UTHealth
East Texas
Preventive Healthcare Services

Application for Healthcare Programs

To apply, you must return:

- Completed and **signed/dated** Household Eligibility Application
- **Signed/dated** Applicant's Rights and Responsibility Form
- **Signed/dated** Patient Agreement Form
- Include your Proof of Income (2 **current** pay stubs--within the previous 30 days) or a Letter of Support (if unemployed)
- If receiving SNAP, CHIP, or TANF, your proof of income may be waived if you attach a current award/certification letter and/or WIC approved shopping list or a recent WIC purchase receipt with remaining balance
- **If multiple people are applying on the same application and live in the same household, they must also sign the above listed forms**

Incomplete or missing application pages will NOT be processed.

For questions call:

English: 903.877.8186--Suprina Kenney

OFC Cell: 903.216.2615

Español: 903.877.7498--Argelia Espinoza

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:

UTHealth East Texas Preventive Healthcare Services

TEXAS Health and Human Services

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 other beneficiary responsibilities.

_____

Please Initial

UTHealth East Texas Preventive Healthcare Services

TEXAS Health and Human Services

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

Preventive Healthcare Programs
Patient Agreement Form
for
The Family Planning Program (FPP) & Primary Healthcare Program (PHC)

You must read all of this document

COVERED SERVICES

- Wellness exams for men and women
- Clinical breast exams and pelvic exams
- Breast cancer screenings (Mammogram) and Cervical cancer screenings (Pap Smears)
- Screenings for cholesterol, diabetes and high blood pressure
- Visits for cholesterol, hypertension and diabetes
- Screenings for depression
- Screenings for HIV. Visits and treatment for sexually transmitted infections (**ONLY STI treatment medications are covered)**
- Pregnancy testing and limited prenatal benefits
- Long-acting reversible contraceptives and oral contraceptive pills
- Contraceptive methods, such as condoms, diaphragm, vaginal spermicide and injections
- **Limited routine labs** and **limited** immunizations
- (PHC program only) Visits for possible contagious conditions, such as cold, flu or viruses

SERVICES NOT COVERED

- Any and all clinic visits **not** in the specific locations listed on your eligibility letter will **not be covered**.
- Any and all visits for pain (including but not limited to foot, hand, knee, back, neck, arm, leg, shoulder, etc. or headaches) will **not be covered**.
- Any and all visits with a specialist such as for the heart, lung, stomach, brain, foot, etc. or for renal, cardiac, pulmonary, podiatry, etc. will **not be covered**.
- Any and all specialty laboratory or radiology tests or diagnostics will **not be covered**.
- Any and all visits to the emergency room will **not be covered**.
- Any and all inpatient services will **not be covered**.
- Any and all visits for ADHD, anxiety or bipolar disorders will **not be covered**.
- Any and all medications other than contraception and/or STI/STD treatment will **not be covered**.
- Any and all surgeries will **not be covered**.

- ✓ Applicants must meet program requirements to be eligible.
- ✓ Once approved, you will receive an ID card and eligibility letters. You must have your ID card and your eligibility letters with you at your visits.
- ✓ It is your responsibility to re-apply annually.
- ✓ Services will be provided while funds are available.
- ✓ If you have any questions about covered and/or non-covered services, please call (903) 877-8186 or (903) 877-7498

"I understand if I request certain medical services, labs, X-Rays, and/or medications, etc., **I will be solely responsible for the full payment of those services.** I further understand that if the provider deems other medical services are necessary for my continuity of care (such as labs, X-Rays, surgery, hospitalization and/or medications, etc.), those services **will not be covered** under this grant and **I will be solely responsible for the full payment of those services**. I further acknowledge that I have read and fully understand the services offered and not offered by the Family Planning Grant and/or the Primary Healthcare Grant"

PRINTED NAME	SIGNATURE	DATE
PRINTED NAME	SIGNATURE	DATE

TEXAS Health and Human Services

Primary Health Care (PHC)

Statement of Applicant's Rights and Responsibilities

Declaración de los derechos y responsabilidades del solicitante

By signing this application for assistance, I affirm the following:	Al firmar esta solicitud para recibir asistencia, afirmo lo siguiente:
The information on the application and its attachments is true and correct. This application is a legal document. Deliberately omitting information or giving false information may cause the Provider to terminate services to a member of my household/family or me.	La información en la solicitud y en sus anexos es verdadera y correcta. Esta solicitud es un documento legal. Omitir información deliberadamente o proporcionar datos falsos podría causar que el Proveedor cancele los servicios a un miembro de mi familia o a mí.
If I omit information, fail or refuse to give information, or give false or misleading information about these matters, I may be required to reimburse the State for the services rendered if I am found to be ineligible for services. I will report changes in my household/family situation that affect eligibility during the certification period (changes in income, household/family members, and residency).	Si omito o me niego a proporcionar información o doy información falsa o engañosa acerca de estos asuntos, se me puede exigir que reembolse al Estado por los servicios recibidos si no califico para recibirlos. Reportaré los cambios en mi situación familiar que afecten el acceso a los servicios durante el período de certificación (cambios en el ingreso, miembros de la familia y de residencia).
I authorize the release of all information, including but not limited to income and medical information by and to the Texas Health and Human Services Commission (HHSC) and Provider in order to determine eligibility, to bill or to render services to my household/family or me.	Autorizo la divulgación de toda la información, incluyendo, pero sin limitarse al ingreso, información médica de y para el Texas Health and Human Services Commission (HHSC) y el Proveedor para determinar si puedo recibir los servicios y para facturar o brindar los servicios a mi familia o a mí personalmente.
I understand I may be asked by the Provider to provide proof of any of the information provided in this application.	Entiendo que el Proveedor me puede pedir comprobantes de la información proporcionada en esta solicitud.
Health insurance coverage, including but not limited to individual or group health insurance, health maintenance organization membership, Medicaid, Medicare, Veterans Administration benefits, TRICARE, and Worker's Compensation benefits, must be reported to the Provider. Benefits from health insurance may be considered the primary source of payment for health care received. I hereby assign to the Provider any such benefits. I also assign payment for benefits and services received from and through the Provider directly to the service providers.	La cobertura de seguro médico, incluyendo pero sin limitarse a seguro individual o grupal, membresía a organizaciones para el cuidado de la salud, Medicaid, Medicare, beneficios de la administración de veteranos, TRICARE y de compensación laboral, deben ser reportados al Proveedor. Los beneficios de esos seguros pueden ser considerados como la fuente principal de pago por los servicios recibidos. Por este medio, asigno al Proveedor cualquier beneficio de este tipo. También asigno el pago de los beneficios recibidos de y a través del Proveedor, directamente a los proveedores de servicios.
I understand that to maintain program eligibility, I will be required to reapply for assistance at least every twelve months.	Entiendo que para mantener los servicios, se me pedirá que vuelva a solicitar asistencia al menos cada doce meses.
I am a bona fide resident of Texas or a dependent. I physically live in Texas, maintain living quarters in Texas, and do not claim to be a resident of another state or country, or am a dependent of a bona fide Texas resident.	Soy residente legítimo de Texas o dependiente. Vivo físicamente en Texas, mantengo residencia en Texas y no pretendo ser residente de otro estado o país, o soy dependiente de un residente legítimo de Texas.
Some programs provide care through program-approved providers. I understand that to receive benefits from such programs, treatment must be received through those program-approved providers.	Algunos programas brindan atención a través de proveedores aprobados por el programa. Entiendo que para recibir beneficios de estos programas, el tratamiento debe ser recibido a través de los proveedores aprobados por el programa.
I understand that criteria for participation in the program are the same for everyone regardless of sex, age, disability, race, or national origin.	Entiendo que el criterio para participar en el programa es el mismo para todos sin importar el sexo, la edad, la discapacidad, la raza o la nacionalidad.
I understand I have the right to file a complaint regarding the handling of my application or any action taken by the program with the HHSC Civil Rights Office at 1-888-388-6332.	Entiendo que tengo el derecho de presentar una queja con relación al manejo de mi solicitud o cualquier acción tomada por el programa con la oficina de derechos humanos de HHSC al 1-888-388-6332.
I understand that I will receive written documentation concerning the services for which my household/family or I is eligible or potentially eligible.	Entiendo que recibiré documentación por escrito concerniente a los servicios para los cuales mi familia o yo calificamos o potencialmente lleguemos a calificar.
With few exceptions, you have the right to request and be informed about 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. (Reference: Government Code, Section 552.021, 522.023 and 559.004)	Salvo algunas excepciones, tiene el derecho de solicitar y ser informado sobre la información que el estado de Texas recopila sobre usted. Tiene derecho de recibir y revisar la información previa solicitud. También tiene derecho de pedirle a la agencia estatal que corrija cualquier información que sea incorrecta. (Referencia: Government Code, sección 552.021, 522.023 y 559.004)

	Applicant's Signature / Firma del solicitante	Date / Fecha	Provider Staff Signature	Date
1.				
2.	Applicant's Signature / Firma del solicitante	Date / Fecha		

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.

Información importante para antiguos miembros de las Fuerzas Armadas
Las mujeres y los hombres que hayan pertenecido a cualquier cuerpo de las Fuerzas Armadas de los Estados Unidos (incluidos el Ejército, la Armada, la Infantería de Marina, la Fuerza Aérea, la Guardia Costera, el cuerpo de reservistas o la Guardia Nacional) podrían recibir beneficios y servicios adicionales. Para más información, visite el Portal de Texas para Veteranos en https://veterans.portal.texas.gov.

UTHealth
The University of Texas Health Science Center at Tyler

Alphabetical Index of Clinics, Offices & Services

Building A
✚ Emergency Room – A1
Geriatric Behavioral Health – A4
GI Lab – A1
Hurst Chapel – A1
NeuroRestorative – A6

Building B
Cafeteria – B1
Human Resources – B3
Inpatient Pharmacy – B1
Red & Kim Little Conference Room – B6
Tranquility Garden – B1
UT Health North Campus Gift Shop – B1

Building C
Plant Operation/Facilities – C115

Building D
Hudnall Auditorium – D2
Lab (After-Hours) – D1
Outpatient Pharmacy – D1
***Preventive Healthcare Office - D206

Building E
Riter Center
Cystic Fibrosis Clinic – E4
Family Health Clinic – E2
Infectious Disease Clinic – E1
Internal Medicine Clinic – E3
Laboratory (Lab) – E1
Occupational Medicine Clinic – E3
Pulmonary Clinic – E1
Radiology/X-ray – E1
Rehabilitation Services – E2
Riter Center Gift Shop – E1

Building F
Acute Behavioral Health – F1
Behavioral Health Clinic – F1

Building G
Breast Center – G2
GI Clinic – G2

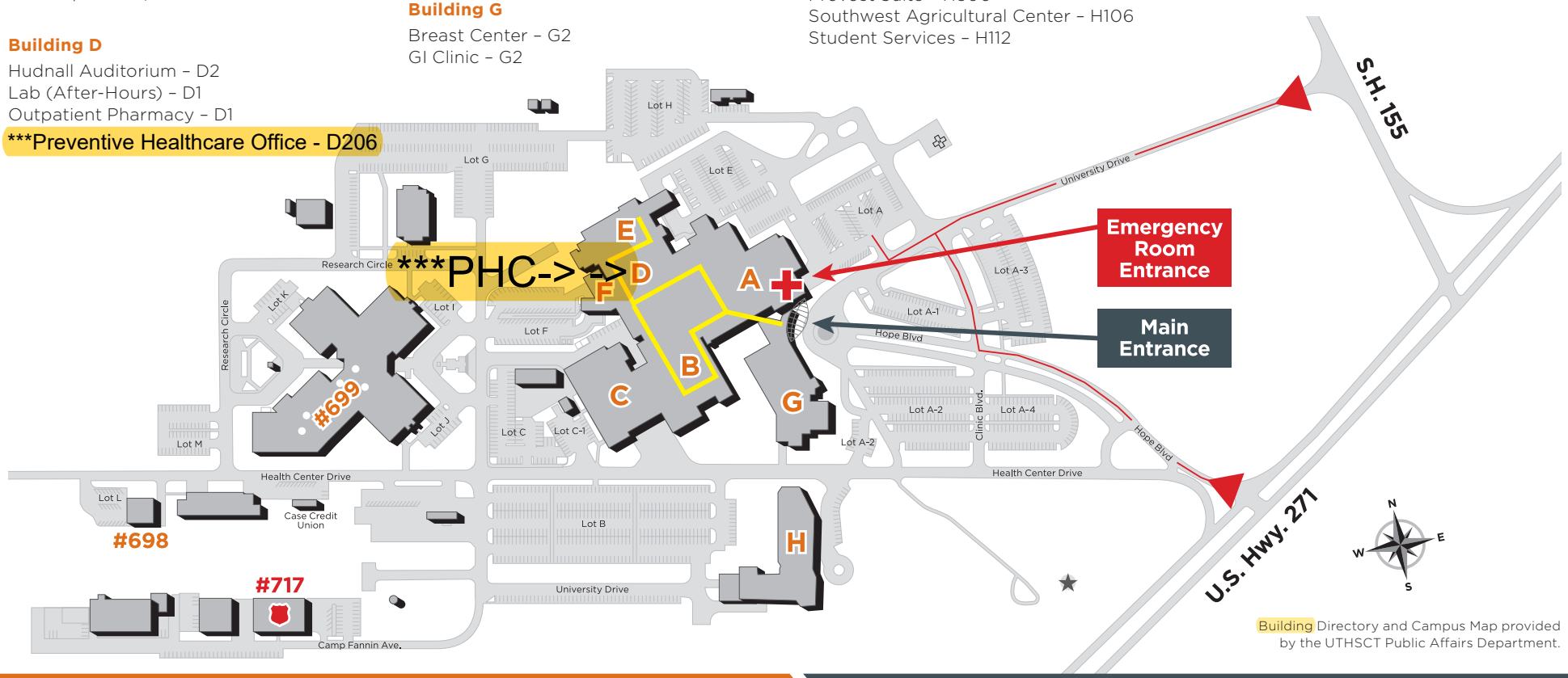
The Louise & Joseph Z. Ornelas Academic Amphitheater – G3
Plastic Surgery Clinic – G2
Podiatry Clinic – G2
Urology Clinic – G2
UT Health North Campus Tyler MD Anderson Cancer Center – G1
Watson W. Wise Medical Library – G3

Building H
School of Community and Rural Health
Center for Population Health, Analytics & Quality Advancement - H212
Community Teaching Kitchen – H140
Dean's Suite – H201
Executive Suite – H327 - H351
President's Event Center – H127 & H128
Provost Suite – H306
Southwest Agricultural Center – H106
Student Services – H112

Building #698
Outpatient Counseling

Building #699
Biomedical Research Center

Building #717
Police



Building Directory and Campus Map provided by the UTHSCT Public Affairs Department.

UTHealth East Texas
Preventive Healthcare Services

Please help us process your application faster by including all your supporting documents.

Return your application to:

Suprina Kenney

Preventive Healthcare Grants
Attn: Suprina Kenney
11937 US Hwy 271, Box 34
Tyler, TX 75708

- ✓ Applicants must meet all eligibility requirements and it is **your** responsibility to reapply annually
- ✓ Once approved, you will receive a wallet card
- ✓ **Call to make an appointment: 903-596-3862**

If you have any questions, email or call me:

Email: suprina.kenney@uthct.edu

OFC Phone: 903.877.8186
Cell: 903.216.2615
FAX: 903.877.5905

~ ~

Devuelva su solicitud a:

Argelia Espinoza

Preventive Healthcare Grants
Attn: Argelia Espinoza
11937 US Hwy 271, Box 34
Tyler, TX 75708

- ✓ Es **su responsabilidad** volver a aplicar cada año y deben cumplir con todos los requisitos de elegibilidad
- ✓ Después de estar aprobado, recibirá un carta
- ✓ **Llame para hacer una cita: 903-596-3862**

Si tienes preguntas, mándame un correo electrónico o llamame:

Email: argelia.espinoza@uthct.edu

Telefono: 903.877.7498
FAX: 903.877.5905

Por favor ayúdenos a procesar su solicitud más rápido al incluir todos sus documentos de respaldo.