Form 3029
July 2020-E

Office of Primary and Specialty Health

Application for Program Benefits

This form can be used to apply for health care assistance through the Primary Health Care (PHC) Services Program, the Title V Fee-for-Service Program, and/or the Epilepsy Program.

Section I. Primary Applicant Information

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

Communication Preferences

The following form fields are optional and do not affect eligibility.

Preferred method of contact (check all that apply): .... ☐ Email ☐ Phone ☐ Mail

Preferred Spoken Language: .... ☐ English ☐ Spanish ☐ Other ______

Preferred Written Correspondence: .... ☐ English ☐ Spanish ☐ Other ______

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

Do you have an immediate medical need? ◯ Yes ◯ No

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

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 Comprehensive Health Care Coverage? (Y/N)*
					◯ Yes ◯ No
					◯ Yes ◯ No
					◯ Yes ◯ No
					◯ Yes ◯ No
					◯ Yes ◯ No
					◯ Yes ◯ No
					◯ Yes ◯ No

* Comprehensive 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 comprehensive coverage.

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

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

Section III. Other Benefits

Check all benefits that you receive:

- ☐ Children's Health Insurance Program (CHIP) Perinatal
- ☐ Women, Infants and Children (WIC) Program
- ☐ Healthy Texas Women (HTW)
- ☐ Supplemental Nutrition Assistance Program (SNAP)
- ☐ Medicaid for Pregnant Women
- ☐ None of these

Were you referred to Primary Health Care from a Healthy Texas Women provider? .... ◯ Yes ◯ No

Section IV. Acknowledgment

The statement I have made, including my answers to all questions, are true and correct to the best of my knowledge and belief. I agree to give eligibility staff any information necessary to prove statements about my eligibility. I understand that giving false information could result in disqualification and repayment.

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.)

Acknowledgment

I understand that this application is a legal document and that by signing this form, I am stating that from 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 and that if I am approved to receive program services, I will be held accountable for complying with program policies, including maintaining eligibility and fulfilling all other beneficiary responsibilities.

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.

Coverage Attestation

I attest that I, the primary applicant, have no other health insurance coverage than what is listed in Section III, Health Care Information, of this application. I authorize the program to bill the coverage sources listed for any services provided.

Applicant Signature ____________ Date ____________

Relationship to Applicant ____________ Signature of Person Assisting Applicant ____________ Date ____________

For Facility Office Use Only

Name of Applicant	Type of Determination ◯ New ◯ Re-Certification	Client/Case No.
Case Record Action ◯ Approved ◯ Presumptive Supplemental Denied		Eligibility Effective Date

Section V. Household Income Information

List the applicant's household income below. Be sure to include the following types of income: Gross earned income; cash gifts or contributions; investment dividends, interest or royalties; non-educational loans; lawsuit or lump sum payments; mineral rights; pensions or annuities; reimbursements; Social Security benefit payments; unemployment payments; Veterans Affairs (VA); and workers' compensation. Refer to "OPSH Definition of Income" for additional information about different types of income.

Name of Household Member Receiving Money	Name of Agency, Person or Employer Who Provides Money	Type of Income	Amount Received	How Often Received (Daily, weekly, every two weeks, twice a month, monthly)	Monthly Income Total
				Total Countable Monthly Income	
				Deductions	-
				Net Countable Monthly Income	

Verification of Income:

Section VI. Program Eligibility

Household Member	Meets Program Eligibility		
	☐ PHC	☐ Title V/MCH	☐ Epilepsy
	☐ PHC	☐ Title V/MCH	☐ Epilepsy
	☐ PHC	☐ Title V/MCH	☐ Epilepsy
	☐ PHC	☐ Title V/MCH	☐ Epilepsy
	☐ PHC	☐ Title V/MCH	☐ Epilepsy
	☐ PHC	☐ Title V/MCH	☐ Epilepsy

Section VII. Contractor Eligibility Certification

Eligibility Effective Date: ______________________________

1. Are all household members eligible as Texas residents? .... Yes ◯ No

2. Net Countable Monthly Household Income: .... ______________________________

3. Household Federal Poverty Level: .... ______________________________

4a. Proof of Income: .... ◯ Yes ◯ Waived

4b. Reason for Waiver of Proof of Income: ______________________________

5. Verification of Adjunctive Eligibility (PHC only): .... ◯ Yes ◯ No ◯ N/A

6a. Identified if Potentially Eligible or Ineligible for Other Benefits:

☐ Medicare ☐ Medicaid ☐ CHIP ☐ Private insurance ☐ VA benefits ☐ TRICARE ☐ HTW ☐ FP ☐ BCCS

6b. Assisted with Application for Other Programs: .... ◯ Yes ◯ No

7. Presumptive Eligibility: .... ◯ Yes ◯ No ◯ N/A

8. Presumptive Eligibility End Date: .... ______________________________

Copayment Amount (if applicable): Primary Health Care Services Program ______________________________

Title V Fee-For-Service Program ______________________________

Epilepsy Program ______________________________

Notes:

Name of Facility	Facility/Staff Member Signature	Date

Form should be kept with client’s record. Form should not be submitted to state office.