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).
- Women's health and family planning services for women ages 15-44 (Healthy Texas Women).

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)

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.

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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 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

d. If no, were you pregnant during the last 12 months? ☐ Yes ☐ No

If yes, when did the pregnancy end? (mm/dd/yyyy) _____

8. Healthy Texas Women provides free women's health and family planning services for women ages 15-44. To keep your participation in Healthy Texas Women private, you can get letters about the program at a different address than what is on your application. Fill out the section below to use a confidential address and phone number:

Mailing Address - Street:
City:
State:
Zip:
Phone number:

9. Women 15-44 years old who do not qualify for Medicaid or CHIP are automatically tested for Healthy Texas Women (HTW) eligibility. Check the box below if you waive HTW testing.

Name:_____ I do not want to be tested for HTW. ☐

10. **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.

11. 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

12. Are you a U.S. citizen or U.S. national? ☐ Yes ☐ No

13. **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

14. Are you, or your spouse or parent, an active-duty member of the U.S. military? ☐ Yes ☐ No

15. Are you, or your spouse or parent, a veteran of the U.S. military? ☐ Yes ☐ No

16. Do you want help paying for medical bills from the past 3 months? ☐ Yes ☐ No

17. 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

18. Are you a full-time student? ☐ Yes ☐ No

19. Were you in foster care at age 18 or older? ☐ Yes ☐ No

If yes, in which state? _____

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 (Continue with yourself)

Please answer the following questions if PERSON 1 is age 22 or younger:

20. 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 _____

21. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

22. **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 23.

☐ **Self-employed**
Skip to question 38.

☐ **Not employed**
Skip to question 39.

Your job may take money out of your check before taxes for retirement savings, medical insurance premiums or health savings accounts, dependent care expenses, commuter expenses or life insurance premiums. These are pretax contributions.

CURRENT JOB 1:

23. Employer name and address

24. Employer phone number ( ) -

25. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

26. Average hours worked each WEEK

27. Total pretax contributions per pay period

28. How often is it contributed?

29. Date Contributed

CURRENT JOB 2: (if you have more jobs and need more space,attach another sheet of paper).

30. Employer name and address

31. Employer phone number ( ) -

32. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

33. Average hours worked each WEEK

34. Total pretax contributions per pay period

35. How often is it contributed?

36. Date Contributed

37. **In the past year, did you:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

38. **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**?

$ _____

39. **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: _____

Was the divorce or separation agreement executed or last modified on or before Dec. 31, 2018? ☐ Yes ☐ No

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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 1 (Continue with yourself)

40. **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? _____

Was the divorce or separation agreement executed or last modified on or before Dec. 31, 2018? ☐ Yes ☐ No

☐ Student loan interest $ _____ How often? _____

☐ Other deductions, such as educator expenses, health savings accounts, moving expenses for active duty members of the military, or tuition, and fees.

$ _____ How often? _____ Type: _____

41. **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

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

d. If no, were you pregnant during the last 12 months? ☐ Yes ☐ No

If yes, when did the pregnancy end? (mm/dd/yyyy) _____

9. Healthy Texas Women provides free women's health and family planning services for women ages 15-44. To keep your participation in Healthy Texas Women private, you can get letters about the program at a different address than what is on your application. Fill out the section below to use a confidential address and phone number:

Mailing Address - Street:
City:
State:
Zip:
Phone number:

10. Women 15-44 years old who do not qualify for Medicaid or CHIP are automatically tested for Healthy Texas Women (HTW) eligibility. Check the box below if you waive HTW testing.

Name: _____ I do not want to be tested for HTW. ☐

11 **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.

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

12. 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

13. Is PERSON 2 a U.S. citizen or U.S. national? ☐ Yes ☐ No

14. 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

15. Are you, or your spouse or parent, an active-duty member of the U.S. military? ☐ Yes ☐ No

16. Are you, or your spouse or parent, a veteran of the U.S. military? ☐ Yes ☐ No

17. Does PERSON 2 want help paying for medical bills from the past 3 months?
☐ Yes ☐ No

18. 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

19. Was PERSON 2 in foster care at age 18 or older?
☐ Yes ☐ No
If yes, in which state?_____

Please answer questions 20 and 21 if PERSON 2 is age 22 or younger:

20. 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 _____

21. Is PERSON 2 a full-time student? ☐ Yes ☐ No

22. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

23. **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 24.

☐ **Self-employed**
Skip to question 39.

☐ **Not employed**
Skip to question 40.

Your job may take money out of your check before taxes for retirement savings, medical insurance premiums or health savings accounts, dependent care expenses, commuter expenses or life insurance premiums. These are pretax contributions.

CURRENT JOB 1:

24. Employer name and address

25. Employer phone number
( ) -

26. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
$ _____

27. Average hours worked each WEEK

28. Total pretax contributions per pay period

29. How often is it contributed?

30. Date Contributed

CURRENT JOB 2: (if you have more jobs and need more space,attach another sheet of paper).

31. Employer name and address

32. Employer phone number
( ) -

33. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
$ _____

34. Average hours worked each WEEK

35. Total pretax contributions per pay period

36. How often is it contributed?

37. Date Contributed

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.

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38. **In the past year,did you:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

39. **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**?

$ _____

40. **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: _____

Was the divorce or separation agreement executed or last modified on or before Dec. 31, 2018? ☐ Yes ☐ No

41. **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? _____

Was the divorce or separation agreement executed or last modified on or before Dec. 31, 2018? ☐ Yes ☐ No

☐ Student loan interest $ _____ How often? _____

☐ Other deductions, such as educator expenses, health savings accounts, moving expenses for active duty members of the military, or tuition, and fees.

$ _____ How often? _____

42. **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.

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

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 4 Your Family's Health Coverage

2. **Does the health insurance cover family planning services?** ☐ Yes ☐ No

If yes, if we file a claim on your health insurance will it cause you physical, emotional, or other harm from your spouse, parents or other persons? ☐ Yes ☐ No

If yes, tell us why filing a claim with your health insurance would cause you harm.

_____

3. **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.**

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

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.

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.

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Agency Use Only: Voter Registration Status

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

Agency staff signature: _____

CREASE AND TEAR AT PERFORATION

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

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.

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.

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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 ☐ 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.

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? _____

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CREASE AND TEAR AT PERFORATION

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:
  - 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 (45 CFR §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 (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)

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