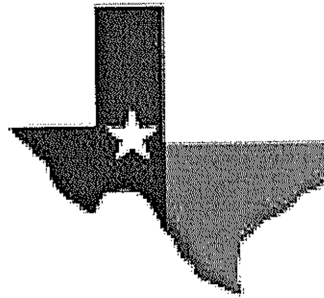
SECTION G



HHSC FORMS

Billable Medicaid Types by Programs

Coverage Code	Type Program	Description	HCS	TxHmL	GR
R or P	01	TANF Basic	X	X	X
R or P	02	Grandfathered LTC Also MBI	X	X	X
R or P	03	Pickle	X	X	X
R or P	04	Medicaid for Deceased Individual			X
R or P	07	Earnings Transitional	X		
R or P	08	Foster Care-Federal Match- with Cash	X	X	X
R or P	09	Non-AFDC Foster Care	X	X	X
R or P	10	State Foster Care-A	X	X	X
R or P	11	SSI Prior			X
R or P	12	Manual SSI	X	X	X
R or P	13	Standard SSI	X	X	X
R or P	14	1915 (c) Waivers (CLASS, MDCP, DBMD, CBA, SPW)	X		
R or P	14	Special Income Limit (LTC Facility)	X		
R or P	15	Adoption Assistance-No federal Match	X	X	X
R or P	18	Disabled Adult Child (aka DAC)	X	X	X
R or P	19	SSI Denied Children	X	X	X
R or P	20	Child Support Transitional			X
R or P	21	Adoption Assistance-Federal Match	X	X	X
R or P	22	Disabled Widow	X	X	X
R or P	23	SLMB-QI			
R or P	24	QMB			
R or P	25	QDWI			
R or P	29	State Time Limit Transitional	X	X	X
R or P	37	EID Transitional	X		
R or P	43	Children Under 1 yrs			X
R or P	44	Children 6 to 19 (income based)	X	X	X
R or P	45	New Born Children			X
R or P	47	Children Denied TANF with applied Income	X	X	X
R or P	48	Children 1 to 5 income based	X	X	X
R or P	51	Rider 51-ICF-IDD, SSLC, Nursing facility	X		
R or P	61	TANF State Program	X	X	X
R or P	78	PCS Medicaid Federal Match no Cash			X
R or P	79	PCS Medicaid No Federal Match No Cash			X
R or P	80	PCS Medicaid Federal Match with Cash			X
R or P	81	PCS Medicaid No Match with Cash			X
R or P	82	ACA (CPS/APS)	X	X	X
R or P	87	Medicaid Buy In (MBI)	X	X	X
R or P	88	Medicaid Buy In for Children (MBIC)	X	X	X

Revised 2.19.2016

CHECKLIST FOR ADULT/CHILD APPLICATIONS THRU HHSC

1. Application for QMB, SLMB, QI-1, ME Waiver, DAC, MBI, MBIC
   a. Form H1200
   b. Form H1200MBI
   c. Form H1200MBIC
   d. Form 1746-A

2. Authorization to Furnish Information – Form H0003

3. Forms to accompany Medicaid Buy In Applications (H1200MBI & H1200MBIC)
   a. Disability Determination Socio-Economic Report – H3034
   b. Medical Information Release/Disability Determination – H3035
   c. Employment Verification Form 1028-MBIC or 1028

What's Medicaid?

Medicaid is a joint federal and state program that helps with medical costs for some people with limited income and resources. Medicaid may also cover services not normally covered by Medicare (like long term supports and services and personal care services). Each state has different rules about eligibility and applying for Medicaid. If you qualify for Medicaid in your state, you automatically qualify for Extra Help paying your Medicare prescription drug coverage (Part D).

You may be eligible for Medicaid if you have limited income and are any of these:

- 65 or older
- A child under 19
- Pregnant
- Living with a disability
- A parent or adult caring for a child
- An adult without dependent children (in certain states)
- An eligible immigrant

In many states, more parents and other adults can get coverage now. If you were turned down in the past, you can try again and may qualify now.

When you enroll, you can get the health care benefits you need, like:

- Doctor visits
- Hospital stays
- Long-term services and supports
- Preventive care, including immunizations, mammograms, colonoscopies, and other needed care
- Prenatal and maternity care
- Mental health care
- Necessary medications
- Vision and dental care (for children)

You should apply for Medicaid if you or someone in your family needs health care. If you aren't sure whether you qualify, a qualified caseworker in your state can look at your situation. Contact your local or state Medicaid office to see if you qualify and to apply. To get information about your state's Medicaid program, visit HealthCare.gov/do-i-qualify-for-medicaid.

3

Dual eligibility

Some people who are eligible for both Medicare and Medicaid are called "dual eligibles." If you have Medicare and full Medicaid coverage, most of your health care costs are likely covered.

You can get your Medicare coverage through Original Medicare or a Medicare Advantage Plan (like an HMO or PPO). If you have Medicare and full Medicaid, Medicare covers your Part D prescription drugs. Medicaid may still cover some drugs and other care that Medicare doesn't cover.

For more information on Medicaid, visit HealthCare.gov/do-i-qualify-for-medicaid. If you have questions about Medicare, visit Medicare.gov, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

CMS Product No. 11306

CARE GUIDE

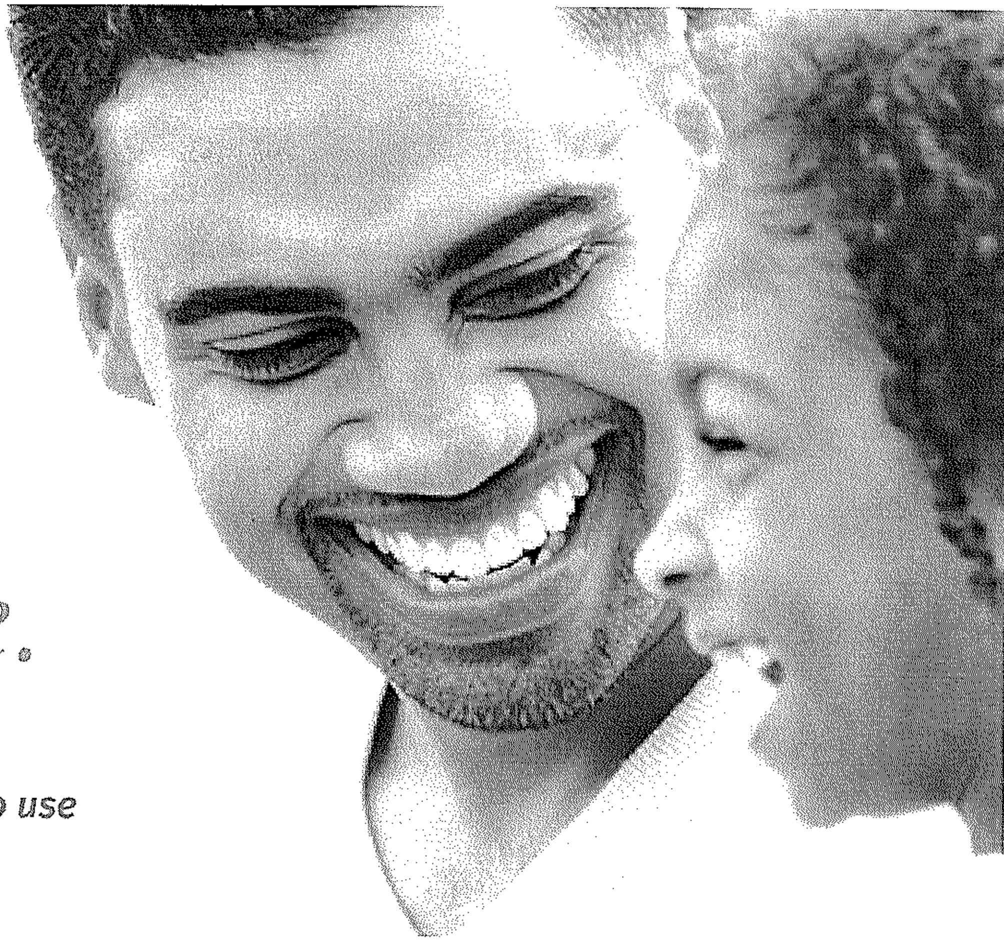
[illegible]ition

Vea al dorso la
version en español.

1-800-335-8957

TEXAS
Health and Human
Services

5



Welcome.

This guide tells you how to use your Medicaid benefits.

Important:

- Pick one doctor or clinic for your health care.
- Get prescriptions only from your main doctor or specialists that your doctor refers you to.
- Try to use one drug store at one location to get all of your medicine.
- Do not get the same type of medicine from different doctors.
- Use an urgent care clinic or the emergency room only when you need treatment right away.
- Tell us if you need an interpreter to talk to us in your language or sign language.
- Take the Your Texas Benefits Medicaid card to doctor visits and to the drug store.
- Do not let anyone else use your Medicaid card.
- If you have a doctor visit and you can't make it, call the doctor's office to cancel. Then set up a new doctor visit.
- Tell us about changes to your case within 10 days of the change. You can report changes by logging in to **YourTexasBenefits.com** or the Your Texas Benefits mobile app. You also can call **2-1-1** or **1-877-541-7905** (after you pick a language, press 2). Tell us about changes in things such as:
  - Your address or phone number.
  - The bills you pay.
  - People living in the home.
  - Amount of money you earn.
  - Insurance (including health insurance premiums).

If you need help with this guide, call the free Medicaid Help Line at 1-800-335-8957.

WHAT'S INSIDE:

Services For Everyone

What Medicaid Covers 5
Using the Your Texas Benefits Medicaid Card.....6
Finding a Medicaid Doctor 6
Getting the Medicine You Need.....7
Getting Medical Supplies and Equipment 7
Getting a Ride to the Doctor, Dentist, or Drug Store 8
Help for Mental Health or Drug or Alcohol Abuse Issues.....9
Reporting Accidents.....9
Other Health Insurance 10
Medicaid Buy-In Programs 11

Services for Children

Medical and Dental Care with Texas Health Steps.....13
Help for Children who are Blind or Visually Impaired 14
Help for Children with Disabilities or Delays in Growing or Learning. . 14
How to Get Extra Help 14

Services for Women

Medicaid for Pregnant Women 15
Medicaid for Breast and Cervical Cancer.....15
Medicaid (Title XIX) Family Planning Services 15

Services for People 65 and Older and People with Disabilities

Long-Term Services and Supports.....16

Medicaid Rules

Medicaid Program Rules 18
Your Rights 19

This guide is from Texas Health and Human Services, which runs Texas Medicaid. If you have a vision disability and need an accessible version of this book, go to **https://hhs.texas.gov/services/health/medicaid-and-chip/programs/medical-and-dental-plans** and click the Member Handbook link under Traditional Medicaid. If you need this book translated into another language, we may be able to help. Call us at **1-800-335-8957.**

GET HELP

All of the numbers in this book are free to call unless otherwise noted.

Get Help on the Phone

Medicaid Help Line
1-800-335-8957
7 a.m. to 7 p.m., Central Time
Monday to Friday
Call this number to:

- Find a Medicaid doctor.
- Learn more about Medicaid services.

Texas Health Steps
1-877-847-8377
8 a.m. to 6 p.m., Central Time
Monday to Friday
Call this number to get help finding a Texas Health Steps doctor, dentist, other provider, or someone to help you find and get other services (case manager). Texas Health Steps is for babies, children, teens, and young adults 20 and younger who have Medicaid.

Rides to the Doctor, Dentist, Therapist, or Drug Store
Call the number below for your area if you need a ride to get to your Medicaid provider. You must call at least two days in advance.

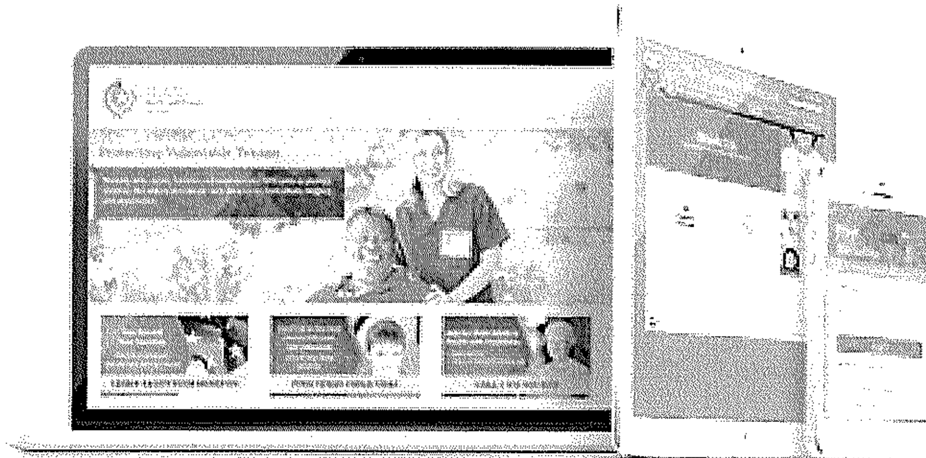
- Houston / Beaumont area: 1-855-687-4786
- Dallas / Fort Worth area: 1-855-687-3255
- All other areas: 1-877-633-8747 (1-877-MED-TRIP)

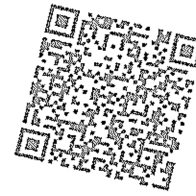
Finding Help in Texas
2-1-1
Dialing 2-1-1 is a free, easy way to find out about services you can get in your area or through state programs. Call 2-1-1 to:

- Report changes to your case. (You should do this within 10 days of the change.)
- Check your Medicaid benefits.
- Check that we received items you sent us.
- Find services in your area such as child care, food pantries, help paying utilities, low-cost legal help, and more.
- Report fraud, waste, or abuse in any of the state's health and human services programs.

You also can go to the 2-1-1 Texas website, www.211Texas.org, to find services in your area.

Complaints about Medicaid Services
2-1-1 or 1-877-541-7905
8 a.m. to 5 p.m., Central Time
Monday to Friday
If you have a complaint, call 2-1-1 or 1-877-541-7905 (after you pick a language, press 2). If you still need help, call 1-877-787-8999.





Have a smartphone or tablet? Look for these codes in this guide to be taken directly to important websites.

Get Help on the Web and on Your Smartphone

YourTexasBenefits.com

On this site you can:

- Check your benefits and report changes to your case.
- Renew benefits and apply for other programs.
- Upload files and forms we need from you.
- Sign up to receive text or email alerts about your case.

Click on Manage > Medicaid & CHIP Services (in the Quick Links Section) > View Services and Available Health Information if you need to:

- View your Medicaid services.
- View, print, or order a new Medicaid card.
- Choose whether or not to share your health information with doctors.
- View your eligibility and program information.
- Adults with Medicaid can view their available health information, such as:
  - Health events.
  - Prescription medicines.
  - Vaccine information.
  - Test information.
  - Past Medicaid visits.

Your Texas Benefits app for smartphones

With this app you can:

- Report most changes to your case.
- Upload pictures of files and forms.
- View files and forms you send to us and we send to you.
- Receive alerts about your case.

MyChildrensMedicaid.org

On this site you can:

- Learn more about your child's Medicaid benefits.
- Learn more about Texas Health Steps.
- Learn more about other available services.

hhs.texas.gov

On this site you can:

- Learn about other benefit programs.
- Find resources near you.
- Learn about ways to stay healthy.
- Report Medicaid abuse or fraud.

EVERYONE

What Medicaid Covers

Medicaid pays for many health-care services. Here are some examples:

- Doctor and clinic visits.
- Hospital visits.
- Emergency care.
- Medicine.
- Medical equipment and supplies.
- Glasses.
- Tests and X-rays.
- Family planning.
- Pregnancy and childbirth care.
- Mental health treatment.
- Treatment for drug or alcohol abuse issues.
- Personal care services.
- Care in a nursing home or other place of care.
- Care in your home.
- Rides to your doctor, dentist, or drug store.
- Speech therapy—help learning to speak again or speak better.
- Physical therapy—help learning how to move around better or become stronger.
- Occupational therapy—help learning how to do everyday activities like getting around your home, getting in a car, and getting dressed.

To find out about other services, call the Medicaid Help Line at 1-800-335-8957 or the Texas Medicaid Call Transfer Line at 1-800-252-8263 from 7 a.m. to 7 p.m., Central Time, Monday to Friday.

Using the Your Texas Benefits Medicaid Card

What is the Your Texas Benefits Medicaid card?

It's your permanent Medicaid ID card. The card is plastic and it has your name, Medicaid ID number, and other facts you need to get Medicaid services.

How often will I get a new card?

You will get a new Medicaid card:

- When you are first approved for Medicaid.
- If your card is lost, stolen, or damaged and you ask for a new one.

You can keep using your Medicaid card even if you change your medical or dental plan. We will not send you another Medicaid card unless your card is damaged, lost, or stolen.

When do I use the Medicaid ID card?

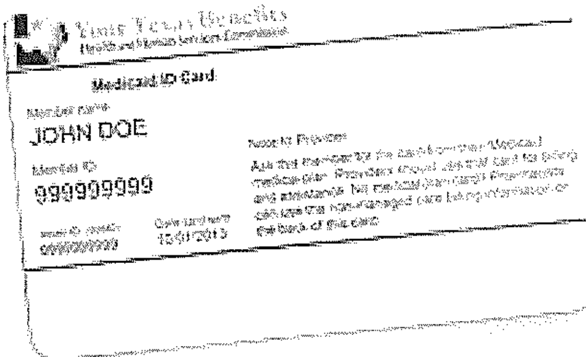
Carry the card with you—just like your driver's license or a credit card. Take it with you every time you:

- Visit your Medicaid doctor, dentist, or therapist.
- Get medicine at the drug store.
- Go to the hospital.

Your Medicaid ID number will be checked to make sure you're covered by Medicaid.

What if I lose my card?

If you lose your card, or have problems using it, call **1-855-827-3748**. If you don't have your card, you can still go to your doctor, dentist, therapist, or drug store. Before your visit, they will need to make a call or go online to make sure you're covered by Medicaid. You may also log on to **www.YourTexasBenefits.com** to order a new card, print out a temporary one, or view it on your smartphone.



Finding a Medicaid Doctor

What if I don't have a doctor or my doctor doesn't take Medicaid?

- Call the Medicaid Help Line at **1-800-335-8957**.
- Find a doctor who takes Medicaid by going to: **hhs.texas.gov > Services > Questions About Your Benefits > Find a Doctor**.

How will I know when to use the emergency room or an urgent care clinic?

The first time you visit your Medicaid doctor, ask what health problems you should call him or her about. Also, ask if your doctor's office is open in the evenings or on the weekends, or if they have a number you can call after hours. This will help you avoid going to the emergency room when it's better to go to the doctor's office. Most health problems do not need a trip to the emergency room.

Go to an urgent care clinic if:

- You need treatment right away.
- You can't visit with your doctor.

and

- It's not an emergency.

Urgent care clinics usually have night and weekend hours. You must go to a clinic that takes Medicaid. To find one near you, call **1-800-335-8957**. Call 7 a.m. to 7 p.m., Central Time, Monday to Friday.

Getting the Medicine You Need

How do I get my medicine?

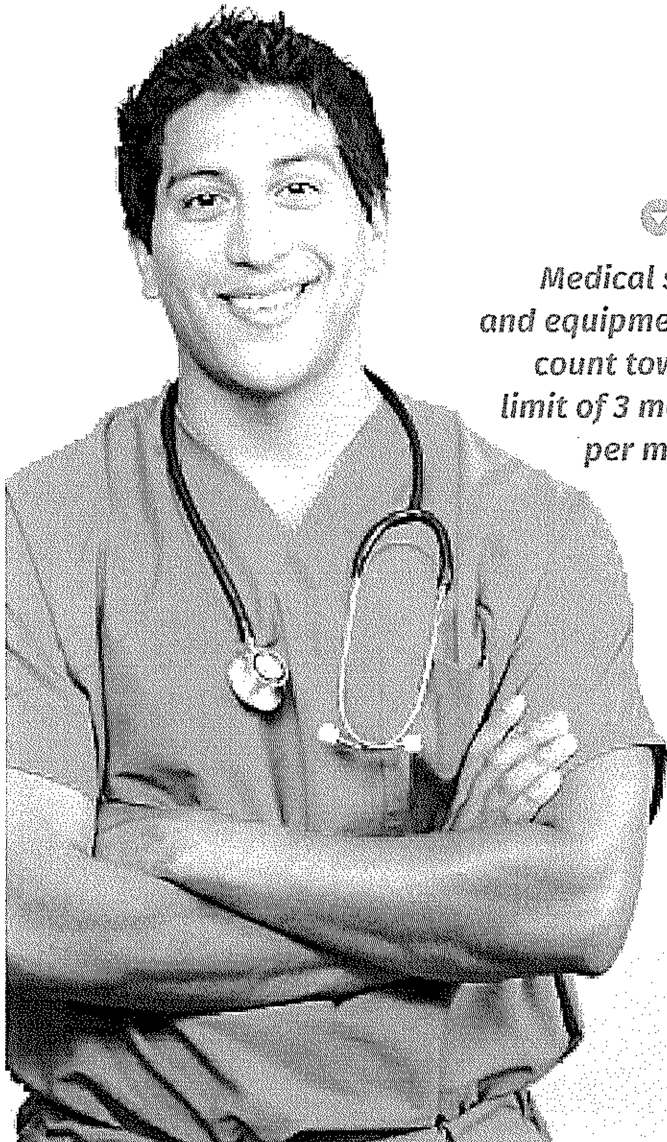
- Medicaid pays for most medicine that your doctor says you need. Your doctor will write a prescription so you can take it to the drug store.
- Children 20 and younger don't have a limit on medicines.
- Most adults (age 21 and older) have a limit of 3 medicines each month.
- Medicine that helps you quit smoking doesn't count toward the limit of 3 medicines.
- Find a drug store that takes Medicaid.
- Use the same drug store every time.

What if my medicine needs "pre-approval"?

Some medicine needs to be pre-approved before you can pick it up from the drug store. The drug store will need to get this pre-approval from your doctor. If they can't reach your doctor right away, they should give you a 3-day supply until your doctor approves the medicine.

How do I find a drug store that takes Medicaid?

- Call **2-1-1** or the Medicaid Help Line at **1-800-335-8957**.
- Go to **hhs.texas.gov** > **Services** > **Questions About Your Benefits** > **Find a Drug Store**.



Medical supplies and equipment don't count toward the limit of 3 medicines per month for adults.

Getting Medical Supplies and Equipment

You can get the following supplies at drug stores that take Medicaid:

- Diabetic supplies such as test strips, syringes, needles, monitors, and lancets.
- Spacer for inhalers to treat asthma or other respiratory diseases.
- Oral electrolyte solutions such as Pedialyte and Oralyte.
- Hypertonic saline solution for inhalation to treat cystic fibrosis
- Vitamin and mineral products if you are age 20 and younger.

Call **1-800-335-8957** to find a drug store that can help you get other supplies or equipment. Other supplies and equipment can include:

- Wheelchairs.
- Bathroom equipment.
- Crutches.

13

Getting a Ride to the Doctor, Dentist, or Drug Store

What if I need a ride?

Children with Medicaid and their parent or guardian can get free rides to and from Medicaid-covered visits. Adults with Medicaid can get free rides, too. You can get rides to:

- Pick up medicines covered by Medicaid at a drug store.
- Go to a Medicaid doctor, dentist, or therapist.
- Go to get lab tests.

Another person (such as a caregiver) can travel with an adult if a doctor agrees that help is needed. Help for the adult rider can include help with physical needs or language translation. We can send your doctor the form that he or she will need to fill out. Your doctor will need to fill out this form before the caregiver is allowed to go.

Who do I call for a ride?

The number you call to set up a ride depends on where you live.

Dallas / Fort Worth area:

Call **1-855-687-3255** if you live in one of these counties: Dallas, Denton, Ellis, Erath, Hood, Hunt, Johnson, Kaufman, Navarro, Palo Pinto, Parker, Rockwall, Somervell, or Tarrant.

Houston / Beaumont area:

Call **1-855-687-4786** if you live in one of these counties: Austin, Brazoria, Chambers, Fort Bend, Galveston, Hardin, Harris, Jasper, Jefferson, Liberty, Matagorda, Montgomery, Newton, Orange, Polk, San Jacinto, Tyler, Walker, Waller, or Wharton.

All other areas: Call **1-877-633-8747 (1-877-MED-TRIP)**.

How do I set up a ride?

You must call at least 2 weekdays (Monday to Friday) before you need a ride. If it will be a long ride, or the doctor is in another county, call at least 5 weekdays ahead. When you call, you will need to give:

- Your Medicaid number.
- The address where you will be picked up.
- The name, address, and phone number of the doctor or drug store you're going to.
- The day and time of your healthcare visit.
- If you need to go to a drug store, give the day and time that your medicine will be ready.

Tell us if you or your children have any special needs so we can send the right type of vehicle. For example, if you use a wheelchair, we can send a van with a wheelchair ramp.

What kind of ride can I get?

You can get rides by bus, van, car, or taxi. If you need to go a long distance, travel by plane might be approved.

If you have a car, you might be able to get paid back by the mile for your trip.

Someone you know (family, neighbor, or friend) can give you a ride and get paid back by the mile. The driver must apply with the Medicaid Transportation Program before they can start getting paid to give rides.

To learn more:

- Go to **hhs.texas.gov > Services > Questions about Your Benefits > How to Get a Ride to the Doctor, Dentist, or Drug Store**.

14

Help for Mental Health or Drug or Alcohol Abuse Issues

What kind of help can I get?

Medicaid covers many mental health and substance abuse services, including:

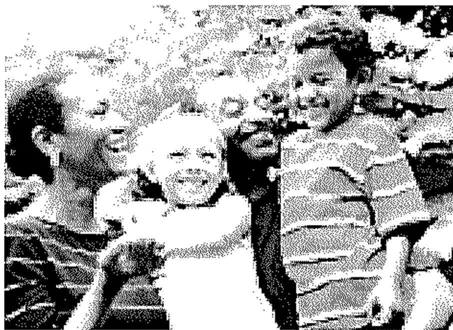
- A visit to find out what type of help you need.
- Counseling.
- Tests.
- Medicine.
- Hospital care.
- Drug and alcohol treatment.

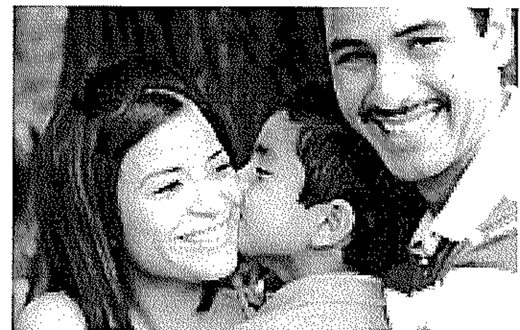
How do I get help for mental health or drug or alcohol issues?

Ask your doctor to help you find a provider who fits your needs. A provider can be a doctor, therapist, hospital, community mental health center, or drug abuse treatment facility.

To learn more:

- Go to **hhs.texas.gov** > **Services** > **Health** > **Mental Health & Substance Abuse**
- Go to **www.mentalhealthtx.org**





Reporting Accidents

If you've had an accident or suffered an injury, and Medicaid paid for your medical care, be sure to call us right away.

What if I have an accident?

If Medicaid paid for medical care that you got for an accident or injury, you must call **1-800-846-7307** (option 3). Call 8 a.m. to 5 p.m., Central Time, Monday to Friday.

When you call, give:

- Your name.
- Your Medicaid ID number. This is on your Medicaid card.
- Date of the accident or injury.

Also, give the name, address, and phone number of your lawyer or insurance company if:

- You have a lawyer working for you.
- There is an insurance company involved.
- You filed a claim for this accident or injury.

You also must tell us about any legal cases you or your family file for being hurt. Tell us the name and address of the lawyer working on your legal case. Also tell us the name of the insurance involved in the case. Follow all of these rules to keep your Medicaid benefits.

You can fax your information to **1-512-514-4225** (not toll-free) or mail your information to:

TMHP/TORT
PO Box 202948
Austin, TX 78720-2948

15

Other Health Insurance

If I have other insurance, can I still get Medicaid services?

You can still get Medicaid even if you have other insurance. If a Medicaid doctor takes you as a Medicaid patient, the doctor must file claims with your other insurance first.

You must tell us about any other health insurance you have. This includes insurance for medicine. You also must tell us if:

- You lose your insurance.
- You get new insurance.

To tell us about your other insurance, call **1-800-846-7307**. You can call 7 a.m. to 7 p.m., Central Time, Monday to Friday. You can also call if you have questions about other insurance.

Will Medicaid help me pay for other insurance?

The Medicaid Health Insurance Premium Payment (HIPP) program might pay you for your employer-sponsored insurance premiums if:

- Someone in your family gets Medicaid. It could be you, your spouse, or your child.

and

- Someone in your family can get health insurance at work.

You might be eligible for HIPP if it costs the Medicaid program less money to pay for your employer-sponsored insurance premiums than it would to pay for your Medicaid services.

How does HIPP work?

With HIPP, you don't lose your Medicaid benefits. HIPP pays you back for the money taken out of your paycheck for health insurance. When you see a Medicaid doctor for a covered service, Medicaid pays your co-pays and deductibles. Family members who are covered by your work's health plan but who don't get Medicaid must pay their own co-pays and deductibles.

To learn more:

- Call the HIPP helpline **1-800-440-0493**, 7 a.m. to 7 p.m., Central Time, Monday to Friday.
- Go to **GetHIPPTexas.com**.

Medicaid Buy-In Programs

What are the Medicaid Buy-In programs?

Medicaid Buy-In programs offer health-care services to people who make too much money to get other types of Medicaid. Buy-in programs allow some people to get Medicaid by paying a monthly fee. Services can include community-based services and supports.

To be in the Medicaid Buy-In program, a person must:

- Have a physical, intellectual, developmental, or mental disability.
- Work.
- Live in Texas.

and

- Not live in a state institution or nursing facility all the time.

Medicaid Buy-In programs offer health-care services to people who might not qualify for Medicaid.

The Medicaid Buy-In for Children program is for children 18 and younger who:

- Aren't married.
- Meet the same rules for a disability that are used to get Supplemental Security Income (SSI). The child doesn't have to get SSI.

and

- Live in Texas.

To learn more:

- Go to **hhs.texas.gov > Services > Health > Medicaid and CHIP.**

How do I renew Medicaid benefits?

Most people must renew their Medicaid benefits every 12 months. You will get a renewal letter from us that tells you if we were able to renew your health-care benefits with the facts on file for you. If we need more items from you, the letter will let you know. You can renew your benefits by:

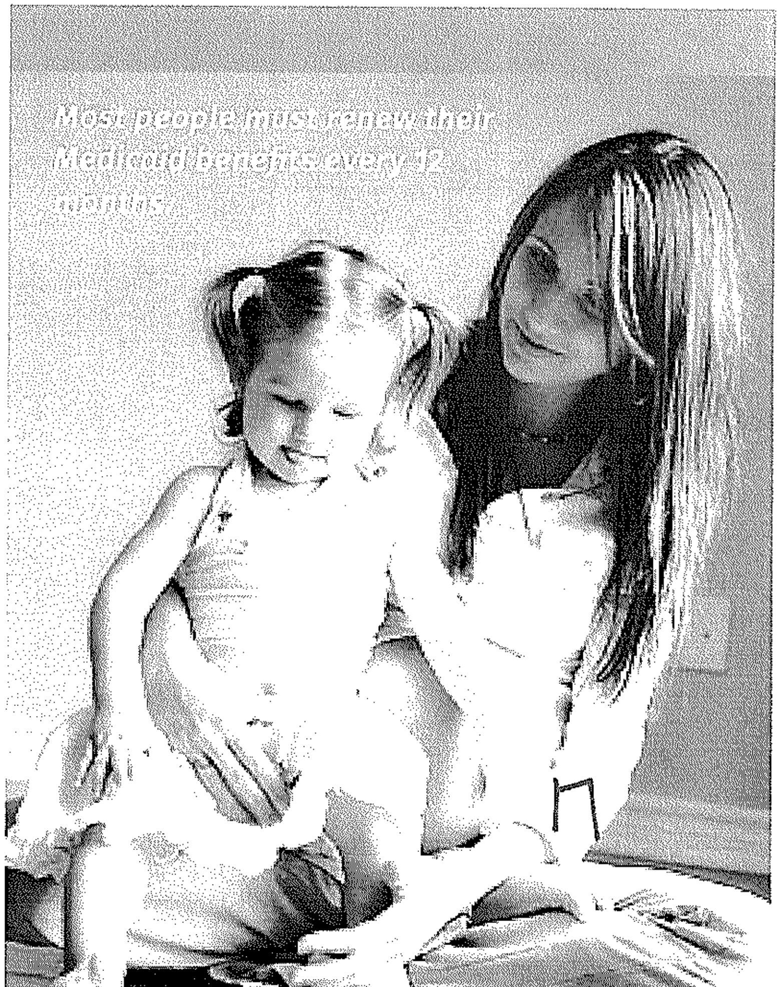
(1) Going to **YourTexasBenefits.com**

(2) Calling **2-1-1**

or

(3) Visiting a benefits office.

If you have questions, call **2-1-1** or **1-877-541-7905** (after you pick a language, press 2).



CHILDREN

Medical and Dental Care with Texas Health Steps

Texas Health Steps is for people 20 and younger who have Medicaid.

Texas Health Steps services include:

- Free medical checkups starting at birth.
- Free dental checkups starting at 6 months of age.
- A case manager to help you find and get other services.

Texas Health Steps will help you:

- Find a doctor, dentist, or case manager.
- Set up doctor and dentist checkups.
- Learn about services for your child.
- Get a free ride to checkups or the drug store.

Children need checkups even when they are healthy.

Medical and dental checkups will:

- Help find problems before they get worse and are harder to treat.
- Prevent health problems that make it hard for your child to learn and grow.
- Help your child have a healthy smile.

When is the right time for a Texas Health Steps checkup?

Texas Health Steps will send you a letter when your child is due for a medical or dental checkup. Even if your child is not due for a checkup, Medicaid will pay for health services if your child is sick or in pain. Medicaid also will pay to treat other health issues found during a Texas Health Steps checkup.

To learn more:

- Call 1-877-847-8377 or 2-1-1.
- Go to MyChildrensMedicaid.org

Texas Health Steps

Help for Children who are Blind or Visually Impaired

If you have a child who is blind or visually impaired, the Blind Children's Vocational Discovery and Development Program may be able to help. A specialist can work with you to create a family service plan. This program can:

- Help you manage your case and meet your child's needs and full potential.
- Help your child to be active in the community.
- Help your child in finding and developing a career.
- Give training in areas such as cooking, money management, social activities, and personal care.

To learn more:

- Call 1-877-787-8999, pick a language, and then select Option 3.
- Go to hhs.texas.gov > Services > Disability > Blind and Visually Impaired.

Help for Children with Disabilities or Delays in Growing or Learning

Children 2 and younger who have disabilities or delays in growing or learning can get special help. We can check to see if your child's growth and learning are on target. If any issues are found, we will check to see what services your child can get.

To learn more:

- Call 1-877-787-8999, pick a language, and then select Option 3.
- Go to hhs.texas.gov > Services > Disability > Early Childhood Intervention Services.

How to Get Extra Help

Ask a case manager to help you if:

- Your child has a health issue, disease, or disability (such as asthma, diabetes, or mental health issues).
- Your child is at risk for certain health issues (due to things such as your family's health history or growing or eating issues).

A case manager can:

- Help you work with doctors to get medical services.
- Help you with family, school, housing, and other concerns you have.
- Help you get medical equipment and supplies.
- Help you work with other agencies.

To learn more:

- Call 1-800-252-8023.
- Go to www.dshs.texas.gov/caseman.

How is Your Baby?

Children grow and learn more in their first 3 years than any other time in their lives. Is your baby having a hard time learning to sit up, walk, or talk? If yes, talk to your child's doctor or:

- Call **1-877-787-8999**, pick a language, and then select Option 3.
- Go to **hhs.texas.gov > Services > Disability > Early Childhood Intervention Services**.

20.

WOMEN

Medicaid for Pregnant Women

The Medicaid for Pregnant Women Program offers Medicaid benefits during pregnancy and up to 2 months after the birth of the baby. Services include:

- Doctor visits.
- Tests and X-rays.
- Labor and delivery.
- Hospital care.

Medicaid For Breast and Cervical Cancer

The Medicaid for Breast and Cervical Cancer (MBCC) program may be able to provide full Medicaid benefits for women who:

- Are 18 to 64 years old.
- Have breast or cervical cancer.
- Have early signs of breast or cervical cancer.
- Have no other health insurance.

To see if you qualify, contact a Breast and Cervical Cancer Services clinic. Call 2-1-1 or go to www.healthytexaswomen.org for clinics near you.

Medicaid (Title XIX) Family Planning Services

Medicaid (Title XIX) Family Planning services include:

- Family planning annual exams.
- Family planning office visits.
- Tests and X-rays.
- Birth control.
- Drugs and supplies.
- Medical counseling and education.
- Sterilization and sterilization-related procedures.

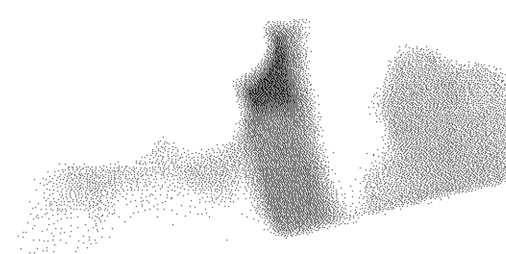
If you don't qualify for Medicaid Family Planning services, you might be able to get services from the Healthy Texas Women Program or the Family Planning Program.

For questions or to find a doctor, call 1-800-335-8957 from 7 a.m. to 7 p.m., Central Time, Monday to Friday. After you pick a language, select Option 5. Or go to www.healthytexaswomen.org.

21

PEOPLE WITH DISABILITIES

Long-Term Services and Supports



If you are 65 or older, or if you have a disability, you might be able to get help with personal care, cleaning the house and health care.

You must apply for and be approved to get services. Depending on your needs, you can get services at home, in an adult day care center or assisted living facility.

A Texas Health and Human Services case manager can help you get the services you need. Examples of long-term services include:

- Help dressing, bathing and using the bathroom.
- Help fixing meals, grocery shopping and eating.
- Help with cleaning house and doing laundry.
- Hospice services (end of life care).
- Day care outside the home, such as in a day activity and health services center.
- Residence in an adult foster care facility.
- Skilled nursing care.
- Respite care (provide relief for the caregiver).
- Protective supervision (supervision for people with memory impairment or physical weakness).
- Dental and minor home modifications.

To learn more:

- Call 1-855-937-2372.
- Go to **hhs.texas.gov > Services > Aging > Care for People 60+**
- Go to **hhs.texas.gov > Services > Disability > People with Medical or Physical Disabilities**

22

MEDICAID RULES

Medicaid Program Rules

If you get Medicaid, you must follow these rules:

- Pick one doctor or clinic to visit when you need care.
- Be sure your main doctor and any specialists you see are the only doctors that give you prescriptions.
- Pick one drug store and try to use it all the time.
- Do not get the same type of medicine from different doctors.
- Do not use the emergency room if you don't have an emergency.

If you don't follow these rules, you might be put in the Medicaid Lock-in Program. This program might limit which doctor and drug store you can use. You also might be put in this program if you commit Medicaid fraud or abuse services.

We will let you know if you are going to be put in the Lock-in Program. People in this program still get Medicaid benefits. To learn more, call 1-800-436-6184 (pick option 8).

Report Medicaid Waste, Abuse, or Fraud

Let us know if you think a doctor, pharmacist, other health-care provider, or a person getting Medicaid is doing something wrong. Doing something wrong could be waste, abuse, or fraud, which is against the law. For example, tell us if you think someone is:

- Getting paid for Medicaid services that weren't given or necessary.
- Getting Medicaid services that are not approved.
- Not telling the truth about a medical condition to get medical treatment.
- Letting someone else use your Medicaid card.
- Using someone else's Medicaid card.
- Not telling the truth about the amount of money or assets he or she has.

To report waste, abuse, or fraud, you can do one of the following:

- Go to https://oig.hhsc.texas.gov. Click on "Report Fraud." Fill out the online form.
- Call 1-800-436-6184.
- Call 2-1-1 instead, then press 3.
- Mail a letter to report a doctor, pharmacist, or other provider to:

  Office of Inspector General
  Intake Resolution Directorate / Mail Code 1361
  PO Box 85200
  Austin, TX 78708-5200

- Mail a letter to report a person who gets Medicaid to:

  Office of Inspector General
  General Investigations / Mail Code 1362
  PO Box 85200
  Austin, TX 78708-5200

Your Rights

Your Rights While Getting Medicaid

You have the right to:

- Be treated fairly and with respect by doctors and medical staff.
- Be treated fairly, regardless of race, color, national origin, sex, age, disability, or religion.
- Pick your doctor as long as he or she is accepting people with Medicaid.
- Have a reasonable amount of time to pick your doctor.
- Change to another doctor in a fair and easy manner.
- Get another doctor's opinion about your treatment.
- Get help, at no charge to you, in talking with your doctor if you speak a different language or use sign language. For example, a doctor's office would need to pay for an interpreter if you needed one.
- Get emergency care from the emergency room closest to you.
- Get a letter that tells you why you can't get a Medicaid service you asked for.
- Use the Medicaid complaint and appeal process.
- Get a fast response to your complaint.
- Get a Medicaid Fair Hearing if you couldn't get a Medicaid service.

Your Right to Privacy

Every time you get a health-care service, your doctor writes down what happened and puts it in your file. This file is kept private. Your doctor can give out your file only if you agree.

Your Right to Your Health Files

Medicaid doctors and other approved providers can use a secure online network to share your Medicaid health records. When doctors can see your Medicaid health records online they can help you faster. Sharing your records online is more secure than mailing or faxing your records.

You have the right to let us know if you don't want us to share your Medicaid health records. If you don't want your Medicaid doctors to see your health records on our secure online network, call 1-877-518-0899. You also can go to www.tmhp.com for more information. Click on "Clients / English." Then look for the picture with the following words and click on it: "A safer and faster way to share your Medicaid health information."

Your Right to Get a Copy of Your Case Files and Health Records

You have the right to get copies of your case files and health records. You might have to pay for the copies. You also can ask for changes to your files or records if you know something is wrong.

You can ask for copies of your health records. If you change your doctor, you can ask that your records be sent to your new doctor. If your doctor, or other Medicaid provider, doesn't give you or your new doctor a copy of your health records within 3 work days, you can call 2-1-1 or 1-800-335-8957.

Your Right to be Treated Fairly

Contact the HHS Civil Rights Office right away if anything like the following happened to you when using Medicaid:

- Someone treated you unfairly because of race, color, national origin, sex, age, disability, or religion.
- You could not get services because of race, color, national origin, sex, age, disability, or religion.
- You could not get services because your language needs were not met.
- You could not use the Your Texas Benefits website because of your disability.
- You were the victim of unwanted sexual advances.
- Someone threatened you with words or actions.

You can contact the HHS Civil Rights Office by:

- Mail or in Person:

  Civil Rights Office
  Texas Health and Human Services
  701 West 51st St.
  MC W206
  Austin, TX 78751

- Phone: **1-888-388-6332.**

To see a list of area offices, go to **hhs.texas.gov > About HHS > Your Rights > Civil Rights Office > Contact Us.**

- Fax: **1-512-438-5885** or **1-512-438-4755** (not toll-free outside the Austin area)
- E-mail: **HHSCivilRightsOffice@hhsc.state.tx.us**

To learn more, go to **hhs.texas.gov > About HHS > Your Rights > Civil Rights Office.**

Your Right to a Fair Hearing

A fair hearing is a chance for you to tell us the reasons you think you should have a Medicaid service you asked for but did not get. You can ask for a hearing within 90 days of the date of the letter that said you could not get the service.

You can ask for a fair hearing by calling **1-800-414-3406**. If you would like to ask for a hearing in writing, send it to the following address:

Texas Medicaid & Healthcare Partnership (TMHP)
Attention: Fair Hearings
PO Box 204270
Austin, TX 78720-4270

After we get your phone call or letter, a hearing officer will send you a letter. The letter will tell you the date and time of the hearing. It also will tell you what you need to know to get ready for the hearing. The hearing can take place by phone or in person.

During the Hearing

You can tell us why you asked for the service that you didn't get. You can speak for yourself or you can ask someone else to speak for you. This could be a friend, family member, or lawyer. Let your hearing officer know if you need an interpreter. The hearing officer will listen to what you have to say. The hearing officer also will listen to the reasons why you were told you couldn't get the service. You can ask questions about these reasons. The hearing officer might ask you some questions. A final decision will be made within 90 days from the date you asked for the hearing.

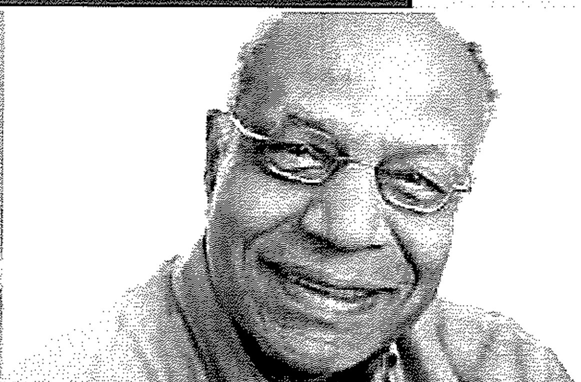
Your Right to File a Complaint

If you have a complaint about Medicaid services, call **2-1-1** or **1-877-541-7905** (after you pick a language, press 2). If you don't get the help you need there, contact the HHS Office of the Ombudsman by:

- Mail:

  HHS Office of the Ombudsman
  PO Box 13247
  Mail Code H-700
  Austin, TX 78711-3247

- Phone: **1-877-787-8999**
  Relay Texas: **7-1-1** or **1-800-735-2989** (for people with a hearing or speech disability)
- Fax: **1-888-780-8099**



What help can I get

You do not need to login

You can fill out this screening form to find out which benefits and support services you might be able to get. At the end of the form, you can decide if you want to log in and: (1) apply for benefits, and (2) send your form to support programs and ask them to contact you about their services.

Apply for benefits

You need to login

You can apply online for:

- SNAP food benefits (food stamps)
- Health-care benefits (Medicaid and CHIP)
- Cash help for families (TANF)
- Medicare savings programs
- Long-term care

You can save your online form and work on it at different times.

Find support services

You need to log in

2

You can fill out this screening form to find out if you can get support services. You also can: (1) view your saved screening forms and (2) check the status of screening forms you already filled out. Support services are for:

- People who are older or have a disability and need help with daily living needs.
- People who are caring for someone who needs help with daily living needs . Help can

View my case

You need to login

After you send us the application form, you can:

- Check the status of your case.
- See your benefits and amounts.
- Report changes to your case.
- Renew your benefits.
- Print a Medicaid card.
- View Medicaid serivces.
- Upload files you want to send to us.
- View items you sent us online
- Check interview time.

Apply for benefits

Your Texas Benefits: Getting started

We can send you emails or text messages about your case and online account.

We also can send you alerts when a new letter or form is posted to your account. (You can sign up to get all your letters and forms posted to your online account instead of mailed to you.)

Do you want to sign up now?

Yes | No

28

Apply for benefits

Show Getting started in a PDF pag

Your Texas Benefits: Getting started

How does the online form work?

This online form might take you 20 to 45 minutes to fill out.

You will be asked questions about:

- People applying for benefits.
- People living in your home.
- Money you get from jobs and other sources.
- Costs you pay.
- Things you pay for or own.

For some benefits, including SNAP food benefits (food stamps), the first month's amount will be based on:

1. When we get the name and address of the contact person or head of household. (You will be asked for this when you get to the "Contact person or head of household" page.)

and

2. When we get your signature. (To learn more about how we get your signature, read the "What happens when I am done filling out this form?" section on this page.)

If you send the form to us without filling out all the questions that apply to your case, you will have to fill them out before you can get benefits.

What facts will I need to give on this form?

What happens when I am done filling out this form?

What if I want to stop and finish my application later?

What should I know before I apply?

29

Start application

Apply for benefits

Show Getting started in a PDF pa

Your Texas Benefits: Getting started

How does the online form work?

What facts will I need to give on this form?

Before you start, you need to know the following:

- Money you get from jobs and other sources.
- Social Security numbers and birth dates of everyone who wants to apply.
- Costs you pay for bills, such as: rent, mortgage, water, gas, electric, sewage, and phone.
- The value of items you pay for or own, such as: vehicles, money in bank accounts, stocks, etc.
- Amount you get or pay for child support.
- Health insurance information.
- Car insurance information.

What happens when I am done filling out this form?

What if I want to stop and finish my application later?

What should I know before I apply?

30

Start application

Apply for benefits

Show Getting started in a PDF pac

Your Texas Benefits: Getting started

- How does the online form work?
- What facts will I need to give on this form?
- What happens when I am done filling out this form?

You must sign the form.

We might be able to accept an electronic signature (e-signature):
If you are applying yourself or you have the right to act for the person applying (you are an authorized representative):

We can accept an e-signature.

When you click on the "Send" button at the end of the form it is the same as signing your name. When you click on "Send," that means you agree to everything in the form.

We might need to send you the form to sign:
If someone is helping you fill out this form, but they don't have the right to act for you (they are not your authorized representative):

We must mail the form to you so you can sign it.

When you click on the "Send" button at the end of the form, we will know we need to mail the form to you.

When you get the form, sign it. And then send it back to us (we will send a pre-paid envelope).

We will find out which benefits you can get.

After you click on the "Send" button at the end of the form, your form will be sent to the Texas Health and Human Services Commission (HHSC). We will look at your form to see which benefits you can get.

- What if I want to stop and finish my application later?
- What should I know before I apply?

Start application

TEXAS Health and Human Services Commission

Your Texas Benefits

English | Español Text size

Log out

Home | What help can I get | Apply for benefits | Find support services | View my case | Find office | FAQs

Apply for benefits

Show Getting started in a PDF pa

Your Texas Benefits: Getting started

You can print and save your form.

If you are applying for yourself or you have the right to act for the person applying (you are an authorized representative):

When you get to the end of the form, you can:

- Print your form.
- Save your form to your computer (PDF).
- View your form in the "View my case" section of this site.
- Ask us to mail a copy of your form to you.

We will let you know the status of your case.

We will send you letters letting you know the status of your case. You also can check the status by going to the "View my case" section of this site.

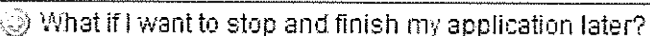
We might need to ask you to send us other facts about your case.

We might send a letter asking you to send us proof of the facts you gave on the form.

We might send your facts to the federal Health Insurance Marketplace

If you apply for health-care benefits, but we can't approve you for those benefits. We might send all the facts you give us on the application form to the Marketplace if: (1) you apply for health-care benefits, and (2) we can't approve you for health-care benefits.

The Marketplace will: (1) review your facts, and (2) let you know if you can get health insurance through their program. To learn more, go to HealthCare.gov or call 1-800-318-2596 (toll-free).



Start application

Apply for benefits

Show Getting started in a PDF pa

Your Texas Benefits: Getting started

- How does the online form work?
- What facts will I need to give on this form?
- What happens when I am done filling out this form?
- What if I want to stop and finish my application later?

We will save your form for 60 days from the last time you save your form.

You can save your form by clicking on either a "Save and exit" or "Save and go to next page" button. These buttons are on almost every page.

- What should I know before I apply?

Start application

Apply for benefits

Show Getting started in a PDF page

Your Texas Benefits: Getting started

- How does the online form work?
- What facts will I need to give on this form?
- What happens when I am done filling out this form?
- What if I want to stop and finish my application later?
- What should I know before I apply?

Help you can get without filling out this form.

You don't have to fill out this form to get the help listed below.

All phone and fax numbers are free to call. If you are deaf, hard of hearing, or speech impaired, you can call any number by calling 7-1-1 or 1-800-735-2989.

Services in your area

Do you need help finding services?
Visit www.211Texas.org. Or call 2-1-1 (if you can't connect, call 1-877-541-7905). After you pick a language, press 1.
Learn about services in your area, such as:

- Food banks
- Senior services
- Housing
- Help after a disaster
- Help with gas, electric, and water bills
- Tax help
- Child care
- After-school programs
- Family violence programs
- Legal help

Apply for benefits

Show Getting started in a PDF p

Your Texas Benefits: Getting started

How does the online form work?

This online form might take you 20 to 45 minutes to fill out.

You will be asked questions about:

- People applying for benefits.
- People living in your home.
- Money you get from jobs and other sources.
- Costs you pay.
- Things you pay for or own.

For some benefits, including SNAP food benefits (food stamps), the first month's amount will be based on:

1. When we get the name and address of the contact person or head of household. (You will be asked for this when you get to the "Contact person or head of household" page.)

and

2. When we get your signature. (To learn more about how we get your signature, read the "What happens when I am done filling out this form?" section on this page.)

If you send the form to us without filling out all the questions that apply to your case, you will have to fill them out before you can get benefits.

What facts will I need to give on this form?

What happens when I am done filling out this form?

What if I want to stop and finish my application later?

What should I know before I apply?

Start application

Pick the programs you want to apply for.

Food Benefits

- [ ] SNAP food benefits (food stamps)

Helps buy food for good health. Some people might get help the next work day. The first month's amount will be based on the date we get your application.

Cash Help for Families (TANF)
Temporary Assistance for Needy Families

- [ ] Cash help

Helps pay for things like food, clothing, and housing.

Health-care Benefits (Medicaid and CHIP)

- [ ] Adults caring for a child
- [ ] Pregnant women
- [ ] Person age 65 or older
  or
  Person who has a disability that is expected to last a year or longer
- [ ] Children
- [ ] Adult who isn't taking care of a child
- [ ] Person who: (1) is age 25 or younger, and (2) was age 18 or older when they were in foster care or the Unaccompanied Refugee Minors Resettlement Program

Helps with medical bills such as bills for doctors, hospitals, nursing homes, and medicine.

If you apply for health care for a person with a disability: The person must have a disability that is expected to last a year or longer.

If you apply for health care for children or pregnant women: We first look to see if you can get Medicaid. If you can't get Medicaid, we find out if you can get CHIP.

Medicare Savings Programs

- [ ] Medicare Savings Programs

Helps people who already get Medicare. Helps people pay Medicare costs. Costs can include, Medicare premiums, co-pays, and deductibles. These programs also are known as:

- Qualified Medicare Beneficiaries (QMB)
- Specified Low-income Medicare Beneficiaries (SLMB)
- Qualifying Individuals (QI-1)
- Qualified Disabled and Working Individuals (QDWI)

Long-term Care Services

- [ ] Help for a person with intellectual or developmental disabilities
- [ ] Help for a person with no intellectual or developmental disabilities.

Note: If you pick one or both of these items, the Department of Aging and Disability Services (DADS) will contact you.

If you have a long-lasting illness or disability you might be able to get help with daily health-care and living needs. This help can be at home or in certain places of care. Help can include:

- Help dressing, bathing, and using the bathroom.
- Help fixing meals, grocery shopping, and using money.
- Help with light housework.
- Nursing care in the home.
- Hospice services (care for people in severe pain due to diseases such as cancer).
- Care in a nursing home or other place of care.

36

Contact person or head of household.

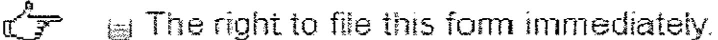
= Items you must fill out

* First name:	
Middle name or initial:	
* Last name:	
Suffix:	Pick one
Sex:	Pick one
Date of birth:	mm/dd/yyyy
Social Security number:	- -

You need to give the Social Security number for only people who want benefits.

E-mail address:	
Retype e-mail address:	
Home phone:	- -
Cell or daytime phone:	- -
* Home address (line 1):	
Address (line 2):	
County:	Pick one
* City:	
* State:	Pick one
* ZIP:	xxxxx

Is your mailing address different than your home address? ○ Yes ○ No



The right to file this form immediately.

You have the right to file this form immediately if it has your name, address, and signature.

Because this is an online form, some people can give us an electronic signature (e-signature).

If you are applying for SNAP food benefits, the first month's amount will be based on the date we get your name, address, and signature. This also applies to other benefits.

To file your form immediately you can:

(1) Click on the Save and go to next page button on this page.

and

(2) Click on the circle on the progress bar at the top of the page.

If you send the form to us without filling out all the questions that apply to your case, you will have to answer them before you can get benefits.

Language for letters and forms

= Items you must fill out

Language for letters and forms we send you: Pick one

37

What language do you speak?

= Items you must fill out

Who is filling out this form?

* Items you must fill out

* I'm filling out this form for: (•) Myself (or people I live with) ( ) Someone else

* Do you want to give someone the right to act for you - to be your authorized representative? ( ) Yes (•) No

Contact person or head of household.

* Items you must fill out

* First name: Mary

Middle name or initial:

* Last name: Smith

Suffix: Pick one

Sex: Pick one

Date of birth: mm/dd/yyyy

Social Security number:

E-mail address:

Retype e-mail address:

Home phone:

Cell or daytime phone:

* Home address (line 1):

Address (line 2):

County:

* City: Round Rock

* State:

* ZIP:

Checking Home Address

* It doesn't look like the address you entered is right.

Pick an option below

( ) Use the validated address: 1009 N Georgetown St | Round Rock, TX 78664 | Williamson County(Recommended)

( ) Keep the address you entered

( ) Edit the address

The right to file this form immediately.

Language for letters and forms

* Items you must fill out

Language for letters and forms we send you: Pick one

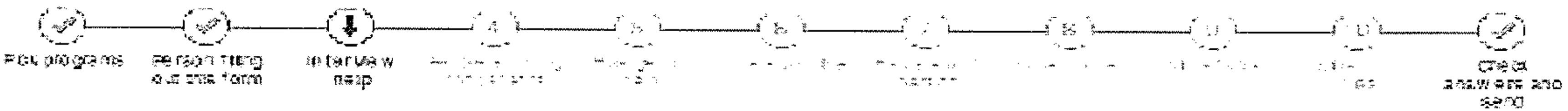
What language do you speak?

* Items you must fill out

What language do you speak most often? Pick one

38

Go back | Save and go to next page | Save and exit



Apply for benefits

Pick programs — Person filling out this form — Interview help — … — Check answers and send

Interview help

*Items you must fill out

Most people applying for benefits must be interviewed. We often interview people on the phone.
It helps to know if any of the reasons below make it hard for you to get to a benefits office.

- You live more than 30 miles away from the closest benefits office.
- The weather is bad.
- Your work or training doesn't allow you to get to a benefits office when it's open.
- You can't travel because you are age 60 or older or you have a disability.
- You are sick.
- You can't get a ride.
- You are a victim of family violence.
- You must take care of someone in your home.

Does any of the reasons above apply to you? ◯ Yes ◯ No

Most people don't need to be interviewed for these programs:

- Medicaid
- Medicare Savings Programs

We can interview you if you want to be interviewed.

If you come to our office, will you need special help or equipment? ◯ Yes ◯ No

Will you need an interpreter? We can get you one for free. ◯ Yes ◯ No

[Go back] [Save and go to next page] [Save and exit]

People who are part of your benefits case

People you need to count in the question below are:

- People who are applying for benefits.
- Parents and stepparents who aren't applying for benefits, but they live with a child who is applying for benefits.
- A spouse who isn't applying for benefits.
- Anyone age 20 and younger who (1) is living in your home, and (2) is cared for by someone applying for benefits.

Later in this form, we will ask which program each person listed in this section wants to apply for. If anyone listed in this section doesn't mark a program, we know they don't want benefits.

The contact person (head of household) is Person 1 — even if this person doesn't want benefits. If you add more people in the question below, you will be asked to give facts about each person, starting with Person 2. You already gave us Person 1's facts on the page before this one.

How many people do you need to count as part of your benefits case? [1]

Does a child applying for health care travel with a family member who is a migrant farm worker? ◯ Yes ◯ No

Does anyone applying for benefits have a disability? ◯ Yes ◯ No

Is anyone living with you disqualified from getting cash help or food benefits anywhere in the United States? ◯ Yes ◯ No

Other people we need to know about

People you need to count in this question are:

- Adults and children applying for benefits
- Parents and stepparents living with a child who is applying for benefits and
- Caretakers of a child who is applying for benefits. To be a caretaker, you need to:
  1. Be related to the child who is applying for benefits and
  2. Live with and care for the child who is applying for benefits.

Later in this form, we will ask which program each person wants to apply for. If a parent or caretaker doesn't mark a program for themselves, we know that they're applying only for the children.

Is there anyone living in your home who isn't part of your benefits case? (See the section above for those who should be counted as part of your benefits case.) ◯ Yes ◯ No

[Go back] [Save and go to next page] [Save and exit]

40

TEXAS
Health and Human
Services Commission

Your Texas Benefits

English | Español Text size A A A
Log out

Home | What help can I get | Apply for benefits | Find support services | View my case | Find office | FAQs

Apply for benefits

Emergency help

Items you must fill out

Emergency SNAP food benefits

You might be able to get SNAP food benefits the next workday based on your answers to these questions.
(The next workday is based on when you hit "Send" at the end of this form. Work days are Monday to Friday. They don't include state holidays.)

Answer these questions for everyone living in the home.

Is anyone a migrant worker or a seasonal farm worker? ◯ Yes ◯ No

Is the total amount of money that everyone has today $100 or less? ◯ Yes ◯ No

Do you expect the total amount of money everyone will have this month to be less $150? ◯ Yes ◯ No

Is the amount of your housing bills more than the amount of money (cash and money in the bank) everyone expects to have this month? ◯ Yes ◯ No

Medicaid for pregnant women

You might get Medicaid benefits within 15 workdays for anyone who is pregnant.

Is anyone in your home pregnant? ◯ Yes ◯ No

Go back | Save and go to next page | Save and exit

41

TEXAS Health and Human Services Commission

Your Texas Benefits

English | Español Text size A A A

Log out

Home | What help can I get | Apply for benefits | Find support services | View my case | Find office | FAQs

Apply for benefits

Where you live

—Items you must fill out

Where does everyone applying for benefits live?

Mary Smith: Pick one

Housing costs: Mary Smith

	You pay	Someone else pays
Rent or home payment:	$	Name of person who pays
Tax on home:	$	Name of person who pays
Water and sewer:	$	Name of person who pays
Electricity:	$	Name of person who pays
Natural gas or propane:	$	Name of person who pays
Phone:	$	Name of person who pays
Home insurance:	$	Name of person who pays
Food and other	$	Name of person who pays

Go back | Save and go to next page | Save and exit

Facts about person: Mary

= Items you must fill out

Marital status [Pick one ▾]

Home phone:

Social Security number

Is Mary Hispanic OR Latino? ○ Yes ○ No

What is Mary's race? (Mark all that apply)
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African-American
- ☐ Native Hawaiian or Pacific Islander
- ☐ White

Pick programs for Mary
- ☑ SNAP Food benefits

Health care for:

Is Mary a U.S. citizen? ○ Yes ○ No

Was Mary in: (1) foster care at age 18 or older, or (2) the Unaccompanied Refugee Minor Resettlement Program at age 18 or older? ○ Yes ○ No

Does Mary live in Texas? ○ Yes ○ No

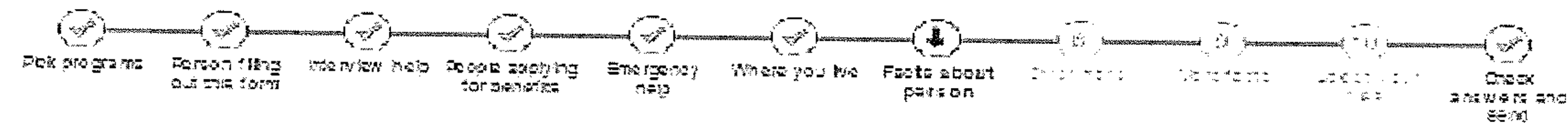
Answer the next few questions about going to school if:
- This person is age 18 or it is the month of their 19th birthday
  and
- This person has a parent or a related caregiver applying for Medicaid or TANF.

Is Mary going to school? ○ Yes ○ No

43

Has Mary been charged with or convicted of a felony fleeing the police?
or
[illegible] ○ Yes ○ No

Apply for benefits



Facts about person (Mary): Medical Facts

– Items you must fill out

Does Mary get Medicare? ◯ Yes ◯ No

You must have Medicare Part A if you apply for the Medicare Savings Program.

Does Mary have health insurance other than Medicare, Medicaid, or CHIP? ◯ Yes ◯ No

Go back | Save and go to next page | Save and exit

TEXAS
Health and Human
Services Commission

Your Texas Benefits

English | Español Text size A A A

Log out

Home | What help can I get | Apply for benefits | Find support services | View my case | Find office | FAQs

Apply for benefits

Facts about person (Mary): Things you are paying for or own

* Items you must fill out

Does Mary own or is Mary paying for a:
- Car
- Truck
- Boat
- Motorcycle
- Other?

◯ Yes ◯ No

Does Mary own or share ownership in a home or property including mobile homes? ◯ Yes ◯ No

Does Mary have a life estate or remainder interest in property? ◯ Yes ◯ No

[Go back] [Save and go to next page] [Save and exit]

Apply for benefits

Pick programs — Person filling out this form — Interview help — People applying for benefits — Emergency help — Where you live — Facts about person — ... — ... — ... — Check answers and send

Facts about person (Mary): Things you are paying for or own

= Items you must fill out

Does Mary (1) own, (2) co-own (3) pay for, or (4) is an authorized signer for items such as, cash, bank accounts, Life Settlement, savings bonds, stocks, mutual funds, or other? ◯ Yes ◯ No

Facts about person (Mary): Things you are paying for

= Items you must fill out

Did Mary have any costs to take care of others? ◯ Yes ◯ No

Does Mary have a life insurance? ◯ Yes ◯ No

[Go back] [Save and go to next page] [Save and exit]

TEXAS Health and Human Services Commission

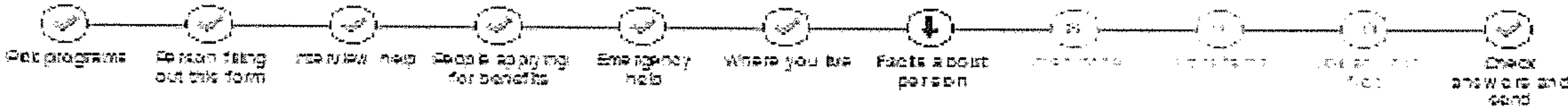
Your Texas Benefits

English | Español Text size a A A

Log out

Home | What help can I get | Apply for benefits | Find support services | View my case | Find office | FAQs

Apply for benefits



Facts about person (Mary): Money coming into the home

= Items you must fill out

Did Mary get money working for someone else in the past 3 months? ◯ Yes ◯ No

Did Mary get money working for themselves in the last 3 months? ◯ Yes ◯ No

Did Mary get money from training in the past 3 months? ◯ Yes ◯ No

[Go back] [Save and go to next page] [Save and exit]

47

TEXAS Health and Human Services Commission
Your Texas Benefits
English | Español Text size A A A
Log out
Home
What help can I get
Apply for benefits
Find support services
View my case
Find office
FAQs
Apply for benefits
Pick programs
Person filling out this form
Interview help
People applying for benefits
Emergency help
Where you live
Facts about person
Check answers and send
Facts about person (Mary): Other money
Did Mary get or expect to get other money(not from a job or training)?
Yes
No
Go back
Save and go to next page
Save and exit

Apply for benefits

Pick programs — Person filling out this form — Interview help — People applying for benefits — Emergency help — Where you live — Facts about person — Other money — … — … — Check answers and send

Other money

* Items you must fill out

Is Mary getting cash help, food, or health-care benefits from another state? ◯ Yes ◯ No

Money from other programs:

Is Mary waiting for an answer on an application for one of the programs listed below? ◯ Yes ◯ No

Mark the programs.

- ☐ Social Security (RSDI)
- ☐ Supplemental Security Income (SSI)
- ☐ Veterans benefits
- ☐ Unemployment compensation
- ☐ Other benefits

Does Mary get any money or benefits now that they should have gotten in the past? ◯ Yes ◯ No

Examples:

- You applied for SSI 2 years ago and they just decided that you should get benefits.
- You are now getting paid for benefits you should have gotten 2 years ago.

[Go back] [Save and go to next page] [Save and exit]

49

TEXAS
Health and Human
Services Commission

Your Texas Benefits

English | Español Text size A A A

Log out

Home | What help can I get | Apply for benefits | Find support services | View my case | Find office | FAQs

Apply for benefits

More facts

= Items you must fill out

Signing up to vote:

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you are not registered to vote where you live now, would you like to apply to register to vote here today? ○ Yes ○ No

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME. If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private. If you believe that someone has interfered with your right to register or to decline to register to vote or your right to choose your own political party or other political preference, you may file a complaint with the Elections Division, Secretary of State, P.O. Box 12060 Austin, TX 78711. Phone: 1-800-252-8683

Go back | Save and go to next page | Save and exit

TEXAS
Health and Human Services Commission

Your Texas Benefits

English | Español Text size A A A

Log out

Home | What help can I get | Apply for benefits | Find support services | View my case | Find office | FAQs

Apply for benefits

Upload your files

Upload now | Files you uploaded

Three easy steps to upload your files:

Files must be in one of these formats: PDF, JPG, TIFF, or GIF. Each file must be 5 MB or smaller. The total size of all files that can be uploaded at one time must be 30 MB or smaller. No more than 10 files can be uploaded at one time.

You can upload files that show proof of the facts you gave us on this form. For example, if you get money from a job, you can upload a copy of your paystub from the last 30 days.

We will try to get proof of the facts you gave us by checking online sources. If we need more proof we will let you know. If you upload files showing proof now, it might help us to review your case faster.

1. Click on the button, "Pick files to upload."
   - Find the file on your computer.
   - After you pick the file on your computer, you will need to click on a button that says something like, "Open" or "OK"
   - The name of the files you picked to upload will be listed under "File."

2. Pick the type of proof for each file listed.
Go to the "Type of proof" column and click on the dropdown menu.

3. Click on "Begin upload."
If you want to view files click on the "Files you uploaded" tab.

Watch video: Learn how to upload files.

Pick files to upload

Go back | Save and go to next page | Save and exit

Apply for benefits

Home | Benefits you can get | Apply for benefits | Find support services | View my case | Find offices | FAQs

Check your answers

Do you want to check your answers?

If yes, we will show your form in a new window. It might take at least 20 seconds to load.

Yes | No

52

You are done

You are done filling out this form. All your answers are listed below.

To see your answers

How to change your answers
You can change your answers by clicking on "Make changes" next to each section.

Save your form to finish later
If you want to save this form and finish filling it out at another time, click on the "Save and exit" button.

Send your form to us
When you are ready to send your application to us, click on the "Send" button.

After you click on the "Send" button, you can't go back and change your answers.

After you send the form to us, we will look at your case to see which benefits you can get.

Check your answers [illegible]

Home address:	1009 N Georgetown St
	Round Rock TX 78664
Mailing address:	Same as home address
Home phone:	
Programs applied for:	SNAP food benefits

Your uploaded files

No documents uploaded

Your Household

Make changes

Head of House	First name: Mary	Middle name:	Last name: Smith	Suffix:

Statement of Understanding

All Benefit Programs

Facts HHSC has about me
HHSC uses facts about people applying for benefits to decide (1) who can get benefits, and (2) the amount of benefits. HHSC checks facts with the federal Income and Eligibility Verification System. If any facts don't match, HHSC will check other sources (banks, employers, etc.). If anyone applying for benefits has an immigration registration number, HHSC must check with the U.S. Citizenship and Immigration Services (USCIS) system. HHSC will not give anyone's facts to USCIS.

In most cases, I can see and get facts HHSC has about me. This includes facts I give HHSC and facts HHSC gets from other sources (medical records, employment

Your Texas Benefits: Form

Please use dark ink. Please print. If you need more room, add pages.
Fill in the circles (○) like this → ●

Section A
Your Facts

If you're applying to get SNAP food benefits, the first month's amount will be based on the date we get pages 1 and 2.

Other benefits also are based on when we get pages 1 and 2.

If you send only pages 1 and 2 now, you will still need to fill out the rest of the application to get benefits.

You have the right to file this form immediately if it has your name, address, and signature.

Mark the benefits anyone on your case is applying for:

- ● Food Benefits (SNAP)
- ○ Cash Help for Families (TANF)
- Health Care (Medicaid or CHIP):
  - ○ Children
  - ○ Adult Caring for a Child
  - ○ Pregnant Woman

Person 1: contact person or head of household

First name	Middle name	Last name
Mary		Smith

Social Security number: ___-__-____
Birth date (month/day/year): __/__/____

Mailing address: 1009 N Georgetown St

City	State	ZIP
Round Rock	Texas	78664

Home phone	Cell or daytime phone

Home address	County
1009 N Georgetown St	Williamson

City	State	ZIP
Round Rock	Texas	78664

Section B
Food Benefits

This section is only for people applying for food benefits.

You might be able to get SNAP food benefits the next work day based on your answers to these questions. Answer them for everyone living in your home.

1. Is anyone a migrant worker or seasonal farm worker? ○ Yes ○ No
2. Is the total amount of money that everyone has today $100 or less? (include cash and money in the bank) ○ Yes ○ No
3. Do you expect the total amount of money everyone will

Your Household

Make changes

Head of house | First name: Mary | Middle name: | Last name: Smith | Suffix

Statement of Understanding

All Benefit Programs

Facts HHSC has about me

HHSC uses facts about people applying for benefits to decide: (1) who can get benefits, and (2) the amount of benefits. HHSC checks facts with the federal Income and Eligibility Verification System. If any facts don't match, HHSC will check other sources (banks, employers, etc.). If anyone applying for benefits has an immigration registration number, HHSC must check with the U.S. Citizenship and Immigration Services' (USCIS) system. HHSC will not give anyone's facts to USCIS.

In most cases, I can see and get facts HHSC has about me. This includes facts I give HHSC and facts HHSC gets from other sources (medical records, employment records, etc.). I might have to pay to get a copy of these facts. I can ask HHSC to fix anything that is wrong. I do not have to pay to fix a mistake. To ask for a copy or to fix a mistake, I can call 2-1-1 or my local HHSC benefits office.

Keeping my facts private

HHSC will keep my facts private if they were collected:

Show Statement of Understanding in a new page

By signing below, I agree:

- To let HHSC and other state, federal, and local agencies check, share, and get facts about anyone on my case (the household / spouse).
- To let other people, businesses, and organizations share facts they have about anyone on my case (the household / spouse) with HHSC.
- The facts to be checked and shared include anything that helps decide: (1) who can get benefits, and (2) the amount of benefits.

If you aren't going to send your form to us, do you want us to mail you a copy of what you filled out? ◯ Yes ◯ No

If you are sending your form to us, do you want a receipt mailed to you? ◯ Yes ◯ No

[Go back] [Send] [Save and exit]

Confirm that you want to send us your form.

By clicking on "Yes" below, you are sending us your form using this online system.

You also are agreeing to use an electronic signature.

Do you want to send us your form?

Yes No

Apply for benefits

To print or view you may need Acrobat viewer

Success!

Your form has been sent to the Texas Health and Human Services Commission (HHSC).

Print your form

OR

Request a copy by mail

We would like to hear from you.
Take a short survey to help us make this site better.

Items we might need from you

You might need to send us items showing proof of the facts you gave on this form. If we need items showing proof, we will let you know. If you upload files or send us the items showing proof now, it might help us to review your case faster.

Items we might need from anyone on your case

Write your Social Security number on each item you send or give us. You can give us your items one of these ways:

Mail (copies): Health and Human Services Commission
PO Box 149024
Austin, TX 78714-9024

Fax: Fax: 1-877-447-2839 (toll-free)
If your form is 2-sided, fax both sides.

In person: You can bring the items to your local HHSC benefits office.

We might mail you a letter asking for the items we need.

Finish

57

TEXAS Health and Human Services Commission

Your Texas Benefits

English | Español Text size A A A

Log out

Home | What help can I get | Apply for benefits | Find support services | View my case | Find office | FAQs

Login

You are now logged in.

Change my password

What help can I get

You don't need to login.

You can fill out this screening form to find out which benefits and support services you might be able to get. At the end of the form, you can decide if you want to log in and (1) apply for benefits, and (2) send your form to support programs and ask them to contact you about their services.

Apply for benefits

You need to login.

You can apply online for:

- SNAP food benefits (food stamps)
- Health-care benefits (Medicaid and
- Cash help for families (TANF)
- Medicare savings programs
- Long-term care

You can save your online form and work on it at different times.

Find support services

You need to login.

You can fill out this screening form to find out if you can get support services. You also can (1) view your saved screening forms and (2) check the status of screening forms you already filled out.

Support services are for:

- People who are older or have a disability and need help with daily living needs.
- People who need help with a mental health issue.
- People who need help with drug or alcohol abuse issues.
- People who are caring for someone who needs help with daily living needs. Help can include giving the caregiver a short break (respite services).

View my case

You need to login.

After you send us the application form, you can:

- Check the status of your case.
- See your benefits and amounts.
- Report changes to your case.
- Renew your benefits.
- Print a Medicaid card.
- View Medicaid services.
- Upload files you want to send to us.
- View items you sent us online.
- Check your interview time.
- Sign up for email alerts.

Learn more about benefit programs: Go to How to Get Help ▸

Watch help videos ▸

Get healthy recipes and shopping tips ▸

Are you, or do you want to be, a Community Partner? Go to start page

Are you a Qualified Hospital / Qualified Entity? Go to the Presumptive Eligibility start page.

Get a paper form | Services in your area | Children's health-care benefits | Managing your money | Pay for CHIP online

Manage messages

Changes you make on this page might take 24 hours to go into effect.

Tell us how you would like to get letters and forms from us.

If you pick "online / paperless " we won't send you letters and forms in the mail. You will get an alert (email or text) letting you know when a letter or form has been posted to your account

Type of alerts you want: ◯ Emails ◯ Texts

Language for alerts: ? ◉ English ◯ Spa

View messages

You don't have any messages at this time.

60

TEXAS
Health and Human
Services Commission

Do you want to see all your case facts and actions?

Do you want to be able to report a change to your case?

If yes, we need to ask you some questions. We must do this to make sure your facts are kept private. (Most people will need to answer these questions only one time.)

Yes, I want to see all of my case facts and actions and be able to report changes.

Case actions

Application actions

In progress applications

User name	Application start date	Actions you can take

Completed applications

Application	Date and time you sent files or forms	Actions you can take	Items we need from you	Status

Renewal actions

Renewals started

Renewal ID	Case number	EDG number	Program	User name	Status	Due date	Actions

Renewals sent or canceled

Renewal ID	Case number	EDG number	Program	User name	Status	Date sent	Actions

Questions? Call toll-free:2-1-1 or 1-877-541-7905.

Learn more about the Lone Star Card for SNAP and TANF benefits.

Do you want to see all your case facts and actions?

Do you want to be able to report a change to your case?

If yes, we need to ask you some questions. We must do this to make sure your facts are kept private. (Most people will need to answer these questions only one time.)

Yes. I want to see all of my case facts and actions and be able to report changes.

TEXAS
Health and Human Services Commission

Your Texas Benefits

Do you want to see all your case facts and actions?

Do you want to be able to report a change to your case?

If yes, we need to ask you some questions. We must do this to make sure your facts are kept private. (Most people will need to answer these questions only one time.)

Yes, I want to see all of my case facts and actions and be able to report changes.

64

Letters and forms

Letters and forms sent August 1, 2013 to today can be viewed on this page. If a letter or form was printed at a benefits office, it will not show up on this page. Go pa

View letters and forms from: 09/30/2014 to 09/30/2015 OK

Letters and forms shown below were sent between 09/30/2014 to 09/30/2015

65

FAQs - Common Questions

If your question isn't answered here, call 2-1-1 for help with this website. If you can't connect to 2-1-1, call 1-877-541-7905.

All phone and fax numbers on this page are free to call. If you have a speech or hearing disability, call 7-1-1 or any relay service.

HHSC = Texas Health and Human Services Commission

Software needed and screen readers

- What Internet browsers will work with this website?
- What software do I need on my computer so I can use this website?
- I have vision impairment and use a screen reader. What screen reader programs can I use with this website?
- I use the JAWS screen reader. Do I need any software for JAWS to work on this website?
- I use the JAWS screen reader. Are there any tips for using this website?

Account, user name and password

- How do I set up an account?
- What does it mean to see all my case facts and actions?
- Why do I need a user name or password?
- What if I forgot my user name?
- What if I forgot my password?
- How can I get a temporary password?
- How can I change my password?
- Will I ever need to share my password with anyone?

Types of Benefits

- What benefits can I apply for using this site?
- I applied for health-care benefits for my child. How does HHSC decide if my child gets CHIP or Medicaid?
- I'm pregnant and I applied for health-care benefits. How does HHSC decide if my unborn child gets CHIP perinatal or if I get Medicaid?

66

Your Texas Benefits: Getting Started

SNAP Food Benefits

(This used to be called Food Stamps.)

Helps buy food for good health. Some people might get help the next work day.

TANF Cash Help for Families

TANF: Temporary Assistance for Needy Families

Helps pay for things like food, clothing, and housing.

- **TANF:** Helps families with children age 18 and younger pay for basic needs. TANF gives monthly cash payments.
- **One-Time TANF:** Helps families with children age 18 and younger in crisis. Crises include losing a job, not finding a job, losing a home, or a medical emergency. This help is given only once every 12 months.
- **One-Time TANF Grandparent:** Helps grandparents caring for a child who gets TANF.

Medicaid and CHIP

Helps with medical bills such as bills for doctors, hospitals, and medicines.

People who can get health-care benefits are:

- Children age 20 and younger who live with you.
- Pregnant women.
- Adults who either: (1) are caring for a child in their home or (2) were in foster care at age 18 or older.

If you want to apply for Medicaid for the Elderly and People with Disabilities, you need a different form. To get that form, call 2-1-1 (after you pick a language, press 2).

All phone and fax numbers on this form are free to call. If you are deaf, hard of hearing, or speech impaired, you can call any number by calling 7-1-1 or 1-800-735-2989.

How to Apply

What to do:

1. Fill out this form.
2. Sign and date pages 1 and 18.
3. Send "Items we need." See pages C and D.

How to send it:

Mail: HHSC, PO Box 149024, Austin, TX 78714-9968

Fax: 1-877-447-2839. If your form is 2-sided, fax both sides.

In person: At a benefits office. To find one near you, go to YourTexasBenefits.com or call 2-1-1 (after picking a language, press 1).

YourTexasBenefits.com

On this website you can:

- Apply for benefits.
- Find out if you should apply for benefits.
- Report changes.
- Upload items we need from you.
- Renew benefits.

67

Texas Health and Human Services Commission (HHSC)

Questions about this form or about benefits

- Go to YourTexasBenefits.com.
  or
- Call 2-1-1 (if you can't connect, call 1-877-541-7905).
  After you pick a language, press 2 to:
  - Ask questions about this form.
  - Find where to get help filling out this form.
  - Check the status of this form.
  - Ask questions about benefit programs.

Report waste, fraud, and abuse

If you think anyone is misusing HHSC benefits, call 1-800-436-6184.

Helpful Tips

- There are tips in the left side of each page. They can help you save time.
- Sign and date pages 1 and 18.
- Send "Items we need." See pages C and D.

These pictures tell you what sections you need to fill out.

For example, if you see this:

It means that only people applying for SNAP food benefits need to fill out that section.

How to file a complaint

If you have a complaint, first try talking to your benefits advisor or their supervisor. If you still need help, call 1-877-787-8999.

CREASE AND TEAR AT PERFORATION

Help you can get without filling out this form

Services in your area

Do you need help finding services? Call 2-1-1 (if you can't connect, call 1-877-541-7905). After you pick a language, press 1.

Texas Workforce Network

Are you looking for work? You can get help:

- Applying for a job.
- Finding a job.

Call 2-1-1 to find a Texas Workforce Center.

Family Planning

Do you need help with family planning? Men and women can get help with:

- Birth control supplies.
- Other health care.

Call 2-1-1 to find a clinic.

Women age 15 to 44 who can't get Medicaid or CHIP might be able to get services in the Healthy Texas Women program. A parent or legal guardian must apply for young women age 15 to 17. To learn more, go to HealthyTexasWomen.org or call 1-866-993-9972.

Family Violence Program

Are you afraid for your children's or your safety? You can get help:

- Getting a ride to a safe place.
- Finding shelter, legal help, and a job.
- Getting counseling.

Call the hotline anytime at 1-800-799-7233 (1-800-799-SAFE).

Adult Education and Family Literacy Program

Do you want help learning to read or getting a GED? Do you need help with job skills? Or learning to speak English?

Call 1-800-441-7323 (1-800-441-READ).

Women, Infants and Children program (WIC)

Are you pregnant or a new mother? You can get help:

- Getting food for you and your children.
- Getting vaccines.

Call 1-800-942-3678.

Alcohol and Drug Abuse Prevention Program

Do you or someone you know want to stop using alcohol or drugs? You can get help:

- Quitting.
- Dealing with a crisis.
- Keeping others from using drugs or alcohol.

Call 1-877-966-3784 (1-877-9-NO DRUG).

Health Insurance Premium Payment Program (HIPP)

Do you need help paying for your health insurance? Call 1-800-440-0493.

Or write: Texas Health and Human Services Commission TMHP-HIPP, PO Box 201120 Austin, Texas 78720-1120

Important Information for Former Military Service Members

Women and men who served in any branch of the United States Armed Forces, including Army, Navy, Marines, Air Force, Coast Guard, Reserves or National Guard may be eligible for additional benefits and services. For more information, please visit the Texas Veterans Portal at https://veterans.portal.texas.gov.

Items we need from anyone on your case

Look below and on the next page for items we might need from you. If you bring or send copies of these items with your application, it might help us. If you send any items to us, send only copies. Keep the originals for your records.

We only need items that apply to anyone on your case. For example, if no one has a bank account, we do not need bank statements.

If you are applying for

Any Benefit Program

bringing or sending copies of items that apply to anyone on your case might help us review it faster.

- **Identity** (proof of who you are) – Current driver's license or Department of Public Safety ID card. If a person has the right to act for you (as your authorized representative), that person also needs to give proof of identity.
- **Immigration status** – Resident card (I-551), arrival/departure form (I-94). Or papers from the U.S. Citizenship and Immigration Services. We need copies of the front and back of these forms.
- **Legal representative** (a person who has the right to act for you on legal issues) – Power of attorney papers, guardianship order, court order, or similar court documents.
- **Veterans benefits, workers' compensation, or unemployment** – Award letter or pay stubs.
- **Social Security, Supplemental Security Income (SSI), or pension benefits** – Award letter or pay stubs.
- **Military service** – Current Military ID (Form DD-2), military orders, or separation papers (Form DD-214).
- **Loans and gifts** (includes someone paying bills for you) – Loan agreements or statement from the person giving you money or paying your bills. Must show that person's name, address, phone number, and signature.
- **Residence** (proof you live in Texas) – Utility bill, driver's license, Texas Department of Public Safety ID, rent receipt, letter from landlord (can't be a relative).

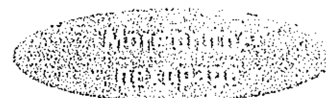
If you are applying for

SNAP food benefits

bringing or sending copies of items that apply to anyone on your case might help us review it faster.

- **Proof of income from your job** – Last 3 pay stubs or paychecks, a statement from your employer, or self-employment records.
- **Bank accounts** – The most current statement for all accounts.
- **Medical costs** – Bills, receipts, or statements from health-care providers (doctors, hospitals, drug stores, etc.). These items should show costs you have now and costs you expect in the future.
- **Rent or mortgage costs** – Recent checks, check stubs, or statement from the mortgage bank or landlord. Renters also need to give the landlord's name, address, and phone number.
- **Dependent care expenses** – Receipts, canceled checks, or a signed statement from the person you pay. A signed statement must show when and how much you pay.
- **Child support anyone pays** – Court papers that show what you must pay for child support. For example: divorce decree, court order, or district clerk record.
- **Child support anyone gets** – District clerk record. Or letter from the parent who pays showing how much, how often and the date it is usually paid. The letter must have the name, address, phone number, and signature of the parent who pays.

To get SNAP, a person must be a U.S. citizen or legal resident.



If you need help getting these items, let us know.

69

More items we need from you

If you are applying for

TANF Cash Help for Families

bringing or sending copies of items that apply to anyone on your case might help us review it faster.

- **Proof of income from your job** – Last 3 pay stubs or paychecks, a statement from your employer, or self-employment records.
- **Bank accounts** – Most current statement for all accounts.
- **Proof a child is related to you** – Legal birth, hospital, or baptismal certificate.
- **Citizenship** – U.S. passport, Certificate of Naturalization, U.S. birth certificate (copies of the front and back), hospital record of birth, or Medicare card. If you were born in Texas, we might be able to look up your birth record.
- **Child's vaccines** – Vaccine records for each child.
- **Proof a child lives with you** – A signed statement from your landlord or a non-relative neighbor that includes his or her name, address, and phone number.
- **Child support anyone pays** – Court papers that show what you must pay for child support. For example: divorce decree, court order, or district clerk record.
- **Child support anyone gets** – District clerk record. Or letter from the parent who pays showing how much, how often and the date it is usually paid. The letter must have the name, address, phone number, and signature of the parent who pays.
- **Health insurance** – Copy of the front and back of the insurance card or policy.

If you are applying for

CHIP or Children's Medicaid

bringing or sending copies of items that apply to anyone on your case might help us review it faster.

- **Proof of income from your job** – One pay stub or paycheck from the last 60 days, a statement from your employer, or self-employment records.
- **Medical costs** – Bills or statements from health-care providers (doctors, drug stores, etc.) from the past 3 months. We only need these items if you haven't already paid for these services.
- **Citizenship** – U.S. passport, Certificate of Naturalization, U.S. birth certificate (copies of the front and back), hospital record of birth, or Medicare card. If you were born in Texas, we might be able to look up your birth record.

If you are applying for

Medicaid for a Pregnant Woman or an Adult

bringing or sending copies of items that apply to anyone on your case might help us review it faster.

- **Proof of income from your job** – Last 3 pay stubs or paychecks, a statement from your employer, self-employment records, or last year's tax return.
- **Medical costs** – Bills or statements from health-care providers (doctors, hospitals, drug stores, etc.) from the past 3 months. We only need these items if you haven't already paid for these services.
- **Citizenship** – U.S. passport, Certificate of Naturalization, U.S. birth certificate (copies of the front and back), hospital record of birth, or Medicare card. If you were born in Texas, we might be able to look up your birth record.

CREASE AND TEAR AT PERFORATION

If you need help getting these items, let us know. Don't send this page with your form. Keep for your records.

Your Texas Benefits: Form

Please use dark ink. Please print. If you need more room, add pages.
Fill in the circles (○) like this ●

PLEASE AND TEAR AT PERFORATION

Section A

Your Facts

If you're applying to get SNAP food benefits, the first month's amount will be based on the date we get pages 1 and 2.

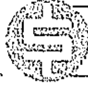
Other benefits also are based on when we get pages 1 and 2.

If you return only pages 1 and 2 now, you still need to fill out pages 3 to 18 before you can get benefits.

You have the right to file this form immediately if it has your name, address, and signature.

Mark the benefits anyone on your case is applying for:

○ SNAP Food Benefits


○ TANF Cash Help for Families

Medicaid or CHIP:
○ Children ○ Adult caring for a child
○ Adult not caring for a child
○ Pregnant women

Person 1: contact person or head of household

First name ______ Middle name ______ Last name ______

Social Security number ___ - __ - ____

Birth date (month/day/year) __ / __ / ____

Mailing address ______

City ______ State ______ ZIP ______

Home phone ( ) - ______ Cell or daytime phone ( ) ______

Home address ______ County ______

City ______ State ______ ZIP ______

Section B

Food Benefits

This section is only for people applying for SNAP SNAP food benefits.

Find out how to return your form: See page 3.

You might be able to get SNAP food benefits the next work day if you:

- Are a migrant or seasonal farm worker,
- Have $100 or less in available cash and bank accounts and expect to earn less than $150 this month, or
- Have costs for housing or utilities that are more than your cash, bank accounts and the income you expect for the month.

Answer them for everyone living in your home.

1. Is anyone in the home a migrant worker or a seasonal farm worker? .... ○ Yes ○ No
2. Does anyone in the home have money in the bank or cash? .... ○ Yes ○ No $ ______ Amount
3. Does anyone in the home expect to receive money this month? (This includes money you get from jobs, child support, social security, and unemployment) .... ○ Yes ○ No $ ______ Amount
4. Does anyone in the home pay costs for housing and utilities? (This includes rent, mortgage, water, gas, electric, sewage, trash, phone and property tax.) .... ○ Yes ○ No $ ______ Amount

Sign here (or have someone with the right to act for you sign) ______ Date ______

More on page 2

TEXAS
Health and Human Services

71

Section C

Pregnant Women

This section is only for people applying for health-care benefits.

Is anyone in your home pregnant? .... ○ Yes ○ No

If yes, who? ____________ Number of babies expected [ ]

Is this your first pregnancy? .... ○ Yes ○ No Due date [ ][ ]/[ ][ ]/[ ][ ][ ][ ]

What is the first and last name of the unborn child's father?

First name ____________ Last name ____________

Section D

Military Service

This section is only for people applying for Medicaid or CHIP.

Is anyone an active duty member of one of these military forces?

- U.S. Armed Forces
- National Guard
- Reserves
- State Military Forces .... ○ Yes ○ No

If yes, who? ____________

Section E

Interview Help

1. Most people applying for benefits must be interviewed. We often interview people on the phone.

   It helps to know if any of the reasons below make it hard for you to get to a benefits office:

   - You live more than 30 miles from the closest benefits office.
   - You can't get a ride.
   - The weather is bad.
   - You are sick.
   - Your work or training hours don't allow you to get to a benefits office when it's open.
   - You can't travel because you are age 60 or older, or you have a disability.
   - You are a victim of family violence.
   - You take care of someone in your home.

   Do any of the reasons above apply to you? .... ○ Yes ○ No

2. If you come to our office, will you need special help or equipment? .... ○ Yes ○ No

   If yes, what do you need? ____________

3. What language do you want to speak during the interview? ____________

4. Will you need an interpreter? We can get one for you for free........ ○ Yes ○ No

   If yes, mark the one you need:

   ○ Spanish ○ Vietnamese
   ○ American Sign Language ○ Other: ____________

Agency Use Only

Expedite? ☐ Yes ☐ No

Date received: ____________ Screened by: ____________

Date screened: ____________ Case: ____________

Social Security number: [ ][ ][ ]-[ ][ ]-[ ][ ][ ][ ]

CREASE AND TEAR AT PERFORATION

72

Your Texas Benefits: Form

Fill in the circles (○) like this ●.
Please use dark ink. Please print. If you need more room, add pages.

Section F

Contacting You

Person 1: Contact Person or Head of Household

First name | Middle name | Last name

Social Security number ___-__-____ | Birth date (month/day/year) __/__/____

Email

Are you applying for benefits for yourself or a child? ○ Yes ○ No

If yes, give your facts below:

Section G

Person 1

Mark the benefits Person 1 is applying for:

○ SNAP Food Benefits

TANF Cash Help for Families:

○ TANF
○ One-Time TANF
○ One-Time TANF Grandparent

Medicaid or CHIP for:

○ Children
○ Adult caring for a child
○ Adult not caring for a child
○ Pregnant women

Person 1

If you get money from Social Security or railroad retirement, list the number you have: Social Security claim number | Railroad retirement number

○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Live in Texas? ○ Yes ○ No
Plan to stay in Texas? ○ Yes ○ No

Optional Question: ○ Male ○ Female

Hispanic or Latino? ○ Yes ○ No

Mark one or more: ○ American Indian or Alaska Native ○ Asian ○ Black or African-American ○ Native Hawaiian or Pacific Islander ○ White

Are you going to school? ○ Yes ○ No | If yes, are you going full-time? ○ Yes ○ No

Are you a U.S. citizen? If no, give facts below. ○ Yes ○ No

Are you a refugee or legally admitted immigrant? ○ Yes ○ No

If you have a sponsor, write your sponsor's name | Date you entered the U.S. (month/day/year) __/__/____

Are you registered with the U.S. Citizenship and Immigration Services? ○ Yes ○ No → Immigrant registration number

Return this completed form by fax, mail, or in person:

Fax: 1-877-447-2839

Mail: HHSC, PO Box 149024
Austin, TX 78714-9968

In person: Call 2-1-1 to find an HHSC benefits office near you.

If you are applying for Medicaid or CHIP:
You also must fill out the attached form titled **"Applying for or renewing Medicaid or CHIP?"**

Section II

People Applying for Benefits

Person 2: adult or child applying, spouse of person applying, or parent living with a child who is applying

First name | Middle name | Last name

Social Security number | Birth date (month/day/year)

This person's relationship to you | If this person gets money from Social Security or railroad retirement, list the number here: Social Security claim # | Railroad retirement #

Mark the benefits Person 2 is applying for:
- O SNAP Food Benefits

TANF Cash Help for Families:
- O TANF
- O One-Time TANF
- O One-Time TANF Grandparent

Medicaid or CHIP for:
- O Children
- O Adult caring for a child
- O Adult not caring for a child
- O Pregnant women

O Married O Single O Divorced
O Separated O Widowed

Live in Texas? .... O Yes O No
Plan to stay in Texas? .... O Yes O No

Optional Questions: O Male O Female O Hispanic or Latino
Mark one or more: O Black or African-American
O American Indian or Alaska Native
O Native Hawaiian or Pacific Islander
O Asian O White

Is this person going to school? O Yes O No If yes, is this person going full-time? O Yes O No

Is this person a U.S. citizen? If no, give facts below. .... O Yes O No

Is this person a refugee or legally admitted immigrant? .... O Yes O No

If this person has a sponsor, write the sponsor's name. | Date person entered the U.S. (month/day/year)

Is this person registered with the U.S. Citizenship and Immigration Services? ..... O Yes O No → Immigrant registration number

If you are applying for Medicaid or CHIP:
You also must fill out the attached form titled "Applying for or renewing Medicaid or CHIP?"

Person 3: adult or child applying, spouse of person applying, or parent living with a child who is applying

First name | Middle name | Last name

Social Security number | Birth date (month/day/year)

This person's relationship to you | If this person gets money from Social Security or railroad retirement, list the number here: Social Security claim # | Railroad retirement #

Mark the benefits Person 3 is applying for:
- O SNAP Food Benefits

TANF Cash Help for Families:
- O TANF
- O One-Time TANF
- O One-Time TANF Grandparent

Medicaid or CHIP for:
- O Children
- O Adult caring for a child
- O Adult not caring for a child
- O Pregnant women

O Married O Single O Divorced
O Separated O Widowed

Live in Texas? .... O Yes O No
Plan to stay in Texas? .... O Yes O No

Optional Questions: O Male O Female O Hispanic or Latino
Mark one or more: O Black or African-American
O American Indian or Alaska Native
O Native Hawaiian or Pacific Islander
O Asian O White

Is this person going to school? O Yes O No If yes, is this person going full-time? O Yes O No

Is this person a U.S. citizen? If no, give facts below. .... O Yes O No

Is this person a refugee or legally admitted immigrant? .... O Yes O No

If this person has a sponsor, write the sponsor's name. | Date person entered the U.S. (month/day/year)

Is this person registered with the U.S. Citizenship and Immigration Services? ..... O Yes O No → Immigrant registration number

← CREASE AND TEAR AT PERFORATION →

14

Section H

People Applying for Benefits

Mark the benefits Person 4 is applying for:
- O SNAP Food Benefits

TANF Cash Help for Families:
- O TANF
- O One-Time TANF
- O One-Time TANF Grandparent

Medicaid or CHIP for:
- O Children
- O Adult caring for a child
- O Adult not caring for a child
- O Pregnant women

If you are applying for Medicaid or CHIP: You also must fill out the attached form titled "Applying for or renewing Medicaid or CHIP?"

Person 4: adult or child applying, spouse of person applying, or parent living with a child who is applying

First name ______ Middle name ______ Last name ______

Social Security number ___-__-____ Birth date (month/day/year) __/__/____

This person's relationship to you ______

If this person gets money from Social Security or railroad retirement, list the number here: Social Security claim # ______ Railroad retirement # ______

O Married O Single O Divorced O Separated O Widowed

Optional questions: O Male O Female O Hispanic or Latino
Mark one or more: O Black or African-American O American Indian or Alaska Native O Native Hawaiian or Pacific Islander O Asian O White

Live in Texas? .... O Yes O No
Plan to stay in Texas? .... O Yes O No

Is this person going to school? O Yes O No If yes, is this person going full-time? O Yes O No

Is this person a U.S. citizen? If no, give facts below. .... O Yes O No

Is this person a refugee or legally admitted immigrant? .... O Yes O No

If this person has a sponsor, write the sponsor's name. ______ Date person entered the U.S. (month/day/year) __/__/____

Is this person registered with the U.S. Citizenship and Immigration Services? ..... O Yes O No → Immigrant registration number ______

Mark the benefits Person 5 is applying for:
- O SNAP Food Benefits

TANF Cash Help for Families:
- O TANF
- O One-Time TANF
- O One-Time TANF Grandparent

Medicaid or CHIP for:
- O Children
- O Adult caring for a child
- O Adult not caring for a child
- O Pregnant women

Person 5: adult or child applying, spouse of person applying, or parent living with a child who is applying

First name ______ Middle name ______ Last name ______

Social Security number ___-__-____ Birth date (month/day/year) __/__/____

This person's relationship to you ______

If this person gets money from Social Security or railroad retirement, list the number here: Social Security claim # ______ Railroad retirement # ______

O Married O Single O Divorced O Separated O Widowed

Optional questions: O Male O Female O Hispanic or Latino
Mark one or more: O Black or African-American O American Indian or Alaska Native O Native Hawaiian or Pacific Islander O Asian O White

Live in Texas? .... O Yes O No
Plan to stay in Texas? .... O Yes O No

Is this person going to school? O Yes O No If yes, is this person going full-time? O Yes O No

Is this person a U.S. citizen? If no, give facts below. .... O Yes O No

Is this person a refugee or legally admitted immigrant? .... O Yes O No

If this person has a sponsor, write the sponsor's name. ______ Date person entered the U.S. (month/day/year) __/__/____

Is this person registered with the U.S. Citizenship and Immigration Services? ..... O Yes O No → Immigrant registration number ______

If more than 5 people are applying for benefits, add more pages with the same facts.

75

Section I

More Facts About Children Age 18 or Younger

This section is only for children applying for TANF.

Time Saving Tip

You only need to give facts for each father and mother one time.

If a child has the same mother or father as another child, you can write something like "same as 1st child" where the parent's name would go.

Are you afraid that giving facts about the child's other parent might put you or your children in danger?

You might not have to help or cooperate with the Office of Attorney General to collect child or medical support if you are afraid. You can ask not to give these facts by:

- Telling your benefits advisor (or designated representative) reasons why this might put you or your children in danger.
- Signing the Good Cause request form. (Your benefits advisor has this form.)

1st child's name:

Father's first and last name

Father's birth date (mm/dd/yyyy) ___/___/_____

Father's Social Security number ___-__-____

Father's phone ( )

Father's mailing address City State ZIP

Father is: ○ In home ○ Out of home ○ Deceased

Employer

Mother's first and last name

Mother's maiden name

Mother's Social Security number ___-__-____

Mother's birth date (mm/dd/yyyy) ___/___/_____

Mother's mailing address City State ZIP

Mother's phone ( )

Employer

Mother is: ○ In home ○ Out of home ○ Deceased

Were these parents ever married to each other? ○ Yes ○ No

2nd child's name:

Father's first and last name

Father's birth date (mm/dd/yyyy) ___/___/_____

Father's Social Security number ___-__-____

Father's phone ( )

Father's mailing address City State ZIP

Father is: ○ In home ○ Out of home ○ Deceased

Employer

Mother's first and last name

Mother's maiden name

Mother's Social Security number ___-__-____

Mother's birth date (mm/dd/yyyy) ___/___/_____

Mother's mailing address City State ZIP

Mother's phone ( )

Employer

Mother is: ○ In home ○ Out of home ○ Deceased

Were these parents ever married to each other? ○ Yes ○ No

CREASE AND TEAR AT PERFORATION

76

Sect G Pt 2

Section I

More Facts About Children Age 18 or Younger (continued)

PLEASE AND TEAR AT PERFORATION

3rd child's name:

FATHER

Father's first and last name

Father's birth date (mm/dd/yyyy) ___ / ___ / ______

Father's Social Security number ___-__-____

Father's phone ( )

Father's mailing address City State ZIP

Father is: ○ In home ○ Out of home ○ Deceased

Employer

MOTHER

Mother's first and last name

Mother's maiden name

Mother's Social Security number ___-__-____

Mother's birth date (mm/dd/yyyy) ___ / ___ / ______

Mother's mailing address City State ZIP

Mother's phone ( )

Employer

Mother is: ○ In home ○ Out of home ○ Deceased

Were these parents ever married to each other? .... ○ Yes ○ No

4th child's name:

FATHER

Father's first and last name

Father's birth date (mm/dd/yyyy) ___ / ___ / ______

Father's Social Security number ___-__-____

Father's phone ( )

Father's mailing address City State ZIP

Father is: ○ In home ○ Out of home ○ Deceased

Employer

MOTHER

Mother's first and last name

Mother's maiden name

Mother's Social Security number ___-__-____

Mother's birth date (mm/dd/yyyy) ___ / ___ / ______

Mother's mailing address City State ZIP

Mother's phone ( )

Employer

Mother is: ○ In home ○ Out of home ○ Deceased

Were these parents ever married to each other? .... ○ Yes ○ No

If you have more than 4 children who are age 18 or younger, add more pages with the same facts.

77

Section J

Other People in the Home

Other people in the home

These people live in my home, but they don't want to apply for benefits.
(Parents living with a child age 18 or younger who is applying or a spouse of a person applying should not be listed here — they should fill out a box in Section H.)

List the birth date only if the person is your relative.

Name	Relationship to you	Birth date (if a relative)
		__/__/____
		__/__/____
		__/__/____

Section K

Other Facts

Other facts

1. Does anyone have a disability? ○ Yes ○ No

   If yes, who?

2. Is anyone getting cash help, food or health-care benefits from another state? ○ Yes ○ No

   If yes, who? Which state? When did that person last get benefits?

Answer 3, 4 and 5 only if anyone is applying for TANF cash help or SNAP food benefits.

3. Has anyone been convicted of a felony that: (1) took place after August 22, 1996, and (2) involved illegal drugs? ○ Yes ○ No

   If yes, who?

4. Is anyone living in a place of care such as:
   - A homeless shelter.
   - A drug treatment center.
   - A shelter for battered women.
   - A group home. ○ Yes ○ No

   If yes, who?

5. When people break program rules, they are sometimes "disqualified" from getting benefits. People who are disqualified are sent a letter and told they can't get TANF cash help or SNAP food benefits.

   Is anyone living with you disqualified from getting cash help or food benefits anywhere in the United States? ○ Yes ○ No

Social Security number:

CREASE AND TEAR AT PERFORATION

18

Medical Facts

This section is only for people applying for TANF, Medicaid, or CHIP.

PLEASE AND TEAR AT PERFORATION

Other health insurance

1. Does anyone get Medicaid or CHIP? .... O Yes O No

   If yes, from which state? ______________________

   If yes, date coverage ends (if not ending, write "Not ending"): ______________

2. Does anyone get health coverage from one the following? .... O Yes O No

   O Medicare O Employer Insurance O TRICARE (don't check if you have direct care or Line of Duty)

   O Peace Corps O VA Health-care programs

   O Other ______________________

   If yes, give facts below.

Name of insured person (first, middle, last) ______________ Insurance company ______________

Policy number ______________ Coverage start date __/__/__ Coverage end date __/__/__

Type of coverage ______________ Amount you pay each month to cover your children on this insurance. $______

Who pays the premium? ______________

Is this COBRA coverage? .... O Yes O No

Is this a retiree health plan? .... O Yes O No

Is this a limited-benefit plan (like a school accident policy)? .... O Yes O No

Is this a state employee benefit plan? .... O Yes O No

Name of insured person (first, middle, last) ______________ Insurance company ______________

Policy number ______________ Coverage start date __/__/__ Coverage end date __/__/__

Type of coverage ______________ Amount you pay each month to cover your children on this insurance. $______

Who pays the premium? ______________

Is this COBRA coverage? .... O Yes O No

Is this a retiree health plan? .... O Yes O No

Is this a limited-benefit plan (like a school accident policy)? .... O Yes O No

Is this a state employee benefit plan? .... O Yes O No

Social Security number: | | | | | | | | | | |

Section L

Medical Facts (continued)

This section is only for people applying for TANF, Medicaid, or CHIP.

Medical bills from the past 3 months

If anyone on your case can't pay their medical bills, Medicaid might pay them.

- The bills must be for services they got in the past 3 months.
- You need to show proof of money you get (income) for the months they got services.

Does anyone applying for benefits have medical bills for services they got in the past 3 months? .... O Yes O No

If yes, who? (first, middle, last)

If yes, who? (first, middle, last)

Section M

Things Anyone is Paying for or Owns

Skip this section if you are applying only for Medicaid or CHIP.

Vehicles

Does anyone own or is anyone paying for a:
• car • truck • boat • motorcycle • other .... O Yes O No
If yes, give facts below.

Name of owner (first, middle, last) | **Make / Model** | **Year**

Name of co-owner if also owned by someone outside the home

O Vehicle is used for a person with a disability. $ **Money still owed on vehicle**

Name of owner (first, middle, last) | **Make / Model** | **Year**

Name of co-owner if also owned by someone outside the home

O Vehicle is used for a person with a disability. $ **Money still owed on vehicle**

Name of owner (first, middle, last) | **Make / Model** | **Year**

Name of co-owner if also owned by someone outside the home

O Vehicle is used for a person with a disability. $ **Money still owed on vehicle**

If you need more room, add more pages with the same facts.

← CREASE AND TEAR AT PERFORATION →

Social Security number:

80

Section M

Things Anyone is Paying for or Owns (continued)

Skip this section if you are applying only for Medicaid or CHIP.

Things anyone is paying for or owns

We need to know about items anyone owns or is paying for, such as:

- cash
- bank accounts
- homes and other property
- insurance policies
- stocks

Does anyone own or is anyone paying for these types of items? .... ○ Yes ○ No

If yes, give facts below.

Item ______ **Account number** ______ **Value** $ ______

Names on account or deeds (include co-owners) ______

Name and address of bank or business (to contact about the item) ______

Item ______ **Account number** ______ **Value** $ ______

Names on account or deeds (include co-owners) ______

Name and address of bank or business (to contact about the item) ______

Item ______ **Account number** ______ **Value** $ ______

Names on account or deeds (include co-owners) ______

Name and address of bank or business (to contact about the item) ______

If you need more room, add more pages.

Section N

Money Coming into the Home

Money anyone might get from other programs

Is anyone waiting for an answer on an application for one of the programs listed below? .... ○ Yes ○ No

If yes, mark the program anyone is waiting to hear from.

○ Social Security (RSDI) ○ Supplemental Security Income (SSI)
○ Other disability ○ Unemployment compensation benefits

Name of person waiting for an answer ______ **Program name** ______

Name of person waiting for an answer ______ **Program name** ______

Social Security number: | | | | | | | | | |

Section N

Money Coming into the Home (continued)

Money from jobs or training

Did anyone get money in the past 3 months from:
(a) working for someone else (b) training, or (c) working for themselves?........ ○ Yes ○ No
If yes, give facts below.

_______ Name of person who got the money | _______ Hours worked | $_______ Amount paid before taxes and deductions are taken out

_______ Start date | _______ Last payment date (month/year)

How often are you paid?
○ daily ○ twice a month
○ once a week ○ once a month
○ every 2 weeks ○ other:_______

Is this person still working at this job or in training? .... ○ Yes ○ No
Was this person working for themselves? .... ○ Yes ○ No
If no, list the person or place that paid the money.

____

_______ Name of person who got the money | _______ Hours worked | $_______ Amount paid before taxes and deductions are taken out

_______ Start date | _______ Last payment date (month/year)

How often are you paid?
○ daily ○ twice a month
○ once a week ○ once a month
○ every 2 weeks ○ other:_______

Is this person still working at this job or in training? .... ○ Yes ○ No
Was this person working for themselves? .... ○ Yes ○ No
If no, list the person or place that paid the money.

____

_______ Name of person who got the money | _______ Hours worked | $_______ Amount paid before taxes and deductions are taken out

_______ Start date | _______ Last payment date (month/year)

How often are you paid?
○ daily ○ twice a month
○ once a week ○ once a month
○ every 2 weeks ○ other:_______

Is this person still working at this job or in training? .... ○ Yes ○ No
Was this person working for themselves? .... ○ Yes ○ No
If no, list the person or place that paid the money.

____

CREASE AND TEAR AT PERFORATION

Social Security number: _ _ _ - _ _ - _ _ _ _

82

Section N

Money Coming into the Home (continued)

Other money

Does anyone get, or expect to get, any of the types of money listed below? .... ○ Yes ○ No
If yes mark other types of money anyone gets or might get soon.

- ○ Cash or gifts
- ○ Supplemental Security Income (SSI)
- ○ Social Security
- ○ Retirement benefits
- ○ Veterans benefits
- ○ Child support anyone gets
- ○ Pensions
- ○ Payments after being hurt at work (workers' compensation)
- ○ Payments after losing a job (unemployment compensation)
- ○ Alimony.
- ○ Interest or dividends
- ○ Payments from private insurance
- ○ Loans paid to anyone on your case
- ○ Payments to help with utilities.
- ○ Farming or fishing (after expenses paid)
- ○ Rent or royalty (after expenses paid)
- ○ Other ________

If anyone gets, or expects to get, any of these types of money, give the facts below.

Type of money (item you marked above) ________ $ ________ **Amount you get paid** ________ **Last payment date** (month/year)

Name of person getting this money (if child support, list child's name) ________

Person, company, or agency paying the money ________

How often are you paid?
○ daily
○ once a week
○ every 2 weeks
○ twice a month
○ once a month
○ other:________

Type of money (item you marked above) ________ $ ________ **Amount you get paid** ________ **Last payment date** (month/year)

Name of person getting this money (if child support, list child's name) ________

Person, company, or agency paying the money ________

How often are you paid?
○ daily
○ once a week
○ every 2 weeks
○ twice a month
○ once a month
○ other:________

Type of money (item you marked above) ________ $ ________ **Amount you get paid** ________ **Last payment date** (month/year)

Name of person getting this money (if child support, list child's name) ________

Person, company, or agency paying the money ________

How often are you paid?
○ daily
○ once a week
○ every 2 weeks
○ twice a month
○ once a month
○ other:________

Type of money (item you marked above) ________ $ ________ **Amount you get paid** ________ **Last payment date** (month/year)

Name of person getting this money (if child support, list child's name) ________

Person, company, or agency paying the money ________

How often are you paid?
○ daily
○ once a week
○ every 2 weeks
○ twice a month
○ once a month
○ other:________

Social Security number: | | | | | | | | | |

Section O

Housing Costs

This section is only for people applying for SNAP food benefits.

Housing costs

1. Does anyone pay any of the costs listed below for the home they are living in? Or for a home they plan to return to? .... ○ Yes ○ No

If yes, mark the costs they have and list the amount:

○ Rent or home payment $ ________ ○ Water and sewer $ ________ ○ Phone $ ________
○ Tax on home $ ________ ○ Electricity $ ________ ○ Home insurance $ ________
○ Natural gas/propane $ ________ ○ Other $ ________

2. If you pay rent, what is your landlord's name and phone number?

________ Landlord's name ________ Phone

3. Does another person not living in the home help anyone on your case pay for housing costs? .... ○ Yes ○ No

CREASE AND TEAR AT PERFORATION

Section P

Costs to Take Care of Others

Costs to take care of others

Does anyone have costs to take care of others? ○ Yes ○ No

If yes, give facts below.

Examples:
- Child care costs so someone can work, look for work, go to training, or go to school.
- Costs for people with disabilities or adults who need help caring for themselves.
- Child support payments, medical bills, and health insurance you pay for a child living outside the home.
- Alimony payments.

Cost 1

________ **Type of cost** ________ **First name** of person who gets care or support

________ **Who pays the cost?** $ ________ **Amount paid** ________ **Date last paid**

________ **Person or company that gets the money** (name, address, and phone number)

How often paid? ○ daily ○ once a week ○ every 2 weeks ○ twice a month ○ once a month ○ other: ________

For court ordered child support list child who gets support (provide copy of court order)

Cost 2

________ **Type of cost** ________ **First name** of person who gets care or support

________ **Who pays the cost?** $ ________ **Amount paid** ________ **Date last paid**

________ **Person or company that gets the money** (name, address, and phone number)

How often paid? ○ daily ○ once a week ○ every 2 weeks ○ twice a month ○ once a month ○ other: ________

For court ordered child support list child who gets support (provide copy of court order)

Cost 3

________ **Type of cost** ________ **First name** of person who gets care or support

________ **Who pays the cost?** $ ________ **Amount paid** ________ **Date last paid**

________ **Person or company that gets the money** (name, address, and phone number)

How often paid? ○ daily ○ once a week ○ every 2 weeks ○ twice a month ○ once a month ○ other: ________

For court ordered child support list child who gets support (provide copy of court order)

Social Security number: ___ ___ ___ - ___ ___ - ___ ___ ___ ___

84

Section O

Medical Costs

This section is only for people applying for Medicaid, CHIP, or SNAP food benefits.

Medical costs

Does anyone age 60 or older, or anyone with a disability, pay medical costs? .... O Yes O No

If yes, mark the type of costs they pay: O Doctor O Hospital O Medicine O Health insurance

Section R

People Helping You

People helping you

Did someone help you fill out this form? .... O Yes O No

If yes, tell us about that person:

Name

Relationship or organization

( ) Phone

Address

Preferred Method of Contact by Health Plan Providers or Managed Organizations

For pregnant individuals only

If you get health benefits from us, your health plan provider or mangaged care organization may contact you for things like appointment reminders and information about immunizations or well-check visits. You can choose to have them contact you by telephone, text message, or email. Please rank how you would prefer to be contacted, with 1 being your most preferred.

Name ______

Language you prefer to be contacted in: ______

☐ By Telephone	Telephone number: ______ (If contaced by cellular telephone, the call may be autodialed or prerecorded, and your carrier's usage rates my apply.)
☐ By text message	Cellular telephone number: ______ (Carrier message and data rates may apply)
☐ By e-mail	E-mail address: ______

Social Security number:

Section [illegible]

Signing Up to Vote
(optional)

Signing up to vote

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you are not registered to vote where you live now, would you like to apply to register to vote here today? .... ○ Yes ○ No

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME. If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private. If you believe that someone has interfered with your right to register or to decline to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Elections Division, Secretary of State, PO Box 12060, Austin, TX 78711. Phone: 1-800-252-8683

Agency Use Only: Voter Registration Status

☐ Already registered ☐ Client declined ☐ Agency transmitted
☐ Client to mail ☐ Mailed to client ☐ Other

____
Agency staff signature

Section [illegible]

A Person Who Can Act for You

Don't forget to sign page 19.

Person who has the right to act for you

If you want, you can give someone the right to act for you (an authorized representative). That person can:

- Give and get facts for this application.
- Take any action needed for the application process. This includes appealing an HHSC decision.
- Take any action needed to enroll in Medicaid or CHIP. This includes picking a health plan.
- Take any action needed to get benefits. This includes reporting changes and renewing benefits.

If you give someone the right to act for you, that person agrees to:

- fulfill all your responsibilities related to Medicaid;
- keep information about you private;
- obey state and federal laws about conflict of interest and keeping information private, including:
  - o laws that protect information on people who apply for or receive Medicaid (42 CFR part 431, subpart F);
  - o laws about the privacy and safety of personally identifiable information (45 CFR §155.260(f)); and
  - o laws barring the state from paying anyone other than your provider or you for Medicaid services, except in a few circumstances (42 CFR §447.10).

Do you want to give someone the right to act for you — to be your authorized representative? .... ○ Yes ○ No

If yes, tell us about that person (the authorized representative) by filling out Appendix C. It is attached to this form.

Social Security number:

← CREASE AND TEAR AT PERFORATION →

86

Section 0

Legal Information

Legal information

Your Right to be Treated Fairly

This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and in some cases religion or political beliefs.

The U.S. Department of Agriculture also prohibits discrimination based on race, color, national origin, sex, religious creed, disability, age, political beliefs or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

Supplemental Nutrition Assistance Program (SNAP)

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027), found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the State Information/Hotline Numbers (click the link for a listing of hotline numbers by State); found online at: http://www.fns.usda.gov/snap/contact_info/hotlines.htm.

Medicaid and Temporary Assistance for Needy Families

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (800) 537-7697 (TTY).

This institution is an equal opportunity provider.

You also can file a complaint with the Texas Health and Human Services Commission, Civil Rights Office. Email HHSCivilRightsOffice@hhsc.state.tx.us, call 1-888-388-6332, fax (512) 438-5885, or write Texas Health and Human Services Commission, Civil Rights Office, 701 W. 51st St., MC W206, Austin, Texas 78751.

Citizenship and Immigration Status

You can get benefits for your children who are U.S. citizens or legal immigrants even if you are not a U.S. citizen or a legal immigrant. You do not have to give your citizenship or immigration status to get benefits for your children. You only have to give the citizenship or immigration status of people who want benefits. If you are not a U.S. citizen or a legal immigrant, the only benefits you might be able to get are emergency Medicaid services. Getting long-term care (Medicaid for the Elderly and People with Disabilities) or cash help (TANF) could affect your immigration status and your chances of getting a Permanent Resident Card (green card). Getting other benefits will not affect your immigration status and your chances of getting a Permanent Resident Card. You might want to talk to an agency that helps immigrants with legal questions before you apply. If you are a refugee or have been given asylum, getting benefits will not affect your chances of getting a Permanent Resident Card or becoming a citizen.

Social Security Numbers

You only need to give the Social Security numbers (SSNs) for people who want benefits. Giving or applying for an SSN is voluntary; however, anyone who doesn't apply for an SSN or doesn't give an SSN can't get benefits. If you don't have an SSN, we can help you apply for one if you are a U.S. citizen or a legal immigrant. You must be a U.S. citizen or a legal immigrant to get an SSN. You can get benefits for your children if they have an SSN and you don't. We will not give SSNs to the Bureau of Immigration and Customs Enforcement. We will use SSNs to check the amount of money you get (income), if you can get benefits, and the amount of benefits you can get. (7 C.F.R 273.6 for food benefits; 45 C.F.R 205.52 for TANF; and 42 C.F.R 435.910 for health care.)

Social Security number:

87

Section V

Statement of Understanding

Read Section V before signing page 19.

All Benefit Programs

Facts HHSC Has About Me

HHSC uses facts about people applying for benefits to decide: (1) who can get benefits, and (2) the amount of benefits. HHSC checks facts with the federal Income and Eligibility Verification System. If any facts don't match, HHSC will check other sources (banks, employers, etc.). If anyone applying for benefits has an immigration registration number, HHSC must check with the U.S. Citizenship and Immigration Services' (USCIS) system. HHSC will not give anyone's facts to USCIS.

In most cases, I can see and get facts HHSC has about me. This includes facts I give HHSC and facts HHSC gets from other sources (medical records, employment records, etc.). I might have to pay to get a copy of these facts. I can ask HHSC to fix anything that is wrong. I do not have to pay to fix a mistake. To ask for a copy or to fix a mistake, I can call 2-1-1 or my local HHSC benefits office.

Keeping My Facts Private

HHSC will keep my facts private if they were collected:

- By HHSC staff or contracted provider staff.
- To find out if I can get state benefits.

HHSC can share facts about me:

- When needed for me to get state health-care benefits.
- With phone and utility companies. They will find out if my bill amount can be lowered. HHSC will give them my name, address, and phone number.

TANF Cash Help for Families

Child Support or Alimony

I agree to:

- Let the state keep any child support or alimony money owed to anyone during the time they get TANF.
- Let the state keep this money after TANF benefits end, if the TANF amount anyone got still needs to be paid off.
- Tell HHSC about money anyone gets.
- Work with HHSC to get this money; if I don't, I am breaking the law.

The state will keep only the amount allowed by law.

If I Give False Information

If I choose not to tell the truth, I might:

- Be charged with and punished for a crime. (This could include going to prison for up to 10 years or community supervision.)
- Have to repay benefits.
- Never get TANF again.

SNAP Food Benefits

Telling the Truth

Anyone who applies for or gets SNAP must:

- Tell the truth.
- Never trade or sell SNAP benefits, Lone Star Cards, or other devices that allow people to get SNAP.
- Never use or have Lone Star Cards or other devices if they don't belong to them.

Anyone who chooses not to tell the truth might:

- Not get SNAP for a year or more.
- Be fined up to $250,000, jailed up to 20 years, or both.
- Lose income tax refunds.
- Be charged with other crimes.
- Have to repay benefits.
- Never get SNAP again.

The same is true if anyone lets someone else use their Lone Star Card.

Facts Anyone Tells or Gives HHSC

HHSC uses the facts anyone tells or gives HHSC, including Social Security numbers to:

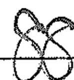
- Check if that person can get benefits.
- Check that person's facts with computer matching programs and credit reporting agencies.
- Make sure that person is following benefit program rules.
- Help other agencies check if that person can get other benefits.
- Recover benefits that person wasn't supposed to get.
- Share facts about that person: (1) with other state and federal agencies (for example, the Texas Workforce Commission, the Social Security Administration, and the Internal Revenue Service); (2) with law enforcement officials so they can find people on that person's benefits case (the household) who are wanted for fleeing the law; and (3) with federal, state, and private claims collecting agencies for food benefit overpayment claims collection action.

(Food and Nutrition Act of 2008, as amended, 7 U.S.C. 2011-2036.)

More on next page

CREASE AND TEAR AT PERFORATION

Social Security number:



Section IV

Statement of Understanding

Did you...

1. Sign and date page 1 (if you have not already sent it in).
2. Include the "items we need" listed in the cover section.
3. Sign and date this page.

Medicaid

If I give false information

If I choose not to tell the truth, I might:

- Be charged with a crime.
- Have to repay benefits.

The same is true if I let someone else use my medical card or Medicaid ID.

Giving Out Facts About Me

I agree to let Medicaid health-care providers (doctors, drug stores, hospitals, etc.) give out any facts about me to HHSC. This will allow the providers to be paid by Medicaid.

Medical and Child Support Payments

Depending on my benefits case, the Attorney General (the state) might check that I am getting the right amount of child or medical support payments and coverage.

- If only my child gets Medicaid, I can decide if I want the state to help get any payments and coverage we should get, but don't get right now.
- If my child and I both get Medicaid, I must:
  - Help the state get any payments and coverage we should get, but don't right now.

  If I don't help the state, my child can get Medicaid, but I might not.
  - Identify who the child's other parent is.
  - Allow the state to keep any medical support payments.
- I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell HHSC and I may not have to cooperate.

If I get Medicaid, HHSC will keep medical service payments I can get from other sources, such as:

- My health insurance.
- Money I got because of injuries.
- Money collected for me or my children by the Office of Attorney General.

I must tell HHSC about these sources. If I don't, I am breaking the law.

HHSC will only keep the amount of medical support and service payments allowed by law. I will work with HHSC to get these funds.

By signing below, I agree:

- To let HHSC and other state, federal, and local agencies check, share, and get facts about anyone on my benefits case (the household).
- To let other people, businesses, and organizations share facts they have about anyone on my benefits case (the household) with HHSC.
- The facts to be checked and shared include anything that helps decide: (1) who can get benefits, and (2) the amount of benefits.

My Answers Are True

Sign here to show you agree:

I certify under penalty of perjury that the information I have provided on this application is true and complete to the best of my knowledge. If it is not, I may be subject to criminal prosecution.

☐ Person applying or their authorized representative:

Sign here ______________________ Date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

☐ Parent, guardian, or power of attorney for the person applying:

Sign here (you must give proof of this right) ______________ Phone ( ) - ______ Date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

☐ Witness (only needed if anyone above signed with an "X" or other mark):

Sign here ______________________ Date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

Printed name of witness ______________________

Ready to send this form? See How to send us your application in the cover section.

Social Security number: __ __ __ - __ __ - __ __ __ __

Applying for or renewing Medicaid or CHIP? If yes, you must fill out this form.

NEED HELP WITH YOUR APPLICATION?

We can help you at no cost to you. Call us at 2-1-1 or 1-877-541-7905 (after you pick a language, press 2). If you have a hearing or speech disability, call 7-1-1 or any relay service.

Section 1

Your Tax Return

This form needs to be filled out, signed, and sent back with your application for benefits.

Are you afraid that giving us facts about someone could cause harm (physical or emotional) to you or your child?

If yes, you might not have to give us facts about that person. You might be able to get the "Family Violence Exemption."

Each person listed in **Section H** of the **Your Texas Benefits** application needs to answer the questions below (Section 1). The people who should be included in Section H and who should answer the questions below are:

- Yourself.
- Your spouse.
- Your children age 20 and younger who live with you.
- Anyone you include on your tax return, even if they don't live with you.
- Anyone else age 20 and younger who you take care of and lives with you.

(You can still apply for health insurance even if you don't file a federal income tax return.)

Person 1: (main contact or head of household)

____

First name **Middle name** **Last name**

If married, name of spouse:

____

Do you plan to file a federal income tax return next year? ○ Yes ○ No

If yes, answer questions a to c. If no, skip to question c.

a. Will you file jointly with a spouse? ○ Yes ○ No

b. Will you claim any dependents on your tax return? ○ Yes ○ No

If yes, list name(s) of dependents:

____

c. Will you be claimed as a dependent on someone's tax return? ○ Yes ○ No

If yes, list the name of the tax filer: ______________ **How are you related to the tax filer?** ______________

TEXAS Health and Human Services

More on page 2-A

90

CREASE AND TEAR AT PERFORATION

Section 1

Your Tax Return

(continued)

Person 2:

First name Middle name Last name

If married, name of spouse:

Do you plan to file a federal income tax return next year? ○ Yes ○ No

If yes, answer questions a to c. If no, skip to question c.

a. Will you file jointly with a spouse? ○ Yes ○ No

b. Will you claim any dependents on your tax return? ○ Yes ○ No

If yes, list name(s) of dependents:

c. Will you be claimed as a dependent on someone's tax return? ○ Yes ○ No

If yes, list the name of the tax filer: **How are you related to the tax filer?**

Does Person 2 live at the same address as Person 1? ○ Yes ○ No

If no, what is Person 2's address?

Person 3:

First name Middle name Last name

If married, name of spouse:

Do you plan to file a federal income tax return next year? ○ Yes ○ No

If yes, answer questions a to c. If no, skip to question c.

a. Will you file jointly with a spouse? ○ Yes ○ No

b. Will you claim any dependents on your tax return? ○ Yes ○ No

If yes, list name(s) of dependents:

c. Will you be claimed as a dependent on someone's tax return? ○ Yes ○ No

If yes, list the name of the tax filer: **How are you related to the tax filer?**

Does Person 3 live at the same address as Person 1? ○ Yes ○ No

If no, what is Person 3's address?

CREASE AND TEAR AT PERFORATION

91

Section 1

Your Tax Return

(continued)

Person 4:

First name | Middle name | Last name

If married, name of spouse:

Do you plan to file a federal income tax return next year? ○ Yes ○ No
If yes, answer questions a to c. If no, skip to question c.

a. Will you file jointly with a spouse? ○ Yes ○ No

b. Will you claim any dependents on your tax return? ○ Yes ○ No
If yes, list name(s) of dependents:

c. Will you be claimed as a dependent on someone's tax return? ○ Yes ○ No
If yes, list the name of the tax filer: **How are you related to the tax filer?**

Does Person 4 live at the same address as Person 1? ○ Yes ○ No
If no, what is Person 4's address?

Person 5:

First name | Middle name | Last name

If married, name of spouse:

Do you plan to file a federal income tax return next year? ○ Yes ○ No
If yes, answer questions a to c. If no, skip to question c.

a. Will you file jointly with a spouse? ○ Yes ○ No

b. Will you claim any dependents on your tax return? ○ Yes ○ No
If yes, list name(s) of dependents:

c. Will you be claimed as a dependent on someone's tax return? ○ Yes ○ No
If yes, list the name of the tax filer: **How are you related to the tax filer?**

Does Person 5 live at the same address as Person 1? ○ Yes ○ No
If no, what is Person 5's address?

If more than 5 people are applying for benefits, add more pages with the same facts.

↟ CREASE AND TEAR AT PERFORATION ↡

Section 2

Tax deductions you claim

Tell us about things that can be deducted on a federal income tax return. If anyone has deductions, health coverage costs might be a little lower.

Tax deductions

Mark all that apply, give the amount, and how often you pay it.
(You shouldn't include a cost that you already considered as part of your net self-employment.)

O Alimony paid $__________ How often?__________

O Student loan interest $__________ How often?__________

O Other deductions, such as educator expenses, health savings accounts, moving expenses, tuition and fees $________ How often? ________ Type: ________

If you have any of these deductions, you will need to send us a copy of your last year's income tax return.

Section 3

Information about people applying for benefits

Information about people applying for benefits

1. Does a child applying for health care travel with a family member who is a migrant farm worker? .... O Yes O No
   If yes, what is the name of that child or children?
   ____
2. Is a child in the Children with Special Health Care Needs program? .... O Yes O No
   If yes, who?
   ____
3. Is anyone an American Indian or Native Alaskan? .... O Yes O No
   If yes, you must fill out "Appendix B: American Indian or Alaska Native Family Member." It is attached to this form.
4. Was anyone in foster care when they were age 18 or older? .... O Yes O No
   If yes, who? __________ **In which state?** __________
5. Does any child on this application have a parent living outside of the home? .... O Yes O No

↑ CREASE AND TEAR AT PERFORATION ↑

93

CREASE AND TEAR AT PERFORATION

Section 4

Money you get

Money you get

Fill out this section only if the amount of money you get changes or might change from month to month. If you don't expect changes to your monthly income, skip this question.

Your total income this year: $ ______

Your total income next year (if you think it will be different): $ ______

Section 5

Insurance offered through your job

Insurance offered through your job

1. Can anyone listed on this form get health insurance through a job? (Check yes even if the coverage is from someone else's job,such as a parent or spouse.) .... ○ Yes ○ No
   If yes, fill out "Appendix A: Health coverage from job."

2. Did anyone have insurance through a job and lose it within the past 3 months? .... ○ Yes ○ No
   If yes, who? ______ **If yes, end date:** ______

   If yes, reason the insurance ended:
   - ○ Parent's job ended due to layoff or business closing.
   - ○ Parent's COBRA or ERS coverage ended.
   - ○ Change in parent's marital status.
   - ○ CHIP benefits from another state ended.
   - ○ Medicaid benefits from another state ended.
   - ○ Private health coverage ended.
   - ○ Death of a parent.
   - ○ The child has special health-care needs.
   - ○ Medicaid benefits ended (for any reason).
   - ○ Other: ______

Section 6

Read and sign this form

A. Is anyone who is applying for health coverage in jail (incarcerated)? .... ○ Yes ○ No
   If yes, who is in jail? ______

B. Renewing your health coverage in future years

To make it easier to find out if I can get help paying for health coverage in future years, I agree to allow the agency to use facts about money I get (income data), including information from tax returns. The agency will send me a notice, let me make any changes, and I can cancel (opt out) at any time.

I agree: Yes, the agency can get facts listed above and renew my health coverage without asking me for the next:

- ○ 5 years (the maximum number of years allowed)
- ○ 4 years
- ○ 3 years
- ○ 2 years
- ○ 1 year
- ○ Don't use information from tax returns to renew my coverage.

______
Sign here

__ __ / __ __ / __ __ __ __
Date (mm/dd/yyyy)

APPENDIX A

Health Coverage from Jobs

You **DON'T** need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

Tell us about the **job** that offers coverage.

Take the Employer Coverage Tool on the next page to the employer who offers coverage to help you answer these questions. You only need to include this page when you send in your application, not the Employer Coverage Tool.

EMPLOYEE Information

1. Employee name (First, Middle, Last)
2. Employee Social Security number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

EMPLOYER Information

3. Employer name
4. Employer Identification Number (EIN) ___ ___ - ___ ___ ___ ___ ___ ___ ___
5. Employer address
6. Employer phone number ( ) -
7. City
8. State
9. ZIP code
10. Who can we contact about employee health coverage at this job?
11. Phone number (if different from above) ( ) -
12. Email address

13. **Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?**

☐ **Yes** (Continue)

13a. If you're in a waiting or probationary period, when can you enroll in coverage? ______________ (mm/dd/yyyy)

List the names of anyone else who is eligible for coverage from this job.

Name: ______________ Name: ______________ Name: ______________

☐ **No** (Stop here and go to page 9, Section L)

Tell us about the **health plan** offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*? ☐ Yes ☐ No

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? **$** ______________

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

16. What change will the employer make for the new plan year (if known)?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? **$** ______________

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

Date of change (mm/dd/yyyy): ______________

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

← CREASE AND TEAR AT PERFORATION →

CREASE AND TEAR AT PERFORATION

EMPLOYER COVERAGE TOOL

Use this tool to help answer questions in Appendix A about any employer health coverage that you're eligible for (even if it's from another person's job, like a parent or spouse). The information in the numbered boxes below match the boxes on Appendix A. For example, the answer to question 14 on this page should match question 14 on Appendix A.

Write your name and Social Security number in boxes 1 and 2 and ask the employer to fill out the rest of the form. Complete one tool for each employer that offers health coverage.

EMPLOYEE Information

The **employee** needs to fill out this section.

1. Employee name (First, Middle, Last)	2. Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

EMPLOYER Information

Ask the **employer** for this information.

3. Employer name		4. Employer Identification Number (EIN) ___ ___ - ___ ___ ___ ___ ___ ___ ___
5. Employer address (HHSC will send notices to this address)		6. Employer phone number ( ) –
7. City	8. State	9. ZIP code
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above) ( ) –	12. Email address	

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? ____________________ (mm/dd/yyyy) (Continue)

☐ **No** (STOP and return this form to employee)

Tell us about the **health plan** offered by this **employer**.

Does the employer offer a health plan that covers an employee's spouse or dependent?

☐ Yes. Which people? ☐ Spouse ☐ Dependent(s)

☐ No

(Go to question 14)

14. Does the employer offer a health plan that meets the minimum value standard*?

☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $ __________

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? $ __________

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

Date of change (mm/dd/yyyy): ____________________

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

96

APPENDIX B

American Indian or Alaska Native Family Member (AI/AN)

Complete this appendix if you or a family member are American Indian or Alaska Native. Submit this with your application.

Tell us about your American Indian or Alaska Native family member(s).

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach.

	AI/AN PERSON 1	AI/AN PERSON 2
1. Name (First name, Middle name, Last name)	First Middle Last	First Middle Last
2. Member of a federally recognized tribe?	☐ Yes **If yes,** tribe name ________ ☐ No	☐ Yes **If yes,** tribe name ________ ☐ No
3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?	☐ Yes ☐ No **If no,** is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No	☐ Yes ☐ No **If no,** is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No
4. Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources: • Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties • Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations) • Money from selling things that have cultural significance	**$** ________ How often?________	**$** ________ How often?________

⬅ CREASE AND TEAR AT PERFORATION ⬅

97

APPENDIX C

Assistance with Completing this Application

You can choose an authorized representative.

If you want, you can give someone the right to act for you (an authorized representative).
That person can:

- Give and get facts for this application.
- Take any action needed for the application process. This includes appealing an HHSC decision.
- Take any action needed to enroll in Medicaid or CHIP. This includes picking a health plan.
- Take any action needed to get benefits. This includes reporting changes and renewing benefits.

If you give someone the right to act for you, that person agrees to:

- fulfill all your responsibilities related to Medicaid;
- keep information about you private;
- obey state and federal laws about conflict of interest and keeping information private, including:
  - o laws that protect information on people who apply for or receive Medicaid (42 CFR part 431, subpart F);
  - o laws about the privacy and safety of personally identifiable information (45 CFR §155.260(f)); and
  - o laws barring the state from paying anyone other than your provider or you for Medicaid services, except in a few circumstances (42 CFR §447.10).

You can have only one authorized representative for all your benefits from HHSC. If you want to change your authorized representative: (1) log in to your account on YourTexasBenefits.com and report a change, or (2) call 2-1-1 (after you pick a language, press 2). If you're a legally appointed representative for someone on this application, send proof with the application.

1. Name of authorized representative (First name, middle name, last name)

2. Address		3. Apartment or suite number
4. City	5. State	6. ZIP code

7. Phone number
( ) –

8. Organization name	9. Organization ID number (if applicable)

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.

10. Your signature	11. Date (mm/dd/yyyy)

For certified application counselors, navigators, agents, and brokers only.

Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)

2. First name, middle name, last name, & suffix

3. Organization name	4. Organization ID number (if applicable)

↑ CREASE AND TEAR AT PERFORATION ↑

98

TEXAS
Health and Human Services

Application for Health Coverage & Help Paying Costs

CREASE AND TEAR AT PERFORATION

THINGS TO KNOW

Use this application to see what coverage choices you qualify for

- Affordable private health insurance plans that offer comprehensive coverage to help you stay well.
- A new tax credit that can immediately help pay your premiums for health coverage.
- Free or low-cost insurance from Medicaid or the Children's Health Insurance Program (CHIP).

Who can use this application?

- Use this application to apply for anyone in your family.
- Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage.
- If you're single, you may be able to use a short form. Visit HealthCare.gov.
- Families that include immigrants can apply. You can apply for your child even if you aren't eligible for coverage. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.
- If someone is helping you fill out this application, you may need to complete Appendix C.

Apply faster online

Apply faster online at YourTexasBenefits.com.

What you may need to apply

- Social Security numbers (or document numbers for any legal immigrants who need insurance).
- Employer and income information for everyone in your family (for example, from pay stubs, W-2 forms, or wage and tax statements).
- Policy numbers for any current health insurance.
- Information about any job-related health insurance available to your family.

Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. **We'll keep all the information you provide private and secure, as required by law.**

What happens next?

After you fill out and sign your application, mail or fax it to us (See Step 6 on Page 8). If you don't have all the information we ask for, sign and send your application anyway. We'll follow up with you within 2 weeks. You'll get instructions on the next steps to complete your health coverage. If you don't hear from us, call **2-1-1** or 1-877-541-7905 (after you pick a language, press 2). Filling out this application doesn't mean you have to buy health coverage.

Get help with this application

- **Online:** YourTexasBenefits.com
- **Phone:** Call us at **2-1-1** or 1-877-541-7905.
  After you pick a language, press 2.
- **In person:** At a benefits office. To find an office near you, go to YourTexasBenefits.com or call **2-1-1** (after you pick a language, press 1).

NEED HELP WITH YOUR APPLICATION? We can help you at no cost to you. Call us at **2-1-1** or 1-877-541-7905 (after you pick a language, press 2). If you have a hearing or speech disability, call 7-1-1 or any relay service.

STEP 1 Tell us about yourself

(We need one adult in the family to be the contact person for your application.)

1. First name, middle name, last name, & suffix

2. Home address (Leave blank if you don't have one.)			3. Apartment or suite number
4. City	5. State	6. ZIP code	7. County

8. Do you live in Texas? ☐ Yes ☐ No

9.Do you plan to stay in Texas? ☐ Yes ☐ No

10. Mailing address (if different from home address)			11. Apartment or suite number
12. City	13. State	14. ZIP code	15. County

16. Phone number ( ) -

17. Other phone number ( ) -

18. Do you want to get information about this application by email? ☐ Yes ☐ No
Email address: ______________________

19. Preferred spoken or written language (if not English)

CREASE AND TEAR AT PERFORATION

STEP 2 Tell us about your family

Who do you need to include on this application?

If you file taxes: We need to know about everyone on your tax return.

If you don't file a tax return: We need to know about family members who live with you. (You don't need to file taxes to get health coverage).

DO Include:

- Yourself
- Your spouse
- Your children under 21 who live with you
- Anyone you include on your tax return, even if they don't live with you
- Anyone else under 21 who you take care of and lives with you

You DON'T have to include:

- Your unmarried partner who doesn't need health coverage
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you're over 21)
- Other adult relatives who file their own tax return

The amount of assistance or type of program you qualify for depends on the number of people in your family and their incomes. This information helps us make sure everyone gets the best coverage they can.

Complete Step 2 for each person in your family. Start with yourself, then add other adults and children. If you have more than two people in your family, you'll need to make a copy of the pages and attach them. You don't need to provide immigration status or a Social Security number (SSN) for family members who don't need health coverage. We'll keep all the information you provide private and secure as required by law. We'll use personal information only to check if you're eligible for health coverage.

NEED HELP WITH YOUR APPLICATION? We can help you at no cost to you. Call us at **2-1-1** or 1-877-541-7905 (after you pick a language, press 2). If you have a hearing or speech disability, call 7-1-1 or any relay service.

STEP 2: PERSON 1 (Start with yourself)

Complete Step 2 for yourself, your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, middle name, last name, & suffix

2. Relationship to you? SELF

3. Date of birth (mm/dd/yyyy)

4. Sex ☐ Male ☐ Female

5.Social Security number (SSN) ___ - ___ - ____

We need this if you want health coverage and have an SSN. Providing your SSN can be helpful if you don't want health coverage too since it can speed up the application process. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778.

6. **Do you plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)
☐ YES. **If yes,** please answer questions a–c. ☐ NO. **If no,** skip to question c.
a. Will you file jointly with a spouse? ☐ Yes ☐ No
If yes, name of spouse: ____________
b. Will you claim any dependents on your tax return? ☐ Yes ☐ No
If yes, list name(s) of dependents: ____________
c. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
If yes, please list the name of the tax filer: ____________
How are you related to the tax filer? ____________

7. Are you pregnant? ☐ Yes ☐ No
a. **If yes,** how many babies are expected during this pregnancy? ______
b. **If yes,** due date (mm/dd/yyyy) ______
c. Is this your first pregnancy? ☐ Yes ☐ No

8. **Do you need health coverage?**
(Even if you have insurance, there might be a program with better coverage or lower costs.)
☐ YES. **If yes,** answer all the questions below.
☐ NO. **If no,** SKIP to the income questions on page 4. Leave the rest of this page blank.

9. Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home? ☐ Yes ☐ No

10. Are you a U.S. citizen or U.S. national? ☐ Yes ☐ No

11. **If you aren't a U.S. citizen or U.S. national,** do you have eligible immigration status? ☐ Yes ☐ No
If yes, answer these questions: a. Immigration document type ______
b. Document ID number ______
c. Have you lived in the U.S. since 1996? ☐ Yes ☐ No

12. Are you, or your spouse or parent, an active-duty member of the U.S. military? ☐ Yes ☐ No

13. Are you, or your spouse or parent, a veteran of the U.S. military? ☐ Yes ☐ No

14. Do you want help paying for medical bills from the past 3 months? ☐ Yes ☐ No

15. Do you live with at least one child under the age of 19, and are you the main person taking care of this child? ☐ Yes ☐ No

16. Are you a full-time student? ☐ Yes ☐ No

17. Were you in foster care at age 18 or older? ☐ Yes ☐ No
If yes, in which state? ______

Please answer the following questions if PERSON 1 is age 22 or younger:

18. Did PERSON 1 have insurance through a job and lose it within the past 3 months? ☐ Yes ☐ No
a. **If yes,** end date: ______
b. Reason the insurance ended:
☐ Parent's job ended due to layoff or business closing.
☐ Parent's COBRA or ERS coverage ended.
☐ Medicaid benefits from another state ended.
☐ CHIP benefits from another state ended.
☐ Change in parent's marital status.
☐ Private health coverage ended.
☐ Death of a parent.
☐ The child has special health-care needs.
☐ Medicaid benefits ended (for any reason).
☐ Other ______

NEED HELP WITH YOUR APPLICATION? We can help you at no cost to you. Call us at **2-1-1** or 1-877-541-7905 (after you pick a language, press 2). If you have a hearing or speech disability, call 7-1-1 or any relay service.

102

STEP 2: PERSON 1 (Continue with yourself)

19. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other ________

20. Race (OPTIONAL—check all that apply.)

☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander
☐ Other ________

Current Job & Income Information

☐ **Employed**
If you're currently employed, tell us about your income. Start with question 21.

☐ **Self-employed**
Skip to question 30.

☐ **Not employed**
Skip to question 31.

CREASE AND TEAR AT PERFORATION

CURRENT JOB 1:

21. Employer name and address

22. Employer phone number
( ) -

23. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
$ ________

24. Average hours worked each WEEK

CURRENT JOB 2: (if you have more jobs and need more space,attach another sheet of paper).

25. Employer name and address

26. Employer phone number
( ) -

27. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
$ ________

28. Average hours worked each WEEK

29. **In the page year, did you:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

30. **If self-employed, answer the following questions:**

a. Type of work ________

b. How much net income (profits once business expenses are paid) will you get from this self-employment **this month?**
$ ________

31. OTHER INCOME THIS MONTH: Check all that apply, and give the amount and how often you get it..

NOTE: You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

☐ None
☐ Unemployment $ ________ How often? ________
☐ Pensions $ ________ How often? ________
☐ Social Security $ ________ How often? ________
☐ Retirement accounts $ ________ How often? ________
☐ Alimony received $ ________ How often? ________
☐ Net farming/fishing $ ________ How often? ________
☐ Net rental/royalty $ ________ How often? ________
☐ Other income $ ________ How often? ________
Type: ________

32. DEDUCTIONS: Check all that apply, and give the amount and how often you pay it.

If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 30b).

☐ Alimony paid $ ________ How often? ________
☐ Student loan interest $ ________ How often? ________
☐ Other deductions, such as educator expenses, health savings accounts, moving expenses, tuition, and fees
$ ________ How often? ________ Type: ________

33. YEARLY INCOME: Complete only if your income changes from month to month.

If you don't expect changes to your monthly income, skip to the next person.

Your total income **this year**	Your total income **next** year (if you think it will be different)
$	$

THANKS ! This is all we need to know about you

NEED HELP WITH YOUR APPLICATION? We can help you at no cost to you. Call us at **2-1-1** or 1-877-541-7905 (after you pick a language, press 2). If you have a hearing or speech disability, call 7-1-1 or any relay service.

STEP 2: PERSON 2

Complete Step 2 for yourself, your spouse/partner, and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, middle name, last name, & suffix ____

2. Relationship to you? ____

3. Date of birth (mm/dd/yyyy) ____

4. Sex ☐ Male ☐ Female

5. Social Security number (SSN) ___ - __ - ____ **We need this if you want health coverage and have an SSN.**

6. Does PERSON 2 live at the same address as you? ☐ Yes ☐ No
   If no, list address: ____

7. **Does PERSON 2 plan to file a federal income tax return NEXT YEAR?**
   (You can still apply for health insurance even if you don't file a federal income tax return.)
   ☐ YES. **If yes,** please answer questions a–c. ☐ NO. **If no,** skip to question c.
   a. Will PERSON 2 file jointly with a spouse? ☐ Yes ☐ No
      If yes, name of spouse: ____
   b. Will PERSON 2 claim any dependents on his or her tax return? ☐ Yes ☐ No
      If yes, list name(s) of dependents: ____
   c. Will PERSON 2 be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
      If yes, please list the name of the tax filer: ____
      How is PERSON 2 related to the tax filer? ____

8. Is PERSON 2 pregnant? ☐ Yes ☐ No
   a. **If yes,** how many babies are expected during this pregnancy? ____
   b. **If yes,** due date (mm/dd/yyyy) ____
   c. Is this your first pregnancy? ☐ Yes ☐ No

9. **Does PERSON 2 need health coverage?**
   (Even if they have insurance, there might be a program with better coverage or lower costs.)
   ☐ YES. **If yes,** answer all the questions below.
   ☐ NO. **If no,** SKIP to the income questions on page 6. Leave the rest of this page blank.

10. Does PERSON 2 have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? ☐ Yes ☐ No

11. Is PERSON 2 a U.S. citizen or U.S. national? ☐ Yes ☐ No

12. **If you aren't a U.S. citizen or U.S. national, do you have eligible immigration status?** ☐ **Yes** ☐ **No**
    If yes, answer these questions: a. Immigration document type ____
    b. Document ID number ____
    c. Have you lived in the U.S. since 1996? ☐ Yes ☐ No

13. Are you, or your spouse or parent, an active-duty member of the U.S. military? ☐ Yes ☐ No

14. Are you, or your spouse or parent, a veteran of the U.S. military? ☐ Yes ☐ No

15. Does PERSON 2 want help paying for medical bills from the past 3 months? ☐ Yes ☐ No

16. Does PERSON 2 live with at least one child under the age of 19, and are they the main person taking care of this child? ☐ Yes ☐ No

17. Was PERSON 2 in foster care at age 18 or older? ☐ Yes ☐ No
    If yes, in which state? ____

Please answer questions 18 and 19 if PERSON 2 is age 22 or younger:

18. Did PERSON 2 have insurance through a job and lose it within the past 3 months? ☐ Yes ☐ No
    a. **If yes,** end date: ____
    b. Reason the insurance ended:
    - ☐ Parent's job ended due to layoff or business closing.
    - ☐ Parent's COBRA or ERS coverage ended.
    - ☐ Medicaid benefits from another state ended.
    - ☐ CHIP benefits from another state ended.
    - ☐ Change in parent's marital status.
    - ☐ Private health coverage ended
    - ☐ Death of a parent.
    - ☐ The child has special health-care needs.
    - ☐ Medicaid benefits ended (for any reason).
    - ☐ Other ____

19. Is PERSON 2 a full-time student? ☐ Yes ☐ No

20. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**
    ☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other ____

21. **Race (OPTIONAL—check all that apply.)**
    - ☐ White
    - ☐ Black or African American
    - ☐ American Indian or Alaska Native
    - ☐ Asian Indian
    - ☐ Chinese
    - ☐ Filipino
    - ☐ Japanese
    - ☐ Korean
    - ☐ Vietnamese
    - ☐ Other Asian
    - ☐ Native Hawaiian
    - ☐ Guamanian or Chamorro
    - ☐ Samoan
    - ☐ Other Pacific Islander
    - ☐ Other ____

NEED HELP WITH YOUR APPLICATION? We can help you at no cost to you. Call us at **2-1-1** or 1-877-541-7905 (after you pick a language, press 2). If you have a hearing or speech disability, call 7-1-1 or any relay service.

CREASE AND TEAR AT PERFORATION

STEP 2: PERSON 2

Current Job & Income Information

☐ **Employed**
If you're currently employed, tell us about your income. Start with question 22.

☐ **Self-employed**
Skip to question 31.

☐ **Not employed**
Skip to question 32.

CURRENT JOB 1:

22. Employer name and address	23. Employer phone number ( ) -

24. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
$ ____________

25. Average hours worked each WEEK

CURRENT JOB 2: (if you have more jobs and need more space,attach another sheet of paper).

26. Employer name and address	27. Employer phone number ( ) -

28. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
$ ____________

29. Average hours worked each WEEK

30. **In the page year,did you:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

31. **If self-employed, answer the following questions:**
a. Type of work ____________
b. How much net income (profits once business expenses are paid) will you get from this self-employment **this month**?
$ ____________

32. OTHER INCOME THIS MONTH: Check all that apply, and give the amount and how often you get it..
NOTE: You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

☐ None
☐ Unemployment $ ______ How often? ______
☐ Pensions $ ______ How often? ______
☐ Social Security $ ______ How often? ______
☐ Retirement accounts $ ______ How often? ______
☐ Alimony received $ ______ How often? ______
☐ Net farming/fishing $ ______ How often? ______
☐ Net rental/royalty $ ______ How often? ______
☐ Other income $ ______ How often? ______
Type: ____________

33. DEDUCTIONS: Check all that apply, and give the amount and how often you pay it.
If PERSON 2 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.
NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 30b).

☐ Alimony paid $ ______ How often? ______
☐ Student loan interest $ ______ How often? ______
☐ Other deductions, such as educator expenses, health savings accounts, moving expenses, tuition, and fees
$ ______ How often? ______

34. YEARLY INCOME: **Complete only if PERSON 2's income changes from month to month.**
If you don't expect changes to PERSON 2's monthly income, skip to the next section.

PERSON 2's total income **this year**	PERSON 2's total income **next year** (if you think it will be different)
$	$

THANKS! This is all we need to know about PERSON 2.

If you have more than two people to include, make a copy of Step 2: Person 2 (pages 5 and 6) and complete.

STEP 3 American Indian or Alaska Native (AI/AN) family member(s)

1. Are you or is anyone in your family American Indian or Alaska Native?
☐ **If No,** skip to Step 4. ☐ **Yes. If yes,** go to Appendix B.

CREASE AND TEAR AT PERFORATION

NEED HELP WITH YOUR APPLICATION? We can help you at no cost to you. Call us at **2-1-1** or 1-877-541-7905 (after you pick a language, press 2). If you have a hearing or speech disability, call 7-1-1 or any relay service.

STEP 4 Your Family's Health Coverage

Answer these questions for anyone who needs health coverage.

1. Is anyone enrolled in health coverage now from the following?

☐ YES. **If yes,** check the type of coverage and write the person(s') name(s) next to the coverage they have. ☐ NO.

☐ Medicaid ______
Which state? ______
Date coverage ends (if not ending, write "Not ending") ______

☐ CHIP ______
Which state? ______
Date coverage ends (if not ending, write "Not ending") ______

☐ Medicare ______
☐ TRICARE (Don't check if you have direct care or Line of Duty) ______
☐ VA health care programs ______
☐ Peace Corps ______

☐ Employer insurance ______
Name of health insurance: ______
Policy number: ______
Coverage start date: ______
Coverage end date: ______
Amount you pay each month to cover your child(ren) on this insurance? ______
Who pays the premium? ______
Is this COBRA coverage? ☐ Yes ☐ No
Is this a retiree health plan? ☐ Yes ☐ No

☐ Other
Name of health insurance: ______
Policy number: ______
Is this a limited-benefit plan (like a school accident policy)?
☐ Yes ☐ No

2. Is anyone listed on this application offered health coverage from a job? Check yes even if the coverage is from someone else's job, such as a parent or spouse.

☐ **YES. If yes,** you'll need to complete and include Appendix A. Is this a state employee benefit plan? ☐ Yes ☐ No
☐ **NO. If no, continue to Step 5.**

CREASE AND TEAR AT PERFORATION

Facts about people applying for benefits

These questions will not be used to decide if your family can get benefits. They will help us serve you better.

1. Is a child in your home in the Children with Special Health Care Needs program? ☐ Yes ☐ No
   If yes, who? ______
2. Does a child applying for benefits travel with a family member who is a migrant farm worker? ☐ Yes ☐ No
   If yes, who? ______

Family violence exemption: If you're afraid that giving us facts about someone could cause harm (physical or emotional) to you or your child, you might not have to give us facts about that person. You might be able to get the "Family Violence Exemption."

Preferred Method of Contact by Health Plan Providers or Managed Care Organizations

For pregnant individuals only

If you get health benefits from us, your health plan provider or managed care organization may contact you for things like appointment reminders and information about immunizations or well-check visits.

You can choose to have them contact you by telephone, text message, or email. Please rank how you would prefer to be contacted, with 1 being your most preferred.

Name: ______

Language you prefer to be contacted in: ______

☐ By telephone	Telephone number: ______ (If contacted by cellular telephone, the call may be autodialed or prerecorded, and your carrier's usage rates may apply.)
☐ By text message	Cellular telephone number: ______ (Carrier message and data rates may apply)
☐ By e-mail	E-mail Address: ______

Signing up to vote

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you are not registered to vote where you live now, would you like to apply to register to vote here today? ☐ Yes ☐ No

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private. If you believe that someone has interfered with your right to register or to decline to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Elections Division, Secretary of State, PO Box 12060, Austin, TX 78711. Phone: 1-800-252-8683.

NEED HELP WITH YOUR APPLICATION? We can help you at no cost to you. Call us at **2-1-1** or 1-877-541-7905 (after you pick a language, press 2). If you have a hearing or speech disability, call 7-1-1 or any relay service.

Agency Use Only: Voter Registration Status

☐ Already registered ☐ Client declined ☐ Agency transmitted ☐ Client to mail ☐ Mailed to client ☐ Other

Agency staff signature: ____________________

STEP 5 Read & sign this application

- I'm signing this application under penalty of perjury which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false or untrue information.
- I know that I must tell the Texas Health and Human Services Commission (HHSC) if anything changes (and is different than) what I wrote on this application. To report changes, I can go to YourTexasBenefits.com or call 2-1-1 or 1-877-541-7905. I understand that a change in my information could affect the eligibility for member(s) of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.
- I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed). If not,

____________________ is incarcerated.

(name of person)

We need this information to check your eligibility for help paying for health coverage if you choose to apply. We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof.

Renewal of coverage in future years

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the agency to use income data, including information from tax returns. The agency will send me a notice, let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next

☐ 5 years (the maximum number of years allowed), or for a shorter number of years:

☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year ☐ Don't use information from tax returns to renew my coverage

If anyone on this application is eligible for Medicaid

- I am giving to HHSC the rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving to HHSC rights to pursue and get medical support.
- Does any child on this application have a parent living outside of the home? ☐ Yes ☐ No
- If yes, I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell HHSC and I may not have to cooperate.

Important Information for Former Military Service Members

Women and men who served in any branch of the United States Armed Forces, including Army, Navy, Marines, Air Force, Coast Guard, Reserves or National Guard may be eligible for additional benefits and services.
For more information, please visit the Texas Veterans Portal at https://veterans.portal.texas.gov.

My right to appeal

If I think HHSC has made a mistake, I can appeal its decision. To appeal means to tell someone at HHSC that I think the action is wrong and ask for a fair review of the action. I know that I can find out how to appeal by contacting HHSC at 2-1-1 or 1-877-541-7905 (after you pick a language, press 2). I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

Sign this application

The person who filled out Step 1 should sign this application. If you're an authorized representative you may sign here, as long as you have provided the information required in Appendix C.

Signature	Date (mm/dd/yyyy)

STEP 6 Mail or fax your filled out and signed application

Fax: 1-877-447-2839
If your form is 2-sided, fax both sides.

Mail: HHSC
PO Box 149024
Austin, TX 78714-9968

CREASE AND TEAR AT PERFORATION

NEED HELP WITH YOUR APPLICATION? We can help you at no cost to you. Call us at **2-1-1** or 1-877-541-7905 (after you pick a language, press 2). If you have a hearing or speech disability, call 7-1-1 or any relay service.

APPENDIX A

Health Coverage from Jobs

You **DON'T** need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

Tell us about the job that offers coverage.

Take the Employer Coverage Tool on the next page to the employer who offers coverage to help you answer these questions.

You only need to include this page when you send in your application, not the Employer Coverage Tool.

➡ CREASE AND TEAR AT PERFORATION ➡

EMPLOYEE Information

1. Employee name (First, Middle, Last)
2. Employee Social Security number ___ - __ - ____

EMPLOYER Information

3. Employer name
4. Employer Identification Number (EIN) __ - _______
5. Employer address
6. Employer phone number ( ) -
7. City
8. State
9. ZIP code
10. Who can we contact about employee health coverage at this job?
11. Phone number (if different from above) ( ) -
12. Email address

13. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?

☐ **Yes** (Continue)

13a. If you're in a waiting or probationary period, when can you enroll in coverage? __________ (mm/dd/yyyy)

List the names of anyone else who is eligible for coverage from this job.

Name: __________ Name: __________ Name: __________

☐ **No** (Stop here and go to Step 4 in the application)

Tell us about the health plan offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*? ☐ Yes ☐ No

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.
   a. How much would the employee have to pay in premiums for this plan? $ __________
   b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Once a month ☐ Twice a month ☐ Quarterly ☐ Yearly

16. What change will the employer make for the new plan year (if known)?
   ☐ Employer won't offer health coverage
   ☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
   a. How much would the employee have to pay in premiums for this plan? $ __________
   b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Once a month ☐ Twice a month ☐ Quarterly ☐ Yearly
   Date of change (mm/dd/yyyy): __________

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

NEED HELP WITH YOUR APPLICATION? We can help you at no cost to you. Call us at **2-1-1** or 1-877-541-7905 (after you pick a language, press 2). If you have a hearing or speech disability, call 7-1-1 or any relay service.

EMPLOYER COVERAGE TOOL

Use this tool to help answer questions in Appendix A about any employer health coverage that you're eligible for (even if it's from another person's job, like a parent or spouse). The information in the numbered boxes below match the boxes on Appendix A. For example, the answer to question 14 on this page should match question 14 on Appendix A.

Write your name and Social Security number in boxes 1 and 2 and ask the employer to fill out the rest of the form. Complete one tool for each employer that offers health coverage.

← CREASE AND TEAR AT PERFORATION ←

EMPLOYEE Information

The employee needs to fill out this section.

1. Employee name (First, Middle, Last)

2. Social Security Number ___ - __ - ____

EMPLOYER Information

Ask the employer for this information.

3. Employer name

4. Employer Identification Number (EIN) __ - _______

5. Employer address (HHSC will send notices to this address)

6. Employer phone number ( ) -

7. City

8. State

9. ZIP code

10. Who can we contact about employee health coverage at this job?

11. Phone number (if different from above) ( ) -

12. Email address

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

☐ **Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? ______________ (mm/dd/yyyy) (Continue)

☐ **No** (STOP and return this form to employee)

Tell us about the health plan offered by this employer.

Does the employer offer a health plan that covers an employee's spouse or dependent?

☐ Yes. Which people? ☐ Spouse ☐ Dependent(s)

☐ No

(Go to question 14)

14. Does the employer offer a health plan that meets the minimum value standard*?

☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $ ______________

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Once a month ☐ Twice a month ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? $ ______________

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Once a month ☐ Twice a month ☐ Quarterly ☐ Yearly

Date of change (mm/dd/yyyy): ______________

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

NEED HELP WITH YOUR APPLICATION? We can help you at no cost to you. Call us at **2-1-1** or 1-877-541-7905 (after you pick a language, press 2). If you have a hearing or speech disability, call 7-1-1 or any relay service.

APPENDIX B

American Indian or Alaska Native Family Member (AI/AN)

Complete this appendix if you or a family member are American Indian or Alaska Native. Submit this with your application.

CREASE AND TEAR AT PERFORATION

Tell us about your American Indian or Alaska Native family member(s).
American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach.

	AI/AN PERSON 1	AI/AN PERSON 2
1. Name (First name, Middle name, Last name)	First Middle Last	First Middle Last
2. Member of a federally recognized tribe?	☐ Yes **If yes,** tribe name ____________ ☐ No	☐ Yes **If yes,** tribe name ____________ ☐ No
3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?	☐ Yes ☐ No **If no,** is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No	☐ Yes ☐ No **If no,** is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No
4. Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources: • Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties • Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations) • Money from selling things that have cultural significance	$ ____________ How often? ____________	$ ____________ How often? ____________

NEED HELP WITH YOUR APPLICATION? We can help you at no cost to you. Call us at **2-1-1** or 1-877-541-7905 (after you pick a language, press 2). If you have a hearing or speech disability, call 7-1-1 or any relay service.

APPENDIX C

Assistance with Completing this Application

If you want, you can give someone the right to act for you (an authorized representative).

That person can:

- Give and get facts for this application.
- Take any action needed for the application process. This includes appealing an HHSC decision.
- Take any action needed to enroll in Medicaid or CHIP. This includes picking a health plan.
- Take any action needed to get benefits. This includes reporting changes and renewing benefits.

If you give someone the right to act for you, that person agrees to:

- fulfill all your responsibilities related to Medicaid;
- keep information about you private;
- obey state and federal laws about conflict of interest and keeping information private, including:
  - o laws that protect information on people who apply for or receive Medicaid (42 CFR part 431, subpart F);
  - o laws about the privacy and safety of personally identifiable information (45 CFR §155.260(f)); and
  - o laws barring the state from paying anyone other than your provider or you for Medicaid services, except in a few circumstances (42 CFR §447.10).

You can have only one authorized representative for all your benefits from HHSC. If you want to change your authorized representative: (1) log in to your account on YourTexasBenefits.com and report a change, or (2) call 2-1-1 (after you pick a language, press 2). If you're a legally appointed representative for someone on this application, send proof with the application.

CREASE AND TEAR AT PERFORATION

1. Name of authorized representative (First name, middle name, last name)		
2. Address		3. Apartment or suite number
4. City	5. State	6. ZIP code
7. Phone number ( ) -		
8. Organization name		9. Organization ID number (if applicable)

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.

10. Your signature	11. Date (mm/dd/yyyy)

For certified application counselors, navigators, agents, and brokers only.

Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)	
2. First name, middle name, last name, & suffix	
3. Organization name	4. Organization ID number (if applicable)