type="checkbox"/> Indian Health <input type="checkbox"/> Charity Care <input type="checkbox"/> Other _____

Child's Statistical Information

50. Birth Weight lbs: _____ ozs: _____ or grams: _____	51. Infant Head Circumference (cm)	52. Obstetric Estimate of Gestation (completed weeks)
53. Apgar score at 5 minutes _____ If score is less than 6, score at 10 minutes _____		
54. Plurality: <input type="checkbox"/> Single <input type="checkbox"/> twins <input type="checkbox"/> triplets <input type="checkbox"/> other _____		55. If not single birth; birth order: <input type="checkbox"/> first <input type="checkbox"/> second <input type="checkbox"/> third <input type="checkbox"/> other _____
56. Was infant transferred within 24 hours of delivery? If yes, name of facility infant was transferred to:	<input type="checkbox"/> Yes <input type="checkbox"/> No	57. Is infant living at the time of report? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Transferred, status unknown
		58. Is infant being breastfed? <input type="checkbox"/> Yes <input type="checkbox"/> No

Medical and Health Information

59. Risk Factors in this Pregnancy (check all that apply): 1 Diabetes <input type="checkbox"/> Prepregnancy (Diagnosis prior to this pregnancy) <input type="checkbox"/> Gestational (Diagnosis in this pregnancy) 2 Hypertension <input type="checkbox"/> Prepregnancy (Chronic) <input type="checkbox"/> Gestational (PIH, preeclampsia) <input type="checkbox"/> Eclampsia 3 <input type="checkbox"/> Previous preterm births 4 <input type="checkbox"/> Other previous poor pregnancy outcome (includes perinatal death, small-for-gestational age/intrauterine growth restricted birth) 5 <input type="checkbox"/> Vaginal bleeding during this pregnancy prior to the onset of labor 6 <input type="checkbox"/> Pregnancy resulted from infertility treatment - If yes-check all that apply: <input type="checkbox"/> Fertility-enhancing drugs, artificial insemination or intrauterine insemination <input type="checkbox"/> Assisted reproductive technology [e.g., in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT)] 7 <input type="checkbox"/> Mother had a previous cesarean delivery? If Yes, how many _____ 8 <input type="checkbox"/> Group B Streptococcus culture positive 9 <input type="checkbox"/> None of the above	60. Infections Present and/or Treated During this Pregnancy (check all that apply): 1 <input type="checkbox"/> Gonorrhea 2 <input type="checkbox"/> Syphilis 3 <input type="checkbox"/> Herpes Simplex Virus (HSV) 4 <input type="checkbox"/> Chlamydia 5 <input type="checkbox"/> Hepatitis B 6 <input type="checkbox"/> Hepatitis C 7 <input type="checkbox"/> HIV Infection 8 <input type="checkbox"/> Other Specify: _____ 9 <input type="checkbox"/> None of the above	61. Maternal Morbidity (complications associated with labor and delivery) (Check all that apply): 1 <input type="checkbox"/> Maternal transfusion 2 <input type="checkbox"/> Third or fourth degree perineal laceration 3 <input type="checkbox"/> Ruptured uterus 4 <input type="checkbox"/> Unplanned hysterectomy 5 <input type="checkbox"/> Admission to intensive care unit 6 <input type="checkbox"/> Unplanned operating room procedure following delivery 7 <input type="checkbox"/> None of the above
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62. Method of Delivery A. Was delivery with forceps attempted but unsuccessful? <input type="checkbox"/> Yes <input type="checkbox"/> No B. Was delivery with vacuum extraction attempted but unsuccessful? <input type="checkbox"/> Yes <input type="checkbox"/> No C. Fetal presentation at birth <input type="checkbox"/> Cephalic <input type="checkbox"/> Breech <input type="checkbox"/> Other D. Final route and method of delivery (Check One) <u>Vaginal:</u> <input type="checkbox"/> Spontaneous <input type="checkbox"/> Forceps <input type="checkbox"/> Vacuum OR <u>Cesarean:</u> <input type="checkbox"/> If cesarean, was a trial of labor attempted? <input type="checkbox"/> Yes <input type="checkbox"/> No	63. Obstetric procedures (Check all that apply): 1 <input type="checkbox"/> Cervical cerclage 2 <input type="checkbox"/> Tocolysis 3 <input type="checkbox"/> External cephalic version: <input type="checkbox"/> Successful <input type="checkbox"/> Failed 4 <input type="checkbox"/> None of the above 64. Onset of Labor (Check all that apply): 1 <input type="checkbox"/> Premature rupture of the membranes (Prolonged, ≥ 12hr) 2 <input type="checkbox"/> Precipitous Labor (< 3hr) 3 <input type="checkbox"/> Prolonged Labor (≥ 20hr) 4 <input type="checkbox"/> None of the above	65. Characteristics of Labor and Delivery (Check all that apply): 1 <input type="checkbox"/> Induction of labor 2 <input type="checkbox"/> Augmentation of labor 3 <input type="checkbox"/> Non-vertex presentation 4 <input type="checkbox"/> Epidural or spinal anesthesia during labor 5 <input type="checkbox"/> Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery 6 <input type="checkbox"/> Antibiotics received by the mother during labor 7 <input type="checkbox"/> Clinical chorioamnionitis diagnosed during labor or maternal temperature ≥38°C (100.4°F) 8 <input type="checkbox"/> Moderate/heavy meconium staining of the amniotic fluid 9 <input type="checkbox"/> Fetal intolerance of labor such that one or more of the following actions was taken: in-utero resuscitation measures, further fetal assessment, or operative delivery 10 <input type="checkbox"/> None of the above
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66. Abnormal Conditions of the Newborn (Occurring within 24 hours of delivery) (check all that apply): 1 <input type="checkbox"/> Assisted ventilation required immediately following delivery 2 <input type="checkbox"/> Assisted ventilation required for more than six hours 3 <input type="checkbox"/> NICU admission 4 <input type="checkbox"/> Newborn given surfactant replacement therapy 5 <input type="checkbox"/> Antibiotics received by the newborn for suspected neonatal sepsis 6 <input type="checkbox"/> Seizure or serious neurologic dysfunction 7 <input type="checkbox"/> Significant birth injury (skeletal fracture(s), peripheral nerve injury, soft tissue or solid organ hemorrhage which requires intervention) 8 <input type="checkbox"/> None of the above	67. Congenital Anomalies of the Newborn (Observed within 24 hours of delivery) (Check all that apply): 1 <input type="checkbox"/> Anencephaly 2 <input type="checkbox"/> Meningocele / Spina bifida 3 <input type="checkbox"/> Cyanotic congenital heart disease 4 <input type="checkbox"/> Congenital diaphragmatic hernia 5 <input type="checkbox"/> Omphalocele 6 <input type="checkbox"/> Gastroschisis 7 <input type="checkbox"/> Limb reduction defect (excluding congenital amputation and dwarfing syndrome) 8 <input type="checkbox"/> Cleft Lip with or without Cleft Palate 9 <input type="checkbox"/> Cleft Palate alone 10 Down Syndrome <input type="checkbox"/> Karyotype confirmed <input type="checkbox"/> Karyotype pending 11 Chromosomal disorder <input type="checkbox"/> Karyotype confirmed <input type="checkbox"/> Suspected, Karyotype pending 12 <input type="checkbox"/> Hypospadias 13 <input type="checkbox"/> None of the above
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Attendant and Certifier Information

68. Certifier – Name and Title	69. Date Certified (MM/DD/YYYY) / /
70. Attendant – Name and Title (If other than Certifier)	71. NPI of person delivering the baby:



DOH 422-036 March 2017

Center for Health Statistics
P.O. Box 47814
Olympia WA 98504-7814
360-236-4300

Supporting Affidavit

I, [First Name] [Middle Name] [Last Name], declare under penalty of perjury under the laws of

Washington State that the following is true and correct:

[Child's First Name] [Middle Name] [Last Name], sex [sex], was born on [MM/DD/YYYY]

in [City or Town] in the county of [County], state of Washington.

If the child is under the age of 18, were the parents married at any time during the pregnancy?

[] Yes [] No [] Not applicable

Father/parent birth name [First Name] [Full Middle Name] [Last/Maiden Name], and father/parent was

born in the state or country of [State/Country].

Mother/parent birth name [First Name] [Full Middle Name] [Last/Maiden Name], and mother/parent was

born in the state or country of [State/Country].

I am related to the above named child as [Relationship] and I know or have personal

(Parent, Brother, Sister, Aunt, etc.)

knowledge of the facts concerning the above birth to be true because: [Knowledge]

[Knowledge lines]

Note: "Personal knowledge" means having observed an individual's mother in either (a.) an apparent pregnant state within two months before the individual's date of birth and in a non-pregnant state after the individual's date of birth; or (b.) giving birth to the individual. Please provide specific details about the location where the birth took place, in addition to a list of names of those present at the birth.

Affiant's Signature [Signature] Phone ([Area Code]) [Phone Number]

Mailing Address [Street or P.O. Box] [City or Town] [State] [Zip Code]

(seal or stamp)

SUBSCRIBED and SWORN to before me

this [Day] day of [Month], 20 [Year]

NOTARY PUBLIC in and for the State of Washington,

Residing at [Address] [City or Town]

Notary commission expires: [Date]

WASHINGTON STATE VITAL RECORDS ACCEPTABLE PROOFS OF IDENTITY DOCUMENTATION

One of the following government issued documents (must contain photo, full name, and date of birth) that is current or expired less than 60 days:

- Washington State enhanced driver's license (EDL), driver's license (DL), permit, or identification (ID) card
- Out-of-state enhanced driver's license (EDL) or REAL ID license, driver's license (DL) or identification (ID) card
- U.S. passport or card
- Consulate card
- Foreign passport, driver's license, or ID card
- Permanent resident card
- Tribal membership or enrollment ID card from a federally recognized Indian tribe
- U.S. Immigration or naturalization papers
- U.S. Armed Services ID card
- U.S. Bureau of Indian Affairs ID card
- U.S. Certificate of Citizenship or Naturalization
- U.S. Citizenship and Immigration Service ID
- I-571 U.S. Refugee Travel Document
- US alien registration card
- I-327 U.S. Permit to Re-Enter Travel Document
- I-766 Employment Authorization
- NEXUS, SENTRI, or FAST border crossing card
- U.S. Merchant Mariner's card
- U.S. B1/B2 Visa Border Crossing Card (Form DSP-150)

OR

At least two alternative documents (must contain matching first and last names and addresses, or in combination contains full name, date of birth, and photograph):

- Any of the government issued identity documents listed above, if expired more than 60 days or does not contain a photograph
- Adoption court order or decree
- Auto insurance policy
- Business mail from state or federal agency dated within 2 months
- Company identification card
- Current student body card (high school students only)
- DSHS benefits letter indicating unexpired benefits (medical, food, etc.)
- Home utility bill for Washington address (gas, electric, water, garbage, sewer, landline phone, TV, internet, ISTA) dated within the past 2 months
- Individual Tax Identification Number (ITIN) letter from Internal Revenue Service (IRS)

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To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email civil.rights@doh.wa.gov

Acceptable Proofs of Identity Documentation Continued

- Letter attesting residence in alternative housing (e.g. assisted living, college campus, shelter, mission, senior housing, or retirement home) on company letter head with a phone number that could be used in verification of the facility
- Letter from a government agency that you're an employee of and that we have an agreement with (contact your supervising agency and have them send us the letter)
- Letter from DCYF Children's Administration for foster youth
- Medical or hospital card of identification
- Medicare card (not a DSHS medical card)
- Monthly bank account statement (Document must be no more than 30 days old)
- Moorage document (bill, contract, etc.)
- Official corrections department or parole papers
- Official papers issued by courts of record which include date of birth
- Pay check or pay stub with the employer's name and phone number or address (Document must be no more than 30 days old)
- Personalized check or savings account passbook
- Police employee card issued by Washington city or county
- Pre or post-natal care records
- Proof of home ownership (mortgage documents, property tax documents, deed, title, insurance policy, etc.)
- School transcript or records, or Forms I-20 or DS-2019 for foreign exchange students
- School yearbook or copy certified by the school with recognizable photo (high school students only)
- Social Security card
- State hunting or fishing license
- State or Federal government employee badge with photo
- Tax statements – W-2 forms, 1099, etc.
- Transportation Worker Identification Credential (TWIC)
- Tribal membership or enrollment ID card from a federally recognized Indian tribe (without photo)
- U.S. military document issued within 1 year, selective service card, or military discharge paper
- Unexpired concealed weapons permit issued by federal, state, or municipal government
- Unexpired professional license (nurse, physician, engineer, pilot, etc.)
- Union membership card
- Valid food stamp, welfare, or unemployment identification
- Veteran Administration Identification
- Voter registration card issued by a county elections department
- Ward of the Court decree/Order of Dependency
- Washington vehicle registration or title (a quick title isn't acceptable)