UTHealth East Texas Preventive Healthcare Services

TEXAS Health and Human Services

Application for Program Benefits

Section I. Applicant Information

Name (Last, First, Middle)	Sex ☐Male ☐Female	Date of Birth	Race/Ethnicity	
Primary Phone Number (Area code and number)	Mobile Phone Number (Area code and number)			
Home Address (Street, Apt. or P.O. Box)	City	County	State	Zip Code
Email Address				

Communication Preferences

Please contact me by……..☐ Phone ☐ Email ☐ Mail

Preferred spoken language……☐ English ☐ Spanish ☐ Other

_____

Preferred written language……☐ English ☐ Spanish ☐ Other

_____

☐ By checking this box, I authorize my health care provider to contact me via voicemail or text messaging to the mobile number listed above.

Important Information for Former Military Services 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, visit the Texas Veterans Portal at https://veterans.portal.texas.gov/

Are you a veteran? ☐ Yes ☐ No

Section II. Household Information

Do you, or does anyone in your household, have any special circumstances?……☐ Yes ☐ No

If yes, provide a detailed explanation of special circumstances below:

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Number of People in the Household: _____

This number will include you and anyone who lives with you for whom you are legally responsible. Minors should include parent(s)/legal guardian(s).

Household Members (including Primary Applicant)

Name (Last, First, Middle)	Date of Birth	Sex	Race/Ethnicity	Relationship	Has Health Care Coverage? (Y/N)
		☐ Male ☐ Female			☐ Yes ☐ No
		☐ Male ☐ Female			☐ Yes ☐ No
		☐ Male ☐ Female			☐ Yes ☐ No
		☐ Male ☐ Female			☐ Yes ☐ No
		☐ Male ☐ Female			☐ Yes ☐ No
		☐ Male ☐ Female			☐ Yes ☐ No
		☐ Male ☐ Female			☐ Yes ☐ No
		☐ Male ☐ Female			☐ Yes ☐ No

Health care coverage includes Medicare, Medicaid, Children's Health Insurance Program (CHIP), veteran's benefits, TRICARE, private insurance, etc. An authorized program representative will submit a claim for reimbursement from insurer for any benefit, service or assistance received by member with coverage.

Section III. Other Benefits

Check all benefits that you or someone in your household receives:

☐ Children's Health Insurance Program (CHIP) Perinatal

☐ Supplemental Nutrition Assistance Program (SNAP)

☐ Women, Infants and Children (WIC) Program

☐ Healthy Texas Women (HTW)

☐ Medicaid for Pregnant Women

☐ Other: _____

☐ None of these

Were you referred by a Healthy Texas Women provider?..... ☐ Yes ☐ No

Household Income Information

Name of person receiving money	Name of employer/person who provides the money	Amount of money received per month

Type of deduction (if applicable)	Deduction amount

Section IV. Applicant Health Care Information

I have read the rights and Responsibilities statements..... ☐ Yes ☐ No

Privacy Notification

With few exceptions, you have the right to request information that the state of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. (Government Code, Section 552.021, 552.023, 559.003 and 559.004.)

Acknowledgement

I understand that this application is a legal document and that by signing this form, I am stating that, to the best of my personal knowledge, all facts included are true and correct. I understand that giving false information could result in disqualification or reimbursement for the cost of services that if am approved to receive program services, I must comply with program policies, including maintaining eligibility and fulfilling all

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_____other beneficiary responsibilities.
Please Initial

Coverage Attestation

I attest that, to the best of my knowledge, I have no other coverage than what is listed in Section II, Household Information or Section III, Other benefits. I authorize the program to bill the coverage sources listed for any
_____services provided.
Please Initial

Statement of Release of Information

I authorize the release of income and medical information to and by the Texas Health and Human Services Commission and the provider, as necessary, to determine eligibility
_____and to coordinate, render and bill for services.
Please Initial

_____ _____
Applicant Signature Date

_____ _____ _____
Signature of Person Helping Applicant Relationship to Applicant Date

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Section V. Contractor Eligibility Certification (For Facility Office Use Only)	☐ FPG and PHC

Section V. Part 1- Applicant Information		
1. Name (Last, First, Middle)	☐ New	☐ Re-certification
	☐ Approved	☐ Denied
2. Name (Last, First, Middle)	☐ New	☐ Re-certification
	☐ Approved	☐ Denied

Section V. Part II – Household Information	Notes:
1.	
2.	
3.	
4.	
5.	
6	
7.	

Section V. Part III – Income Information

Income		Income Type	Amount	Documentation	
Applicant 1	**Applicant 2**				
		Gross Earned Income	$	☐ Yes	☐ No
		Cash gifts and contributions	$	☐ Yes	☐ No
		Child Support income	$	☐ Yes	☐ No
		Disability Insurance Benefits	$	☐ Yes	☐ No
		Dividends Interest and Royalties	$	☐ Yes	☐ No
		Loans (non-educational)	$	☐ Yes	☐ No
		Lawsuit and Lump-sum Payments	$	☐ Yes	☐ No
		Military Pay	$	☐ Yes	☐ No
		Mineral Rights	$	☐ Yes	☐ No
		Pensions and annuities	$	☐ Yes	☐ No
		Reimbursements	$	☐ Yes	☐ No
		Retirement, Survivors, Disability Insurance (RSDI) Social Security Payments	$	☐ Yes	☐ No
		Social Security Disability Insurance Benefits (SSDI)	$	☐ Yes	☐ No
		Self-employment Income	$	☐ Yes	☐ No
		Unemployment Compensation	$	☐ Yes	☐ No
		Department of Veterans Affairs Payments	$	☐ Yes	☐ No
		Workers' Compensation	$	☐ Yes	☐ No
		Wages, Salaries, and Commissions	$	☐ Yes	☐ No

		Total Countable Income	$
		Deductions	- $
		Total Household Income	**$**

Section V. Part IV – Income Calculations

Applicant 1. Income Documentation:

☐ **Weekly** ☐ **Biweekly** ☐ **Twice per month** ☐ **Monthly** ☐ **Annual** ☐ **Letter of Support**

☐ **Adjunctive Eligibility Documentation:** _____ ☐ **Other:** _____

Calculations:

Applicant 2. Income Documentation:

☐ **Weekly** ☐ **Biweekly** ☐ **Twice per month** ☐ **Monthly** ☐ **Annual** ☐ **Letter of Support**

☐ **Adjunctive Eligibility Documentation:** _____ ☐ **Other:** _____

Calculations:

Section V. Part V – Program Eligibility

Eligibility Effective Date: _____ | **Co-pay amount: $0**

Adjunctive Eligibility: ☐ **Yes** ☐ **No** ☐ **N/A**

Total Household Income: $_____/month | **Total Household Federal Poverty Level (FPL) _____%**

Proof of Income Waived: ☐ **Yes** ☐ **No** ☐ **N/A**

Reason for Waiver of Proof of Income: _____

Are all household members eligible as Texas Residents? ☐ **Yes** ☐ **No**

Identified if Potentially Eligible for Other Benefits:

☐ **Medicare** ☐ **Medicaid** ☐ **CHIP** ☐ **Private Insurance**

☐ **VA Benefits** ☐ **TRICARE** ☐ **HTW** ☐ **BCCS**

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Assisted with Application for Other Programs:	☐ Yes	☐ No	☐ N/A

Agency: The University of Texas Health Science Center at Tyler

_____ _____

Signature – Agency/Staff Member Date