TEXAS Health and Human Services

Form 1065
May 2019-E

Breast and Cervical Cancer Services (BCCS) Program or Family Planning Program (FPP)

Eligibility Application

Section I. Applicant Information

This form can be used to apply for BCCS or FPP.

Name (Last, First, Middle)	Sex ◯ Male ◯ Female	Date of Birth	Race/Ethnicity

Email Address	Primary Area Code and Phone No.	Alternate Area Code and Phone No.

Home Address (Street, Apt. or P.O. Box)	City	County	State	ZIP Code

Communication Preferences

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

Preferred language: ..... ☐ English ☐ Spanish ☐ Other

Section II. Applicant Health Care Information

I have comprehensive health care coverage. This includes Medicaid, Medicare, Children's Health Insurance Program (CHIP), Veterans Benefits, TRICARE, private insurance, etc. (If yes, an authorized program representative will submit a claim for reimbursement from your insurer for any benefit, service or assistance that you have received.) ..... ◯Yes ◯No

Check all benefits that you receive:

☐ Supplemental Nutrition Assistance Program (SNAP)
☐ Women, Infants and Children (WIC) Program
☐ Healthy Texas Women (HTW) Program
☐ CHIP Perinatal
☐ Medicaid for Pregnant Women
☐ Other

Section III. 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), if applicable.

Name (Last, First, Middle)	Date of Birth	Sex	Race/Ethnicity	Relationship

Add Line

Household Income Information

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

Add Line

Type of Deduction	Deduction Amount

Section II. Applicant Health Care Information

I have read the Rights and Responsibilities statements.

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.)

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.

Acknowledgment

_____ Please Initial

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 and that if am approved to receive program services, I must comply with program policies, including maintaining eligibility and fulfilling all other beneficiary responsibilities.

Coverage Attestation

_____ Please Initial

I attest that, to the best of my knowledge, I have no other coverage than what is listed in Section II, Applicant Health Care Information. I authorize the program to bill the coverage sources listed for any services provided.

Statement of Release of Information

_____ Please Initial

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.

_____ Applicant Signature

_____ Date

Section V. Provider Eligibility Certification (completed by provider)

1. Texas resident ..... ◯Yes ◯No
2. Total monthly household income..... _____
3. Household federal poverty level (FPL)..... _____ %
4. Proof of income..... ◯Yes ◯Waived
5. Adjunctively eligible..... ◯Yes ◯No ◯N/A
6. Full eligibility met..... ◯Yes ◯No
7. Full eligibility met date..... _____
8. Is the person eligible for the following program (s)?

   Eligibility effective date:..... _____

   a. BCCS..... ◯Yes ◯No ◯N/A

   b. HHSC FPP..... ◯Yes ◯No ◯N/A

Name of Agency _____ Signature – Agency Staff Member _____ Date