TEXAS
Health and Human Services

Medicaid Buy-In Program

Health care for people with disabilities who work

The Medicaid Buy-In program offers all Medicaid health-care services — including community-based services. Some people must pay a monthly fee to be in this program.

This program is for people who:

- Have a physical, intellectual, developmental, or mental disability.
- Are working.
- Live in Texas.
- Don't live all the time in a nursing home, state hospital, or intermediate care facility for people with intellectual disabilities.

There might be a better form to use if you want Medicaid and any of these apply to you:

- You live all the time in a nursing home or other place of care. (Form H1200)
- You no longer get SSI because your Social Security amount went up. (Form H1200-EZ)
- You want to apply only for a Medicare Savings Program (helps pay Medicare costs such as premiums, co-pays, and deductibles). (Form H1200-EZ)
- You live all the time in a state supported living center or state hospital. (Form H1200-PFS)

To ask for these forms, call 2-1-1 or 1-877-541-7905.

Medicaid Buy-In for Children is a different program. It is for families who have a child with a disability, but make too much money to get other types of Medicaid. To get the form for that program, you can:

- Go to www.hhsc.state.tx.us click on "How to Get Help."
- Call 2-1-1 and ask to have Form H1200-MBIC mailed to you.
- Go to an HHSC benefits office. (Call 2-1-1 to find one near you.)

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

How to apply:

- Fill out the form.
- Sign and date page 16.
- Send "Items we need." See page C.
- If you need more room to answer questions, add more pages.
- Write your Social Security number on the bottom of each page. This will help us track your form.

You can fill in a PDF of this form on our website:

1. Go to www.hhsc.state.tx.us
2. Click on "How to get help."

After you type in your answers, print and sign the form.

Then you can fax, mail, or bring it in person to us.

How to send it in:

Mail
HHSC, PO Box 149024, Austin, TX 78714-9024.

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

In person
At a benefits office. Call 2-1-1 to find one near you.

Other Help and Legal Information

After we get your form:

If you can be in the program, we will send you a letter that will tell you:

- How much your cost will be (your premium).
- When your payment is due (usually the end of the month).
- When your benefits will begin.

Benefits begin when you pay your first premium.

Questions about this form or about benefits

Call 2-1-1 or 1-877-541-7905. After you pick a language, press 2.

- 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.

To learn more about benefits, you also can go to www.hhsc.state.tx.us

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.

Report waste, fraud, and abuse

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

Notice: Your estate might have to pay the state back for services you get. To learn more, see page 16.

Your right to be treated fairly

If you think you have been treated unfairly (discriminated against) because of race, color, national origin, age, sex, disability, or religion, you can file a civil rights complaint.

Contact us at HHSCivilRightsOffice@hhsc.state.tx.us or by:

- Mail: HHSC, Office of Civil Rights
  701 W. 51st St., MC W-206, Austin, TX 78751
- Phone: 1-888-388-6332, 1-877-432-7232 (TTY)
- Fax (not toll-free): 1-512-438-5885

Citizenship and immigration status

- You have to give the citizenship or immigration status of only 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 Medicaid long-term care services could affect your immigration status and your chances of getting a Permanent Resident Card (green card).
- You might want to talk to an agency that helps immigrants with legal questions before you apply.

Social Security numbers

- You need to give the Social Security numbers (SSNs) for only 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.

(42 CFR §435.910)

How to file a complaint

If you have a complaint, call 2-1-1 or 1-877-541-7905. If you still need help, call 1-877-787-8999.

Items We Need

Look below for the items to bring or send with this form.
We only need copies of these items. Keep the originals for your records.

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

You must send copies of these items:

- **Social Security number –** Social Security card or statement.
- **Money from a job –** The last 6 pay stubs or paychecks, a statement from your employer, or self-employment records. If you haven't worked long enough to get 6 pay stubs, send all the pay stubs you have for that job.
- **Citizenship or immigration status –**

  If a citizen: U.S. passport, Certificate of Naturalization, U.S. birth certificate, hospital record of birth, or Medicare card. (If you are renewing benefits, we need this only if your status changed.)

  If an immigrant: Registration card or papers from the U.S. Citizenship and Immigration Services. We need copies of the front and back of these forms. (If you are renewing benefits, we need this only if your status changed.)

Send copies of these items only if they apply to your case:

- **Proof of disability** – Medical records related to your disability from the past 12 months. If you don't have 12 months of records, send as many as you have.

You don't need to send proof of your disability if you get Retirement, Survivors, Disability Insurance (RSDI) or Social Security Disability Insurance (SSDI).

- **Legal representative –** Power of attorney papers, guardianship order, court order, or similar court documents.
- **Social Security, pension, veterans benefits, Supplemental Security Income (SSI), workers' compensation, unemployment, or other government benefits** – Award letter or pay stubs.
- **Child support you pay** – Divorce decree, court order, or district clerk record showing how much you pay.
- **Child support you get** – District clerk record. Or letter from parent who pays showing how much, how often, and the date it is usually paid. The letter must be dated and have the name, address, phone number, and signature of the parent who pays.
- **Stocks, bonds, trusts, annuities** – Trust agreement, annuity contract, stock certificate, bond instrument, or current statements.
- **Loans, repayments, and gifts (includes someone paying bills for you)** – Loan agreement. Or statement from the person giving or repaying you money, or paying your bills. The statement must be dated and have that person's name, address, phone number, and signature.
- **Bank accounts** – Statements you received this month and the past 3 months.
- **Real estate, homes, oil, gas, mineral rights** – Current tax statements, division orders, deeds, promissory or mortgage notes, or royalty statements.
- **Medical, dental, and private insurance costs** – Bills, receipts, statements, or canceled checks from this month and the past 3 months.
- **Insurance policies** – Life, burial, and health insurance policies showing the current value. We also might need your spouse or ex-spouse's job-related health insurance information and policies.

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Application for Benefits
Texas Health and Human Services Commission

Medicaid Buy-In Program

For people with disabilities who work

Please use dark ink. Please print. If you need more room, add pages.

Fill in the circles (○) like this → ● .

Section A

Person applying for benefits

Fill out as much of the form as you can.

First name _____ **Middle name** _____

Last name _____

Social Security number ☐☐☐ – ☐☐ – ☐☐☐☐ **Birth date** ☐☐/☐☐/☐☐☐☐

Mailing address _____

City _____ **State** _____ **ZIP** _____

Home phone _____ **Cell or daytime phone** _____

Home address _____

City _____ **State** _____ **ZIP** _____

County _____ **Email** _____

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

If you get money from Social Security or railroad retirement, list the number. Social Security claim number _____ Railroad retirement number _____

Optional Questions

Sex ○ Male ○ Female **Hispanic or Latino?** ○ Yes ○ No

Mark one or more:

○ America Indian or Alaska Native ○ Asian ○ Black or African-American
○ Native Hawaiian or Pacific Islander ○ White

Mark one: ○ Married ○ Single ○ Divorced ○ Separated ○ Windowed

Spouse's name _____

Agency Use Only

Date received: _____ Case/EDG number: _____

Section B

People helping 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.

By agreeing to act as your authorized representative, I agree 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:
  - laws that protect information on people who apply for or receive Medicaid (42 CFR part 431,subpart F);
  - laws about the privacy and safety of personally identifiable information (45CFR§155.260(f));and
  - laws barring the state from paying anyone other than your provider or you for Medicaid services, except in a few circumstances (42CFR §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. Do you want to give someone the right to act for you to be your authorized representative?..... ○ Yes ○ No

_____ ( ) -

Name **Phone number**

_____

Address

This person is your:

- ○ Power of attorney
- ○ Court-appointed guardian
- ○ Other relationship: _____

Your authorized representative

If this person is filling out this application for you, they also must sign page 16.

_____ _____

The person who agrees to be your authorized representative must sign here. Date

You, the person applying for benefits

_____ _____

Sign here to show you agree to have the person listed above as your authorized representative. Date

Section B

People helping you (continued)

Person helping you fill out this form

Is someone helping you fill out this form? ..... ○ Yes ○ No

If yes, tell us about that person:

Name _____ **Relationship or organization** _____

Address _____ **Phone number** ( ) -

Section C

Citizenship

Citizenship

Are you a U.S. citizen? ..... ○ Yes ○ No

If yes, go to Section D.

If no, give facts below:

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

Do you have a sponsor? ..... ○ Yes ○ No

Sponsor's name _____

Sponsor's address _____ **Sponsor's phone number** ( ) -

Date you entered the U.S.

☐☐ / ☐☐ / ☐☐☐☐
month day year

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

If yes, immigrant registration number: _____

Section D

Interview help

We might need to talk with you to get more facts

If we need to talk with you, do you want us to call you or do you want to come to our office? ..... ○ Call me ○ Come to our office

If you want to come to our office, give facts below:

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

   If yes, what do you need? _____

2. What language do you want to speak during the interview? _____

3. 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 _____

Section E

Medical coverage

Medicare

Do you get Medicare? ..... ○ Yes ○ No

If yes, what type? ○ Part A ○ Part B ○ Part D

If yes, what is your Medicare premium (monthly cost)? $ _____

Other health insurance

Do you have health insurance other than Medicare, Medicaid, or CHIP?
Include health insurance you had during the past year ..... ○ Yes ○ No

If yes, give facts below:

POLICY 1

Name of insured person (first, middle, last) _____ Name of policy holder _____

Insurance company name and address _____ Policy number _____

Coverage Start Date ___/___/___ Coverage end date ___/___/___ Type of coverage _____

How often is the premium paid? ○ Monthly ○ Quarterly ○ Yearly

How much is the premium? $ _____ Who pays the premium? _____

Do you get this insurance through a job you have now or used to have? ..... ○ Yes ○ No

If yes, employer's name _____

POLICY 2

Name of insured person (first, middle, last) _____ Name of policy holder _____

Insurance company name and address _____ Policy number _____

Coverage Start Date ___/___/___ Coverage end date ___/___/___ Type of coverage _____

How often is the premium paid? ○ Monthly ○ Quarterly ○ Yearly

How much is the premium? $ _____ Who pays the premium? _____

Do you get this insurance through a job you have now or used to have? ..... ○ Yes ○ No

If yes, employer's name _____

Reminder:

If you need more room, add more pages.

Other facts

1. Do you get Medicaid benefits from another state? ..... ○ Yes ○ No

If yes, which state? _____ When did you last get benefits? _____

2. Do you get or expect to get money from:
• a lawsuit • personal injury settlement • an accident liability claim? ..... ○ Yes ○ No

If yes, list the name, address, and phone number of your attorney, insurance company, court, or person who has facts about the settlement. _____

Section F

Things you are paying for or own (assets)

Things you are paying for or own

Give facts about items you are paying for or own.

1. Do you have checking accounts? ..... ○ Yes ○ No

If yes, give facts below:

ACCOUNT 1

Account number _____ **Names on account** _____

Bank or company name and address _____ **$ Value** _____

If you own this with someone else, tell us who. ○ Spouse ○ Other: _____

ACCOUNT 2

Account number _____ **Names on account** _____

Bank or company name and address _____ **$ Value** _____

If you own this with someone else, tell us who. ○ Spouse ○ Other: _____

2. Do you have savings accounts? ..... ○ Yes ○ No

If yes, give facts below:

ACCOUNT 1

Account number _____ **Names on account** _____

Bank or company name and address _____ **$ Value** _____

If you own this with someone else, tell us who. ○ Spouse ○ Other: _____

ACCOUNT 2

Account number _____ **Names on account** _____

Bank or company name and address _____ **$ Value** _____

If you own this with someone else, tell us who. ○ Spouse ○ Other: _____

Reminder:

If you need more room, add more pages.

Section F

Things you are paying for or own (continued)

3. Do you have certificates of deposit (CDs), money market accounts, or IRAs? ..... ○ Yes ○ No

If yes, give facts below:

ACCOUNT 1

Account number _____ **Names on account** _____

Bank or company name and address _____ **$ Value** _____

If you own this with someone else, tell us who. ○ Spouse ○ Other: _____

ACCOUNT 2

Account number _____ **Names on account** _____

Bank or company name and address _____ **$ Value** _____

If you own this with someone else, tell us who. ○ Spouse ○ Other: _____

4. Do you have savings bonds, stocks, or annuities? ..... ○ Yes ○ No

If yes, give facts below:

By law, you must tell us if you or your spouse has an interest in an annuity or similar type of investment.

If you get Medicaid, the state of Texas becomes the remainder beneficiary of that annuity or similar type of investment.

ACCOUNT 1

Account number _____ **Names on account** _____

Bank or company name and address _____ **$ Value** _____

If you own this with someone else, tell us who. ○ Spouse ○ Other: _____

If this is an annuity, is the state of Texas named the remainder beneficiary?..... ○ Yes ○ No

ACCOUNT 2

Account number _____ **Names on account** _____

Bank or company name and address _____ **$ Value** _____

If you own this with someone else, tell us who. ○ Spouse ○ Other: _____

If this is an annuity, is the state of Texas named the remainder beneficiary?..... ○ Yes ○ No

Section F

Things you are paying for or own (continued)

5. Do you have signature authority on someone else's account? ..... ○ Yes ○ No

If yes, give facts below:

Account owner's name _____ **Account number** _____ **Value** $ _____

Bank or company name and address _____

6. Do you have a safe deposit box? ..... ○ Yes ○ No

If yes, give facts below:

Name and address of bank or company that keeps the safe deposit box _____

Item _____ **Value** $ _____

Item _____ **Value** $ _____

7. Do you have any cash on hand? ..... ○ Yes ○ No

If yes, how much cash? $ _____

8. Do you have life insurance? ..... ○ Yes ○ No

If yes, give facts below:

POLICY 1

Insurance company name and address _____

Policy number _____ **Face value** $ _____

POLICY 2

Insurance company name and address _____

Policy number _____ **Face value** $ _____

9. Do you have a burial space or plot? ..... ○ Yes ○ No

If yes:

Name of cemetery _____ **Number of spaces** _____ **Value** $ _____

Section F

Things you are paying for or own (continued)

10. Do you have a pre-need burial contract? ..... ○ Yes ○ No

If yes:

Funeral home name and address	Buyer or owner of contract	$ Value

11. Do you have promissory or mortgage notes? ..... ○ Yes ○ No

If yes, are they: ○ Negotiable ○ Non-negotiable

$ _____
Value

If you own this with someone else, tell us who. ○ Spouse ○ Other: _____

12. Do you have any trusts? ..... ○ Yes ○ No

If yes:

What kind	$ Value

If you own this with someone else, tell us who. ○ Spouse ○ Other: _____

13. Do you have any cars, trucks, boats, or other vehicles? ..... ○ Yes ○ No

If yes:

VEHICLE 1

Make / Model	Year	$ Value

If you own this with someone else, tell us who. ○ Spouse ○ Other: _____

VEHICLE 2

Make / Model	Year	$ Value

If you own this with someone else, tell us who. ○ Spouse ○ Other: _____

14. Do you have a home (including a mobile home)? ..... ○ Yes ○ No

If yes:

Address of the home	Amount of land	$ Current Value

If you are not living in your home right now,
do you plan to live in it again? ..... ○ Yes ○ No

Mark all that apply to the home: ○ No one lives there ○ Someone lives there and they pay rent ○ Someone lives there and they don't pay rent ○ For sale

If you own a home, don't forget to give us a copy of the latest tax statement.

Section F

Things you are paying for or own (continued)

15. Do you have a life estate or remainder interest in property? ..... ○ Yes ○ No

16. Do you own or share ownership of any other land, lots, or houses? ..... ○ Yes ○ No

If yes:

ITEM 1

Address or location | **Amount of land** | **$ Current Value**

If you own this with someone else, tell us who. ○ Spouse ○ Other: _____

ITEM 2

Address or location | **Amount of land** | **$ Current Value**

If you own this with someone else, tell us who. ○ Spouse ○ Other: _____

17. Do you have any oil, gas, mineral, or surface rights? ..... ○ Yes ○ No

If yes:

ITEM 1

Address or location | **Amount of land** | **$ Current Value**

If you own this with someone else, tell us who. ○ Spouse ○ Other: _____

ITEM 2

Address or location | **Amount of land** | **$ Current Value**

If you own this with someone else, tell us who. ○ Spouse ○ Other: _____

18. Do you have any livestock (cows, horses, pigs, etc.) or poultry? ..... ○ Yes ○ No

If yes:

○ livestock ○ poultry **Number** **$ Current Value**	○ livestock ○ poultry **Number** **$ Current Value**

19. Do you have any work equipment? ..... ○ Yes ○ No

If yes:

Type **$ Current Value**	**Type** **$ Current Value**

Section F

Things you are paying for or own (continued)

20. Do you get any money or benefits now that you should have gotten in the past? ..... ○ Yes ○ No

Examples:
- You were awarded money from an estate 2 years ago, but you just started getting the money.
- You applied for SSI 3 years ago and they just decided that you should get benefits. You are now getting paid for benefits you should have gotten 3 years ago.

If yes:

Type of money or benefits	$ Amounts you were owed

21. Do you have any personal property (fine china, silver, antiques, etc.)? Don't list items you use for daily living needs. ..... ○ Yes ○ No

If yes:

Item	$ Current Value	Item	$ Current Value

22. Do you own or share ownership of anything not named in Section F? ..... ○ Yes ○ No

If yes:

ITEM 1

Item _____ **$ Current Value** _____

If you own this with someone else, tell us who. ○ Spouse ○ Other: _____

ITEM 2

Item _____ **$ Current Value** _____

If you own this with someone else, tell us who. ○ Spouse ○ Other: _____

Section G

Money or property you sold, traded, or gave away

Money or property you sold, traded, or gave away

1. Did you give up the right to get any money (including income) or an inheritance? ..... ○ Yes ○ No

If yes, explain: _____

2. Did you reduce the amount of benefits you get from any source? ..... ○ Yes ○ No

If yes, explain: _____

Section H

Money coming into your home (income)

Money you might get from other programs

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

If yes,mark the programs below:

○ Social Security ○ Supplemental Security Income (SSI)

○ Veterans benefits ○ Other benefits _____

Money from jobs

Did you get money in the past 3 months from:(a) working for someone else, (b) training, or (c) working for yourself? ..... ○ Yes ○ No

If yes, give facts below:

JOB 1

_____ Hours worked

$ _____ Amount paid (before taxes and deductions are taken out)

/ / Start date

/ Last payment date (month/year)

Did you work for yourself? ..... ○ Yes ○ No

_____

If no, list the person or place that paid the money.

Are you still working at this job? ..... ○ Yes ○ No

Are you on paid leave at this job? ..... ○ Yes ○ No

How often are you paid?

○ Daily ○ Twice a month
○ Once a week ○ Once a month
○ Every 2 weeks ○ Other: _____

JOB 2

_____ Hours worked

$ _____ Amount paid (before taxes and deductions are taken out)

/ / Start date

/ Last payment date (month/year)

Did you work for yourself? ..... ○ Yes ○ No

_____

If no, list the person or place that paid the money.

Are you still working at this job? ..... ○ Yes ○ No

Are you on paid leave at this job? ..... ○ Yes ○ No

How often are you paid?

○ Daily ○ Twice a month
○ Once a week ○ Once a month
○ Every 2 weeks ○ Other: _____

JOB 3

_____ Hours worked

$ _____ Amount paid (before taxes and deductions are taken out)

/ / Start date

/ Last payment date (month/year)

Did you work for yourself? ..... ○ Yes ○ No

_____

If no, list the person or place that paid the money.

Are you still working at this job? ..... ○ Yes ○ No

Are you on paid leave at this job? ..... ○ Yes ○ No

How often are you paid?

○ Daily ○ Twice a month
○ Once a week ○ Once a month
○ Every 2 weeks ○ Other: _____

Section H

Money coming into your home (continued)

Other money

Give facts about other money you get.

1. Do you get Social Security? ..... ○ Yes ○ No

If yes, what is the monthly amount? $ _____

2. Do you get Supplemental Security Income (SSI)? ..... ○ Yes ○ No

If yes, what is the monthly amount? $ _____

3. Do you get veterans benefits? ..... ○ Yes ○ No

If yes, what is the claim number? _____

If yes, what is the monthly amount? $ _____

4. Did you, your spouse, parent, or deceased child ever serve in the armed forces? ..... ○ Yes ○ No

If yes, tell us about the person who served.
We will use these facts to find out if you can get their veterans benefits.

_____
Name

_____ _____ _____
Service number | Service start date | Service end date

5. Do you get railroad retirement? ..... ○ Yes ○ No

_____ $ _____
If yes, what is the claim number? **If yes, what is the monthly amount?**

6. Do you get civil service retirement payments? ..... ○ Yes ○ No

_____ $ _____
If yes, what is the claim number? **If yes, what is the monthly amount?**

7. Do you get any other retirement income? ..... ○ Yes ○ No

_____ $ _____
If yes, what is the claim number? **If yes, what is the monthly amount?**

Section H

Money coming into your home (continued)

8. Do you have payments or annuities from private insurance? ..... ○ Yes ○ No

If yes, what is the company name?

$
If yes, what is the monthly amount?

9. Do you get interest from any of the following sources? ..... ○ Yes ○ No

- checking account
- savings account
- certificate of deposit (CD)
- note payment
- other

$
If yes, what is the amount you get?

If yes, how often?

10. Do you get dividends from stocks, bonds, or insurance? ..... ○ Yes ○ No

$
If yes, what is the amount you get?

If yes, how often?

11. Does anyone pay you rent? ..... ○ Yes ○ No

$
If yes, what is the amount you get?

If yes, how often?

12. Do you get any money from leases or royalties from oil, gas, mineral, or surface rights? ..... ○ Yes ○ No

If yes, write the name of the company that pays you.

$
If yes, what is the amount you get?

If yes, how often?

13. Do you get any money from farming? ..... ○ Yes ○ No

$
If yes, what is the amount you get?

14. Do you get the following types of money from anyone else or anywhere else? ..... ○ Yes ○ No

- cash
- gifts
- payments you get for loaning money to someone else
- rent or bills paid for you
- child support
- training
- other

If yes, what type of money do you get?

If yes, who do you get the money from and why?

$
If yes, what is the amount you get?

Section I

Medical costs

Save Time

This section is only for people applying for the first time. If you are renewing benefits, you can skip this section.

Medical bills from the past 3 months

If you can't pay medical bills from the past 3 months, Medicaid might pay them. We will look at the money you get and the things you own to find out if Medicaid might pay them. If you have paid them, you might be able to get paid back by your health care provider (doctor, hospital, clinic, etc.).

Do you have any medical bills for services from the past 3 months? ..... ○ Yes ○ No

If yes, give facts below:

Type of bill: ○ **Doctor** ○ **Hospital** ○ **Medicine** ○ **Other**

$ _____ $ _____ / / _____ _____

Amount of bill **Amount paid** **Date of service**(mm/dd/yy) **who provided the medical service?**

_____

Address of medical service provider

If yes,we need to know about the money you got(income) and things you were paying for or owned(assets) during those past 3months.

Were they different from what you listed on this form?..... ○ Yes ○ No

Section J

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** ☐ **Agency transmitted** ☐ **Mailed to client**
☐ **Client declined** ☐ **Client to mail** ☐ **Other**

_____
Agency staff signature

Section K

Preferred Method Of Contact

Preferred Method of Contact by Health Plan Providers or Managed Care Organizations

If you get health benefits from us, your health plan provider or managed care organization (MCO) may contact you for the following.

- Appointment reminders
- Eligibility and Enrollment matters
- Information about your health care matters
- Other important notices

You can choose to receive this contact by phone, text message or email.

Text message and e-mail are not encrypted and may not be secure. The risks include an unauthorized third party intercepting confidential or private information. If one of these is your preferred method of communication for your health care, be aware of these risks when sending your personal information by text or email.

Your MCO or health plan provider must take reasonable steps to make sure that your health care information stays private.

By completing the information below, you acknowledge that you understand the risks associated with receiving electronic communications and consent to HHSC sharing your preferred method of contact with your MCO or health plan provider.

Select your preferred contact method from the list below.

Name: _____

Language you prefer to be contacted in: _____

☐ By Telephone	**Telephone Number:** _____ (if contacted by cell phone, the call may be auto-dialed or pre-recorded, and your carrier's usage rates may apply)
☐ By Text message	**Cell phone number:** _____ (Carrier message and data rates may apply)
☐ By e-mail	**E-mail address:** _____

If you choose to provide this information, you will be responsible for notifying your MCO or health plan provider of any changes to your contact information. You can opt out of being contacted by telephone, text message, or email by notifying your MCO or health plan provider.

Section L

Statement of understanding

Read this section before signing.

Statement of understanding

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.

Asset Verification Consent

I know that my signature below and/or on the application lets the HHSC get facts about things I own (including money) from banks, credit unions, or other financial institutions so HHSC can decide if I can get Medicaid.

HHSC can keep checking these facts until:

- HHSC denies my application for Medicaid; or
- I can't get Medicaid anymore; or
- I tell HHSC in writing that I do not want HHSC to check these facts any more.

If I do not let HHSC get facts about me from financial institutions, or I tell HHSC I do not want it to check these facts anymore, I know that HHSC may deny or stop my Medicaid.

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.

Giving out facts about me

Medicaid health care providers (doctors, drug stores, hospitals, etc.) might give out facts about me to HHSC. This will allow the providers to be paid by 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 Medicaid ID card.

Medical payments

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.

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

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

Reporting changes

I agree to let HHSC know, within 10 days, about any changes to my case. This includes changes in facts I give on this form such as money I get, things I am paying for or own, where I live, or insurance I have (including health insurance premiums).

Notice:

Your estate might have to pay the state back for services you get.

Medicaid Estate Recovery Program:

If you get certain Medicaid long-term services, the state of Texas has the right to ask for money back from your estate after you die. In some cases, the state might not ask for anything back. The state will never ask for more money back than what it paid for your services.

The state can ask for money back from your estate only if:
1. you applied for and received certain Medicaid services on or after March 1, 2005; and
2. you were age 55 or older when you got the services.

To learn more about Texas Medicaid Estate Recovery Program, including frequently asked questions, please visit https://hhs.texas.gov/MERP. You also may email questions to merp@hhsc.state.tx.us.

If you have a problem or complaint you should first discuss it with the Texas Medicaid Estate Recovery Program. Many times they can explain specific policies or correct the problem immediately. If your problem or complaint is not resolved to your satisfaction, you can contact the HHS Office of the Ombudsman by calling 1-877-787-8999 or by making an online submission at https://hhs.texas.gov/ombudsman.

By signing below, I agree:

- To let HHSC and other state, federal, and local agencies check, share, and get facts about me, my spouse, or my sponsor.
- To let other people, businesses, and organizations share facts they have about me 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: 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. Sign below to show you agree:

Did you...
1. **Include the "items we need" listed on page C.**
2. **Sign and date this page.**

Person applying:

Sign here _____ Date / /

Parent, guardian, authorized representative, court appointed administrator, executor, or power of attorney for the person applying:

Sign here (You must give proof of this right) _____ Date / /

Sign here (You must give proof of this right) _____ Date / /

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

Sign here _____ Date / /

Printed name of witness _____

Ready to send this form to us? See "How to send it in" at the bottom of page A.