TEXAS
Health and Human Services

Your Texas Benefits: Getting Started

SNAP Food Benefits

(This used to be called Food Stamps.)
Helps buy food for good health. Some people might get help the next work day.

TANF Cash Help for Families

TANF: Temporary Assistance for Needy Families
Helps pay for things like food, clothing, and housing.

- **TANF:** Helps families with children age 18 and younger pay for basic needs. TANF gives monthly cash payments.
- **One-Time TANF:** Helps families with children age 18 and younger in crisis. Crises include losing a job, not finding a job, losing a home, or a medical emergency. This help is given only once every 12 months.
- **One-Time TANF for Relatives:** Helps grandparents, aunts, uncles, brothers or sisters who are 25 or older and caring for related children who get TANF. The relative can get $1,000 once in a lifetime.

Health Care Benefits

Medicaid and CHIP

Helps with medical bills such as bills for doctors, hospitals, and medicines.

People who can get benefits are:

- Children age 18 and younger who live with you.
- Pregnant women.
- Adults who either: (1) are caring for a child in their home or (2) were in foster care at age 18 or older.

Healthy Texas Women

Provides free women's health and family planning services for women ages 15-44.

> If you want to apply for Medicaid for the Elderly and People with Disabilities, you need a different form. To get that form, call 2-1-1 (after you pick a language, press 2).

All phone and fax numbers on this form are free to call. If you are deaf, hard of hearing, or speech impaired, you can call any number by calling 7-1-1 or 1-800-735-2989.

How to Apply

What to do:

1. Fill out this form.
2. Sign and date pages 1 and 20.
3. Send "Items we need."
   See pages C and D.

How to send it:

Mail: HHSC, PO Box 149024, Austin, TX 78714-9968

Fax: 1-877-447-2839. If your form is 2-sided, fax both sides.

In person: At a benefits office. To find one near you, go to YourTexasBenefits.com or call 2-1-1 (after picking a language, press 1).

YourTexasBenefits.com

On this website you can:

- Apply for benefits.
- Find out if you should apply for benefits.
- Report changes.
- Upload items we need from you.
- Renew benefits.

Texas Health and Human Services Commission (HHSC)

Questions about this form or about benefits

- Go to YourTexasBenefits.com.
  or
- Call 2-1-1 (if you can't connect, call 1-877-541-7905).
  After you pick a language, press 2 to:
  – Ask questions about this form.
  – Find where to get help filling out this form.
  – Check the status of this form.
  – Ask questions about benefit programs.

Report waste, fraud, and abuse

If you think anyone is misusing HHSC benefits, call 1-800-436-6184.

Helpful Tips

- There are tips in the left side of each page. They can help you save time.
- Sign and date pages 1 and 20.
- Send "Items we need." See pages C and D.

These pictures tell you what sections you need to fill out.

For example, if you see this:

It means that only people applying for SNAP food benefits need to fill out that section.

How to file a complaint

If you have a complaint, first try talking to your benefits advisor or their supervisor. If you still need help, call 1-877-787-8999.

Help you can get without filling out this form

Services in your area

Do you need help finding services?
Call 2-1-1 (if you can't connect, call 1-877-541-7905).
After you pick a language, press 1.

Texas Workforce Network

Are you looking for work?
You can get help:

- Applying for a job.
- Finding a job.

Call 2-1-1 to find a Texas Workforce Center.

Family Planning

Do you need help with family planning?
Men and women can get help with:

- Birth control supplies.
- Other health care.

Call 2-1-1 to find a clinic.

Women age 15 to 44 who can't get Medicaid or CHIP might be able to get services in the Healthy Texas Women program. A parent or legal guardian must apply for young women age 15 to 17. To learn more, go to HealthyTexasWomen.org or call 1-866-993-9972.

Family Violence Program

Are you afraid for your children's or your safety? You can get help:

- Getting a ride to a safe place.
- Finding shelter, legal help, and a job.
- Getting counseling.

Call the hotline anytime at 1-800-799-7233 (1-800-799-SAFE).

Adult Education and Family Literacy Program

Do you want help learning to read or getting a GED? Do you need help with job skills? Or learning to speak English?

Call 1-800-441-7323 (1-800-441-READ).

Women, Infants and Children program (WIC)

Are you pregnant or a new mother?
You can get help:

- Getting food for you and your children.
- Getting vaccines.

Call 1-800-942-3678.

Alcohol and Drug Abuse Prevention Program

Do you or someone you know want to stop using alcohol or drugs?
You can get help:

- Quitting.
- Dealing with a crisis.
- Keeping others from using drugs or alcohol.

Call 1-877-966-3784 (1-877-9-NO DRUG).

Health Insurance Premium Payment Program (HIPP)

Do you need help paying for your health insurance?
Call 1-800-440-0493.

Or write: Texas Health and Human Services Commission
TMHP-HIPP, PO Box 201120
Austin, Texas 78720-1120

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.

Items we need from anyone on your case

Look below and on the next page for items we might need from you. If you bring or send copies of these items with your application, it might help us. If you send any items to us, send only copies. Keep the originals for your records.

We only need items that apply to anyone on your case. For example, if no one has a bank account, we do not need bank statements.

If you are applying for **Any Benefit Program**

bringing or sending copies of items that apply to anyone on your case might help us review it faster.

- **Identity (proof of who you are) –** Current driver's license or Department of Public Safety ID card. If a person has the right to act for you (as your authorized representative), that person also needs to give proof of identity.
- **Immigration status –** Resident card (I-551), arrival/departure form (I-94). Or papers from the U.S. Citizenship and Immigration Services. We need copies of the front and back of these forms.
- **Legal representative (a person who has the right to act for you on legal issues) –** Power of attorney papers, guardianship order, court order, or similar court documents.
- **Veterans benefits, workers' compensation, or unemployment –** Award letter or pay stubs.
- **Social Security, Supplemental Security Income (SSI), or pension benefits –** Award letter or pay stubs.
- **Military service –** Current Military ID (Form DD-2), military orders, or separation papers (Form DD-214).
- **Loans and gifts (includes someone paying bills for you) –** Loan agreements or statement from the person giving you money or paying your bills. Must show that person's name, address, phone number, and signature.
- **Residence (proof you live in Texas) –** Utility bill, driver's license, Texas Department of Public Safety ID, rent receipt, letter from landlord (can't be a relative).

If you are applying for **SNAP food benefits**

bringing or sending copies of items that apply to anyone on your case might help us review it faster.

- **Proof of income from your job –** Last 2 pay stubs or paychecks, a statement from your employer, or self-employment records.
- **Bank accounts –** The most current statement for all accounts.
- **Medical costs –** Bills, receipts, or statements from health-care providers (doctors, hospitals, drug stores, etc.). These items should show costs you have now and costs you expect in the future.
- **Rent or mortgage costs –** Recent checks, check stubs, or statement from the mortgage bank or landlord. Renters also need to give the landlord's name, address, and phone number.
- **Dependent care expenses –** Receipts, canceled checks, or a signed statement from the person you pay. A signed statement must show when and how much you pay.
- **Child support anyone pays –** Court papers that show what you must pay for child support. For example: divorce decree, court order, or district clerk record.
- **Child support anyone gets –** District clerk record. Or letter from the parent who pays showing how much, how often and the date it is usually paid. The letter must have the name, address, phone number, and signature of the parent who pays.

To get SNAP, a person must be a U.S. citizen or legal resident.

More on the next page

If you need help getting these items, let us know.

More items we need from you

If you are applying for
TANF Cash Help for Families

bringing or sending copies of items that apply to anyone on your case might help us review it faster.

- **Proof of income from your job –** Last 2 pay stubs or paychecks, a statement from your employer, or self-employment records.
- **Bank accounts –** Most current statement for all accounts.
- **Proof a child is related to you –** Legal birth, hospital, or baptismal certificate.
- **Citizenship –** U.S. passport, Certificate of Naturalization, U.S. birth certificate (copies of the front and back), hospital record of birth, or Medicare card. If you were born in Texas, we might be able to look up your birth record.
- **Child's vaccines –** Vaccine records for each child.
- **Proof a child lives with you –** A signed statement from your landlord or a non-relative neighbor that includes his or her name, address, and phone number.
- **Child support anyone pays –** Court papers that show what you must pay for child support. For example: divorce decree, court order, or district clerk record.
- **Child support anyone gets –** District clerk record. Or letter from the parent who pays showing how much, how often and the date it is usually paid. The letter must have the name, address, phone number, and signature of the parent who pays.
- **Health insurance –** Copy of the front and back of the insurance card or policy.

If you are applying for
CHIP or Children's Medicaid or Healthy Texas Women for ages 15-17

bringing or sending copies of items that apply to anyone on your case might help us review it faster.

- A parent or legal guardian must apply for Healthy Texas Women for minors age 15-17.
- **Proof of income from your job –** One pay stub or paycheck from the last 60 days, a statement from your employer, or self-employment records.
- **Medicaid and CHIP only - Medical costs –** Bills or statements from health-care providers (doctors, drug stores, etc.) from the past 3 months. We only need these items if you haven't already paid for these services.
- **Citizenship –** U.S. passport, Certificate of Naturalization, U.S. birth certificate (copies of the front and back), hospital record of birth, or Medicare card. If you were born in Texas, we might be able to look up your birth record.
- Most recent income tax return to verify tax deductions.
- The most recent modification of your divorce decree or separation agreement if you pay or receive alimony.

If you are applying for
Medicaid for a Pregnant Woman or an Adult or Healthy Texas Women

bringing or sending copies of items that apply to anyone on your case might help us review it faster.

- **Proof of income from your job –** Last 2 pay stubs or paychecks, a statement from your employer, self-employment records, or last year's tax return.
- **Medical costs –** Bills or statements from health-care providers (doctors, hospitals, drug stores, etc.) from the past 3 months. We only need these items if you haven't already paid for these services.
- **Citizenship –** U.S. passport, Certificate of Naturalization, U.S. birth certificate (copies of the front and back), hospital record of birth, or Medicare card. If you were born in Texas, we might be able to look up your birth record.
- Most recent income tax return to verify tax deductions.
- The most recent modification of your divorce decree or separation agreement if you pay or receive alimony.

If you need help getting these items, let us know.

Your Texas Benefits: Form

Please use dark ink. Please print. If you need more room, add pages.

Fill in the circles (○) like this →●

Section A

Your Facts

If you're applying to get SNAP food benefits, the first month's amount will be based on the date we get pages 1 and 2.

Other benefits also are based on when we get pages 1 and 2.

If you return only pages 1 and 2 now, you still need to fill out pages 3 to 20 before you can get benefits.

You have the right to file this form immediately if it has your name, address, and signature.

Mark the benefits anyone on your case is applying for:

○ **SNAP Food Benefits**

○ **TANF Cash Help for Families**

Medicaid or CHIP:

- ○ Children
- ○ Adult Caring for a Child
- ○ Adult not Caring for a Child
- ○ Pregnant Women
- ○ Healthy Texas Women

Person 1: contact person or head of household

First name **Middle name** **Last name**

Social Security number

Birth date (month/day/year)

Mailing address

City **State** **Zip**

( ) - **Home phone**

( ) - **Cell or daytime phone**

Home address

County

City **State** **Zip**

Section B

Food Benefits

This section is only for people applying for SNAP food benefits.

You might be able to get SNAP food benefits the next work day if you:

- **Are migrant or seasonal farm worker,**
- **Have $100 or less in available cash and bank account and expect to earn less than $150 this month, or**
- **Have costs for housing or utilities that are more than your cash, bank accounts and the income you expect for the month.**

Answer them for everyone living in your home.

1. Is anyone in the home a migrant worker or seasonal farm worker?	○ **Yes** ○ **No**	
2. Does anyone in the home have money in the bank or cash?.....	○ **Yes** ○ **No**	$ **Amount**
3. Does anyone in the home expect to receive money this month? (This includes money you get from jobs, child support, social security and unemployment).....	○ **Yes** ○ **No**	$ **Amount**
4. Does anyone in the home pay costs for housing and utilities? (This includes rent, mortgage, water, gas, electric, sewage, trash, phone and property tax).....	○ **Yes** ○ **No**	$ **Amount**

I certify under penalty of perjury that the information I have provided on this application is true and complete to the best of my knowledge. If it is not, I may be subject to criminal prosecution.

Sign here (or have someone with the right to act for you sign) **Date**

More on page 2

Find out how to return your form: See page 3.

TEXAS Health and Human Services

Section C

Pregnant Women

This section is only for people applying for health care benefits.

Is anyone in your home pregnant?..... ○ **Yes** ○ **No**

If yes, who?

Number of babies expected ☐

Is this your first pregnancy?..... ○ **Yes** ○ **No**

Due date ☐☐ / ☐☐ / ☐☐

What is the first and last name of the unborn child's father?

First name **Last name**

Was anyone in your home pregnant during the last 12 months? ..... ○ **Yes** ○ **No**

If yes, who?

If yes, when did the pregnancy end? ☐☐ / ☐☐ / ☐☐☐☐

Section D

Military Service

This section is only for people applying for Medicaid or CHIP or Healthy Texas Women.

Is anyone an active duty member of one of these military forces?

- U.S. Armed Forces
- National Guard
- Reserves
- State Military Forces .....

○ **Yes** ○ **No**

If yes, who?

Section E

Interview Help

1.Most people applying for benefits must be interviewed.
We often interview people on the phone.
It helps to know if any of the reasons below make it hard for you to get to a benefits office:

- You live more than 30 miles from the closest benefits office.
- You can't get a ride.
- The weather is bad.
- You are sick.
- Your work or training hours don't allow you to get to a benefits office when it's open.
- You can't travel because you are age 60 or older, or you have a disability.
- You are a victim of family violence.
- You take care of someone in your home.

Do any of the reasons above apply to you? ..... ○ **Yes** ○ **No**

2. If you come to our office, will you need special help or equipment?..... ○ **Yes** ○ **No**

If yes, what do you need?

3. What language do you want to speak during the interview?

4. Will you need an interpreter? We can get one for you for free..... ○ **Yes** ○ **No**
If yes, mark the one you need:
○ Spanish ○ Vietnamese
○ American Sign Language ○ Other:

Agency Use Only

Expedite? ☐ Yes ☐ No

Date received: _____ Screened by: _____

Date screened: _____ Case: _____

Social Security number:

☐☐☐-☐☐-☐☐☐☐

Your Texas Benefits: Form

Fill in the circles (◯) like this →●

Please use dark ink. Please print. If you need more room, add pages.

Section F
Contacting You

Person 1: Contact Person or Head of Household

First name **Middle name** **Last name**

___ ___ ___ - ___ ___ - ___ ___ ___ ___
Social Security number

__ __ / __ __ / __ __ __ __
Birth date (month/day/year)

E-mail

Are you applying for benefits for yourself or a child? ..... ○ **Yes** ○ **No**

If yes, give your facts below:

Section G
Person 1

Person 1

If you get money from Social Security or railroad retirement, list the number you have:

Social Security claim number **Railroad retirement number**

○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Live in Texas? ○ **Yes** ○ **No**

Plan to stay in Texas? ○ **Yes** ○ **No**

Optional Questions

○ Male ○ Female

Hispanic or Latino?..... ○ **Yes** ○ **No**

Mark one or more: ○ American Indian or Alaska Native ○ Asian ○ Black or African-American ○ Native Hawaiian or Pacific Islander ○ White

Mark the benefits Person 1 is applying for:

○ **SNAP Food Benefits**

TANF Cash Help for Families:
○ TANF
○ One-Time TANF
○ One-Time TANF for Relatives

Medicaid or CHIP for:
○ Children
○ Adult caring for a child
○ Adult not caring for a child
○ Pregnant women
○ Healthy Texas Women

Are you going to school?.... ○ **Yes** ○ **No** If yes, are you going full-time? ..... ○ **Yes** ○ **No**

Are you a U.S. citizen? If no, give facts below. ..... ○ **Yes** ○ **No**

Are you a refugee or legally admitted immigrant? ..... ○ **Yes** ○ **No**

If you have a sponsor, write your sponsor's name

__ __ / __ __ / __ __ __ __
Date you entered the U.S. (month/day/year)

Are you registered with the U.S. Citizenship and Immigration Services? ○ **Yes** ○ **No**

Immigrant registration number

Return this completed form by fax, mail, or in person:
Fax: 1-877-447-2839
Mail: HHSC, PO Box 149024, Austin, TX 78714-9968
In person: Call 2-1-1 to find an HHSC benefits office near you.

If you are applying for Medicaid, CHIP, or Healthy Texas Women:
You also must fill out the attached form titled **"Applying for or renewing Medicaid, CHIP, or Healthy Texas Women"**

Section H

People Applying for Benefits

Mark the benefits Person 2 is applying for:
- ○ **SNAP Food Benefits**

TANF Cash Help for Families:
- ○ TANF
- ○ One-Time TANF
- ○ One-Time TANF for Relatives

Medicaid or CHIP for:
- ○ Children
- ○ Adult caring for a child
- ○ Adult not caring for a child
- ○ Pregnant women
- ○ Healthy Texas Women

If you are applying for Medicaid, CHIP, or Healthy Texas Women:
You also must fill out the attached form titled "Applying for or renewing Medicaid, CHIP, or Healthy Texas Women?"

Mark the benefits Person 3 is applying for:
- ○ **SNAP Food Benefits**

TANF Cash Help for Families:
- ○ TANF
- ○ One-Time TANF
- ○ One-Time TANF for Relatives

Medicaid or CHIP for:
- ○ Children
- ○ Adult caring for a child
- ○ Adult not caring for a child
- ○ Pregnant women
- ○ Healthy Texas Women

Person 2: adult or child applying, spouse of person applying, or parent living with a child who is a applying

First name **Middle name** **Last name**

Social Security number **Birth date (month/day/year)**

This person's relationship to you

If this person gets money from Social Security or railroad retirement, list the number here: **Social Security claim #** **Railroad retirement #**

○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

○ Live in Texas? ○ **Yes** ○ **No**

○ Plan to stay in Texas? ○ **Yes** ○ **No**

Optional Questions

○ Male ○ Female ○ Hispanic or Latino?

Mark one or more: ○ Black or African-American ○ American Indian or Alaska Native ○ Asian ○ Native Hawaiian or Pacific Islander ○ White

Is this person going to school? ○ **Yes** ○ **No** If yes, is this person going full-time? ○ **Yes** ○ **No**

Is this person a U.S. citizen? If no, give facts below ..... ○ **Yes** ○ **No**

Is this person a refugee or legally admitted immigrant? ..... ○ **Yes** ○ **No**

If this person has a sponsor, write the sponsor's name.

Date person entered the U.S. (month/day/year)

Is this person registered with the U.S. Citizenship and Immigration Services?... ○ **Yes** ○ **No**

Immigrant registration number

Person 3: adult or child applying, spouse of person applying, or parent living with a child who is a applying

First name **Middle name** **Last name**

Social Security number **Birth date (month/day/year)**

This person's relationship to you

If this person gets money from Social Security or railroad retirement, list the number here: **Social Security claim #** **Railroad retirement #**

○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

○ Live in Texas? ○ **Yes** ○ **No**

○ Plan to stay in Texas? ○ **Yes** ○ **No**

Optional Questions

○ Male ○ Female ○ Hispanic or Latino?

Mark one or more: ○ Black or African-American ○ American Indian or Alaska Native ○ Asian ○ Native Hawaiian or Pacific Islander ○ White

Is this person going to school? ○ **Yes** ○ **No** If yes, is this person going full-time? ○ **Yes** ○ **No**

Is this person a U.S. citizen? If no, give facts below ..... ○ **Yes** ○ **No**

Is this person a refugee or legally admitted immigrant? ..... ○ **Yes** ○ **No**

If this person has a sponsor, write the sponsor's name.

Date person entered the U.S. (month/day/year)

Is this person registered with the U.S. Citizenship and Immigration Services?... ○ **Yes** ○ **No**

Immigrant registration number

Section H

People Applying for Benefits

Mark the benefits Person 4 is applying for:
- ○ **SNAP Food Benefits**

TANF Cash Help for Families:
- ○ TANF
- ○ One-Time TANF
- ○ One-Time TANF for Relatives

Medicaid or CHIP for:
- ○ Children
- ○ Adult caring for a child
- ○ Adult not caring for a child
- ○ Pregnant women
- ○ Healthy Texas Women

If you are applying for Medicaid, CHIP, or Healthy Texas Women:
You also must fill out the attached form titled "Applying for or renewing Medicaid, CHIP, or Healthy Texas Women?"

Mark the benefits Person 5 is applying for:
- ○ **SNAP Food Benefits**

TANF Cash Help for Families:
- ○ TANF
- ○ One-Time TANF
- ○ One-Time TANF for Relatives

Medicaid or CHIP for:
- ○ Children
- ○ Adult caring for a child
- ○ Adult not caring for a child
- ○ Pregnant women
- ○ Healthy Texas Women

If more than 5 people are applying for benefits, add more pages with the same facts.

Person 4: adult or child applying, spouse of person applying, or parent living with a child who is applying

First name **Middle name** **Last name**

Social Security number **Birth date (month/day/year)**

This person's relationship to you

If this person gets money from Social Security or railroad retirement, list the number here: **Social Security claim #** **Railroad retirement #**

○ Married ○ Single ○ Divorced
○ Separated ○ Widowed
○ Live in Texas? ○ **Yes** ○ **No**
○ Plan to stay in Texas? ○ **Yes** ○ **No**

Optional Questions

○ Male ○ Female ○ Hispanic or Latino?
Mark one or more: ○ Black or African-American
○ American Indian or Alaska Native ○ Asian
○ Native Hawaiian or Pacific Islander ○ White

Is this person going to school? ○ **Yes** ○ **No** If yes, is this person going full-time? ○ **Yes** ○ **No**

Is this person a U.S. citizen? If no, give facts below ..... ○ **Yes** ○ **No**

Is this person a refugee or legally admitted immigrant? ..... ○ **Yes** ○ **No**

If this person has a sponsor, write the sponsor's name.

Date person entered the U.S. (month/day/year)

Is this person registered with the U.S. Citizenship and Immigration Services?... ○ **Yes** ○ **No**

Immigrant registration number

Person 5: adult or child applying, spouse of person applying, or parent living with a child who is applying

First name **Middle name** **Last name**

Social Security number **Birth date (month/day/year)**

This person's relationship to you

If this person gets money from Social Security or railroad retirement, list the number here: **Social Security claim #** **Railroad retirement #**

○ Married ○ Single ○ Divorced
○ Separated ○ Widowed
○ Live in Texas? ○ **Yes** ○ **No**
○ Plan to stay in Texas? ○ **Yes** ○ **No**

Optional Questions

○ Male ○ Female ○ Hispanic or Latino?
Mark one or more: ○ Black or African-American
○ American Indian or Alaska Native ○ Asian
○ Native Hawaiian or Pacific Islander ○ White

Is this person going to school? ○ **Yes** ○ **No** If yes, is this person going full-time? ○ **Yes** ○ **No**

Is this person a U.S. citizen? If no, give facts below ..... ○ **Yes** ○ **No**

Is this person a refugee or legally admitted immigrant? ..... ○ **Yes** ○ **No**

If this person has a sponsor, write the sponsor's name.

Date person entered the U.S. (month/day/year)

Is this person registered with the U.S. Citizenship and Immigration Services?... ○ **Yes** ○ **No**

Immigrant registration number

Section I

More Facts About Children Age 18 or Younger

This section is only for children applying for TANF.

Time Saving Tip

You only need to give facts for each father and mother one time.

If a child has the same mother or father as another child, you can write something like "same as 1st child" where the parent's name would go.

Are you afraid that giving facts about the child's other parent might put you or your children in danger?

You might not have to help or cooperate with the Office of Attorney General to collect child or medical support if you are afraid. You can ask not to give these facts by:

- Telling your benefits advisor (or designated representative) reasons why this might put you or your children in danger.
- Signing the Good Cause request form. (Your benefits advisor has this form.)

1st child's name:

FATHER

Father's first and last name

Father's birth date (mm/dd/yyyy)

Father's Social Security number

Father's phone ( ) -

Father's mailing address City State Zip

Father is: ○ In home ○ Out of home ○ Deceased Employer

MOTHER

Mother's first and last name

Mother's maiden name

Mother's Social Security number

Mother's birth date (mm/dd/yyyy)

Mother's mailing address City State Zip

Mother's phone ( ) - Employer

Mother is: ○ In home ○ Out of home ○ Deceased

Were these parents ever married to each other? ..... ○ Yes ○ No

2nd child's name:

FATHER

Father's first and last name

Father's birth date (mm/dd/yyyy)

Father's Social Security number

Father's phone ( ) -

Father's mailing address City State Zip

Father is: ○ In home ○ Out of home ○ Deceased Employer

MOTHER

Mother's first and last name

Mother's maiden name

Mother's Social Security number

Mother's birth date (mm/dd/yyyy)

Mother's mailing address City State Zip

Mother's phone ( ) - Employer

Mother is: ○ In home ○ Out of home ○ Deceased

Were these parents ever married to each other? ..... ○ Yes ○ No

Section I

More Facts About Children Age 18 or Younger (continued)

3rd child's name:

FATHER

Father's first and last name

Father's birth date (mm/dd/yyyy)

Father's Social Security number

Father's phone ( ) -

Father's mailing address City State Zip

Father is: ○ In home ○ Out of home ○ Deceased

Employer

MOTHER

Mother's first and last name

Mother's maiden name

Mother's Social Security number

Mother's birth date (mm/dd/yyyy)

Mother's mailing address City State Zip

Mother's phone ( ) -

Employer

Mother is: ○ In home ○ Out of home ○ Deceased

Were these parents ever married to each other? ..... ○ Yes ○ No

4th child's name:

FATHER

Father's first and last name

Father's birth date (mm/dd/yyyy)

Father's Social Security number

Father's phone ( ) -

Father's mailing address City State Zip

Father is: ○ In home ○ Out of home ○ Deceased

Employer

MOTHER

Mother's first and last name

Mother's maiden name

Mother's Social Security number

Mother's birth date (mm/dd/yyyy)

Mother's mailing address City State Zip

Mother's phone ( ) -

Employer

Mother is: ○ In home ○ Out of home ○ Deceased

Were these parents ever married to each other? ..... ○ Yes ○ No

If you have more than 4 children who are age 18 or younger, add more pages with the same facts.

Section J

Other People in the Home

Other people in the home

These people live in my home, but they don't want to apply for benefits.
(Parents living with a child age 18 or younger who is applying or a spouse of a person applying should not be listed here — they should fill out a box in **Section H**.)
List the birth date only if the person is your relative.

Name	Relationship to you	Birth date (if relative)
		/ /
		/ /
		/ /

Section K

Other facts

Other facts

1. Does anyone have a disability? ..... ○ **Yes** ○ **No**

If yes, who?

2. Is anyone getting cash help, food or health-care benefits from another state? ..... ○ **Yes** ○ **No**

If yes, who? | **Which state?** | **When did that person last get benefits?**

Answer 3, 4, and 5 only if anyone is applying for TANF cash help or SNAP food benefits.

3. Has anyone been convicted of a felony for conduct that:
(1) took place after August 22, 1996, and (2) involved illegal drugs? ..... ○ **Yes** ○ **No**

If yes, who?

4. Is anyone living in a place of care such as:
- A homeless shelter.
- A drug treatment center.
- A shelter for battered women.
- A group home. ..... ○ **Yes** ○ **No**

If yes, who?

5. When people break program rules, they are sometimes "disqualified" from getting benefits. People who are disqualified are sent a letter and told they can't get TANF cash help or SNAP food benefits.

Is anyone living with you disqualified from getting cash help or food benefits anywhere in the United States? ..... ○ **Yes** ○ **No**

Social Security number: ___-___-____

Section L

Medical Facts

This section is only for people applying for TANF, Medicaid, CHIP, or Healthy Texas Women.

Other health insurance

1. Does anyone get Medicaid, or CHIP? ..... ○ **Yes** ○ **No**

If yes, from which state? _____

If yes, date coverage ends (if not ending, write "Not ending"): _____

2. Does anyone get health coverage from one the following? ..... ○ **Yes** ○ **No**

○ Medicare ○ Employer Insurance ○ TRICARE (don't check if you have direct care or Line of Duty)

○ Peace Corps ○ VA Health-care programs

○ Other _____

If yes, give facts below.

Name of insured person (first, middle, last)

Insurance company

Policy number

/ / **Coverage start date**

/ / **Coverage end date**

Type of coverage

$ **Amount you pay each month to cover your children on this insurance.**

Who pays the premium?

Is this COBRA coverage? ..... ○ **Yes** ○ **No**

Is this a retiree health plan? ..... ○ **Yes** ○ **No**

Is this a limited-benefit plan (like a school accident policy)? ..... ○ **Yes** ○ **No**

Is this a state employee benefit plan? ..... ○ **Yes** ○ **No**

Name of insured person (first, middle, last)

Insurance company

Policy number

/ / **Coverage start date**

/ / **Coverage end date**

Type of coverage

$ **Amount you pay each month to cover your children on this insurance.**

Who pays the premium?

Is this COBRA coverage? ..... ○ **Yes** ○ **No**

Is this a retiree health plan? ..... ○ **Yes** ○ **No**

Is this a limited-benefit plan (like a school accident policy)? ..... ○ **Yes** ○ **No**

Is this a state employee benefit plan? ..... ○ **Yes** ○ **No**

3. 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 person? ..... ○ **Yes** ○ **No**

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

Section L

Medical Facts

(continued)

This section is only for people applying for TANF, Medicaid, or CHIP.

Medical bills from the past 3 months

If anyone on your case can't pay their medical bills, Medicaid might pay them.

- The bills must be for services they got in the past 3 months.
- You need to show proof of money you get (income) for the months they got services.

Does anyone applying for benefits have medical bills for services they got in the past 3 months? ..... ○ **Yes** ○ **No**

If yes, who? (first, middle, last)

If yes, who? (first, middle, last)

Section M

Things Anyone is Paying for or Owns

Skip this section if you are applying only for Medicaid, CHIP, or Healthy Texas Women.

Vehicles

Does anyone own or is anyone paying for a:

• car • truck • boat • motorcycle • other ..... ○ **Yes** ○ **No**

If yes, give facts below.

VEHICLE 1

Name of owner (first, middle, last) **Make / Model** **Year**

Name of co-owner if also owned by someone outside the home

○ Vehicle is used for a person with a disability.

$ Money still owed on vehicle

VEHICLE 2

Name of owner (first, middle, last) **Make / Model** **Year**

Name of co-owner if also owned by someone outside the home

○ Vehicle is used for a person with a disability.

$ Money still owed on vehicle

If you need more room, add more pages with the same facts.

VEHICLE 3

Name of owner (first, middle, last) **Make / Model** **Year**

Name of co-owner if also owned by someone outside the home

○ Vehicle is used for a person with a disability.

$ Money still owed on vehicle

Social Security number: ___ - ___ - ____

Section M

Things Anyone is Paying for or Owns

(continued)

Skip this section if you are applying only for Medicaid, CHIP, or Healthy Texas Women.

If you need more room, add more pages.

Things anyone is paying for or owns

We need to know about items anyone owns or is paying for, such as:
• cash • bank accounts • homes and other property • insurance policies • stocks

Does anyone own or is anyone paying for these types of items? ..... ○ **Yes** ○ **No**
If yes, give facts below.

ITEM 1

Item | **Account number** | **Value** $

Names on account or deeds (include co-owners)

Name and address of bank or business (to contact about the item)

ITEM 2

Item | **Account number** | **Value** $

Names on account or deeds (include co-owners)

Name and address of bank or business (to contact about the item)

ITEM 3

Item | **Account number** | **Value** $

Names on account or deeds (include co-owners)

Name and address of bank or business (to contact about the item)

Section N

Money Coming into the Home

Money anyone might get from other programs

Is anyone waiting for an answer on an application for one of the programs listed below? ..... ○ **Yes** ○ **No**

If yes, mark the program anyone is waiting to hear from.

○ Social Security (RSDI) ○ Supplemental Security Income (SSI)
○ Other disability ○ Unemployment compensation benefits

Name of person waiting for an answer | **Program name**

Name of person waiting for an answer | **Program name**

Section N

Money Coming into the Home

(continued)

Money from jobs or training

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

Did anyone get money in the past 3 months from:
(a) working for someone else (b) training, or (c) working for themself?..... ○ **Yes** ○ **No**

If yes, give facts below.

JOB 1

Name of person who got money | **Hours worked** | **Amount paid** $ | before taxes and deductions are taken out

Start date / / | **Last payment date** (month/year) / /

How often are you paid?
○ daily ○ twice a month
○ once a week ○ once a month
○ every 2 weeks ○ other:_____

Is this person currently working at this job or in training?..... ○ **Yes** ○ **No**
Was this person working for themselves? ..... ○ **Yes** ○ **No**
If no, list the person or place that paid the money.

Total pretax contributions per pay period: | **How often is it contributed?** | **Date Contributed**

JOB 2

Name of person who got money | **Hours worked** | **Amount paid** $ | before taxes and deductions are taken out

Start date / / | **Last payment date** (month/year) / /

How often are you paid?
○ daily ○ twice a month
○ once a week ○ once a month
○ every 2 weeks ○ other:_____

Is this person currently working at this job or in training?..... ○ **Yes** ○ **No**
Was this person working for themselves? ..... ○ **Yes** ○ **No**
If no, list the person or place that paid the money.

Total pretax contributions per pay period: | **How often is it contributed?** | **Date Contributed**

JOB 3

Name of person who got money | **Hours worked** | **Amount paid** $ | before taxes and deductions are taken out

Start date / / | **Last payment date** (month/year) / /

How often are you paid?
○ daily ○ twice a month
○ once a week ○ once a month
○ every 2 weeks ○ other: _____

Is this person currently working at this job or in training?..... ○ **Yes** ○ **No**
Was this person working for themselves? ..... ○ **Yes** ○ **No**
If no, list the person or place that paid the money.

Total pretax contributions per pay period: | **How often is it contributed?** | **Date Contributed**

Section N

Money Coming into the Home

(continued)

Other money

Does anyone get, or expect to get, any of the types of money listed below? ..... ○ **Yes** ○ **No**

If yes mark other types of money anyone gets or might get soon.

- ○ Cash or gifts.
- ○ Supplemental Security Income (SSI)
- ○ Social Security
- ○ Retirement benefits
- ○ Veterans benefits
- ○ Child support anyone gets
- ○ Pensions
- ○ Payments after being hurt at work (workers' compensation).
- ○ Payments after losing a job (unemployment compensation).
- ○ Alimony.
- ○ Interest or dividends.
- ○ Payments from private insurance
- ○ Loans paid to anyone on your case.
- ○ Payments to help with utilities.
- ○ Farming or fishing (after expenses paid)
- ○ Rent or royalty (after expenses paid)
- ○ Other _____

If anyone gets, or expects to get, any of these types of money, give the facts below.

MONEY TYPE 1

Type of money (item you marked above) | **Amount you get paid** $ | **Last payment date** (month/year) /

Name of person getting this money (if child support, list child's name)

How often are you paid?
○ daily ○ twice a month ○ once a week ○ once a month ○ every 2 weeks ○ other:_____

Person, company, or agency paying the money

If alimony, was the divorce or separation agreement executed or last modified on or before Dec. 31, 2018? ..... ○ **Yes** ○ **No**

MONEY TYPE 2

Type of money (item you marked above) | **Amount you get paid** $ | **Last payment date** (month/year) /

Name of person getting this money (if child support, list child's name)

How often are you paid?
○ daily ○ twice a month ○ once a week ○ once a month ○ every 2 weeks ○ other:_____

Person, company, or agency paying the money

If alimony, was the divorce or separation agreement executed or last modified on or before Dec. 31, 2018? ..... ○ **Yes** ○ **No**

MONEY TYPE 3

Type of money (item you marked above) | **Amount you get paid** $ | **Last payment date** (month/year) /

Name of person getting this money (if child support, list child's name)

How often are you paid?
○ daily ○ twice a month ○ once a week ○ once a month ○ every 2 weeks ○ other:_____

Person, company, or agency paying the money

If alimony, was the divorce or separation agreement executed or last modified on or before Dec. 31, 2018? ..... ○ **Yes** ○ **No**

MONEY TYPE 4

Type of money (item you marked above) | **Amount you get paid** $ | **Last payment date** (month/year) /

Name of person getting this money (if child support, list child's name)

How often are you paid?
○ daily ○ twice a month ○ once a week ○ once a month ○ every 2 weeks ○ other:_____

Person, company, or agency paying the money

If alimony, was the divorce or separation agreement executed or last modified on or before Dec. 31, 2018? ..... ○ **Yes** ○ **No**

Section O

Housing Costs

This section is only for people applying for SNAP benefits.

Housing costs

1. Does anyone pay any of the costs listed below for the home they are living in? Or for a home they plan to return to? ..... ○ **Yes** ○ **No**

If yes, mark the costs they have and list the amount:

- ○ Rent or home payment $_____
- ○ Tax on home $_____
- ○ Water and sewer $_____
- ○ Electricity $_____
- ○ Natural gas/propane $_____
- ○ Phone $_____
- ○ Home insurance $_____
- ○ Other $_____

2. If you pay rent, what is your landlord's name and phone number?

Landlord's name _____ **Phone** _____

3. Does another person not living in the home help anyone on your case pay for housing costs? ..... ○ **Yes** ○ **No**

Section P

Costs to Take Care of Others

Costs to take care of others

Does anyone have costs to take care of others? ○ **Yes** ○ **No**

If yes, give facts below.

Examples:
- Child care costs so someone can work, look for work, go to training, or go to school.
- Costs for people with disabilities or adults who need help caring for themselves.
- Child support payments, medical bills, and health insurance you pay for a child living outside the home.
- Alimony payments.

COST 1

Type of cost _____ **First name** of person who gets care or support _____

Who pays the cost? _____ **Amount paid** $_____ **Date last paid** / /

Person or company that gets the money (name, address, and phone number) _____

How often you paid?
- ○ daily
- ○ once a week
- ○ every 2 weeks
- ○ twice a month
- ○ once a month
- ○ other: _____

For court ordered child support list child who gets support (provide copy of court order)

COST 2

Type of cost _____ **First name** of person who gets care or support _____

Who pays the cost? _____ **Amount paid** $_____ **Date last paid** / /

Person or company that gets the money (name, address, and phone number) _____

How often you paid?
- ○ daily
- ○ once a week
- ○ every 2 weeks
- ○ twice a month
- ○ once a month
- ○ other: _____

For court ordered child support list child who gets support (provide copy of court order)

COST 3

Type of cost _____ **First name** of person who gets care or support _____

Who pays the cost? _____ **Amount paid** $_____ **Date last paid** / /

Person or company that gets the money (name, address, and phone number) _____

How often you paid?
- ○ daily
- ○ once a week
- ○ every 2 weeks
- ○ twice a month
- ○ once a month
- ○ other: _____

For court ordered child support list child who gets support (provide copy of court order)

Section Q

Medical costs

This section is only for people applying for Medicaid, CHIP, Healthy Texas Women, or SNAP food benefits.

Medical costs

Does anyone age 60 or older, or anyone with a disability, pay medical costs? ..... ○ Yes ○ No

If yes, mark the type of costs they pay:

○ Doctor ○ Hospital ○ Medicine ○ Health insurance

Section R

People Helping You

People helping you

Did someone help you fill out this form?..... ○ Yes ○ No

If yes, tell us about that person:

Name

Relationship or organization

( ) -

Phone

Address

Section S

Preferred Method of Contact

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
- 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:** _____

Section T

Signing Up to Vote

(optional)

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

Agency Use Only: Voter Registration Status

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

Agency staff signature

Section U

A Person Who Can Act for You

Don't forget to sign page 20.

Person who has the right to act for you

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 for you 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).

Do you want to give someone the right to act for you -- to be your authorized representative? ..... ○ **Yes** ○ **No**

If yes, tell us about that person (the authorized representative) by filling out **Appendix C.** It is attached to this form.

Section V

Legal Information

Legal information

Your Right to be Treated Fairly

This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and in some cases religion or political beliefs.

The U.S. Department of Agriculture also prohibits discrimination based on race, color, national origin, sex, religious creed, disability, age, political beliefs or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

Supplemental Nutrition Assistance Program (SNAP)

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027), found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary
for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the
USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the State Information/Hotline Numbers (click the link for a listing of hotline numbers by State); found online at: http://www.fns.usda.gov/snap/contact_info/hotlines.htm.

Medicaid and Temporary Assistance for Needy Families

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 509F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (800) 368-1019 (voice) or (800) 537-7697 (TTY).

This institution is an equal opportunity provider.

You also can file a complaint with the Texas Health and Human Services Commission, Civil Rights Office. Email HHSCivilRightsOffice@hhsc.state.tx.us, call 1-888-388-6332, fax (512) 438-5885, or write Texas Health and Human Services Commission, Civil Rights Office, 701 W. 51st St., MC W206, Austin, Texas 78751.

Citizenship and Immigration Status

You can get benefits for your children who are U.S. citizens or legal immigrants even if you are not a U.S. citizen or a legal immigrant. You do not have to give your citizenship or immigration status to get benefits for your children. You only have to give the citizenship or immigration status of people who want benefits. If you are not a U.S. citizen or a legal immigrant, the only benefits you might be able to get are emergency Medicaid services. Getting long-term care (Medicaid for the Elderly and People with Disabilities) or cash help (TANF) could affect your immigration status and your chances of getting a Permanent Resident Card (green card). Getting other benefits will not affect your immigration status and your chances of getting a Permanent Resident Card. You might want to talk to an agency that helps immigrants with legal questions before you apply. If you are a refugee or have been given asylum, getting benefits will not affect your chances of getting a Permanent Resident Card or becoming a citizen.

Social Security Numbers

You only need to give the Social Security numbers (SSNs) for people who want benefits. Giving or applying for an SSN is voluntary; however, anyone who doesn't apply for an SSN or doesn't give an SSN can't get benefits. If you don't have an SSN, we can help you apply for one if you are a U.S. citizen or a legal immigrant. You must be a U.S. citizen or a legal immigrant to get an SSN. You can get benefits for your children if they have an SSN and you don't. We will not give SSNs to the Bureau of Immigration and Customs Enforcement. We will use SSNs to check the amount of money you get (income), if you can get benefits, and the amount of benefits you can get. (7 C.F.R 273.6 for food benefits; 45 C.F.R 205.52 for TANF; and 42 C.F.R 435.910 for health care.)

Section W

Statement of Understanding

Read Section W before signing page 20.

All Benefit Programs

Facts HHSC Has About Me

HHSC uses facts about people applying for benefits to decide: (1) who can get benefits, and (2) the amount of benefits. HHSC checks facts with the federal Income and Eligibility Verification System. If any facts don't match, HHSC will check other sources (banks, employers, etc.). If anyone applying for benefits has an immigration registration number, HHSC must check with the U.S. Citizenship and Immigration Services' (USCIS) system. HHSC will not give anyone's facts to USCIS.

In most cases, I can see and get facts HHSC has about me. This includes facts I give HHSC and facts HHSC gets from other sources (medical records, employment records, etc.). I might have to pay to get a copy of these facts. I can ask HHSC to fix anything that is wrong. I do not have to pay to fix a mistake. To ask for a copy or to fix a mistake, I can call 2-1-1 or my local HHSC benefits office.

Keeping My Facts Private

HHSC will keep my facts private if they were collected:
- By HHSC staff or contracted provider staff.
- To find out if I can get state benefits.

HHSC can share facts about me:
- When needed for me to get state health-care benefits.
- With phone and utility companies. They will find out if my bill amount can be lowered. HHSC will give them my name, address, and phone number.

TANF Cash Help for Families

Child Support or Alimony

I agree to:
- Let the state keep any child support or alimony money owed to anyone during the time they get TANF.
- Let the state keep this money after TANF benefits end, if the TANF amount anyone got still needs to be paid off.
- Tell HHSC about money anyone gets.
- Work with HHSC to get this money; if I don't, I am breaking the law.

The state will keep only the amount allowed by law.

If I Give False Information

If I choose not to tell the truth, I might:
- Be charged with and punished for a crime. (This could include going to prison for up to 10 years or community supervision.)
- Have to repay benefits.
- Never get TANF again.

SNAP Food Benefits

Telling the Truth

Anyone who applies for or gets SNAP must:
- Tell the truth.
- Never trade or sell SNAP benefits, Lone Star Cards, or other devices that allow people to get SNAP.

Anyone who chooses not to tell the truth might:

- **Not get SNAP for a year or more.**
- **Be fined up to $250,000, jailed up to 20 years, or both.**
- **Lose income tax refunds.**
- **Be charged with other crimes.**
- **Have to repay benefits.**
- **Never get SNAP again.**

If a court of law finds you guilty of using or receiving benefits in a transaction involving the sale of a controlled substance, you will be not be eligible for benefits for two years for the first offense, and permanently for the second offense.

If a court of law finds you guilty of having used or received benefits in a transaction involving the sale of firearms, ammunition or explosives, you will be permanently ineligible to participate in the program upon the first occasion of such violation.

If a court of law finds you guilty of having trafficked benefits for an aggregate amount of $500 or more, you will be permanently ineligible to participate in the Program upon the first occasion of such violation.

An individual found to have made a fraudulent statement or representation with respect to the identity or place of residence of the individual in order to receive multiple SNAP benefits simultaneously shall be ineligible to participate in the program for a period of 10 years.

The same is true if anyone lets someone else use their Lone Star Card.

Facts Anyone Tells or Gives HHSC

HHSC uses the facts anyone tells or gives HHSC, including Social Security numbers to:

- Check if that person can get benefits.
- Check that person's facts with computer matching programs and credit reporting agencies.
- Make sure that person is following benefit program rules.
- Help other agencies check if that person can get other benefits.
- Recover benefits that person wasn't supposed to get.
- Share facts about that person: (1) with other state and federal agencies (for example, the Texas Workforce Commission, the Social Security Administration, and the Internal Revenue Service); (2) with law enforcement officials so they can find people on that person's benefits case (the household) who are wanted for fleeing the law; and (3) with federal, state, and private claims collecting agencies for food benefit overpayment claims collection action.

(Food and Nutrition Act of 2008, as amended, 7 U.S.C. 2011-2036.)

More on next page

Section X

Statement of Understanding

Did you...

1. **Sign and date page 1** (if you have not already sent it in).
2. **Include the "items we need" listed in the cover section.**
3. **Sign and date this page.**

Medicaid

If I Give False Information

If I choose not to tell the truth, I might:

- Be charged with a crime.
- Have to repay benefits.

The same is true if I let someone else use my medical card or Medicaid ID.

Giving Out Facts About Me

I agree to let Medicaid health care providers (doctors, drug stores, hospitals, etc.) give out any facts about me to HHSC. This will allow the providers to be paid by Medicaid.

Medical and Child Support Payments

Depending on my benefits case, the Attorney General (the state) might check that I am getting the right amount of child or medical support payments
and coverage.

- If only my child gets Medicaid, I can decide if I want the state to help get any payments and coverage we should get, but don't get right now.
- If my child and I both get Medicaid, I must:
  - Help the state get any payments and coverage we should get, but don't right now.

If I don't help the state, my child can get Medicaid, but I might not.

- Identify who the child's other parent is.
- Allow the state to keep any medical support payments.

- 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.

If I get Medicaid, HHSC will keep medical service payments I can get from other sources, such as:

- My health insurance.
- Money I got because of injuries.
- Money collected for me or my children by the Office of Attorney General.

I must tell HHSC about these sources. If I don't, I am breaking the law.

HHSC will only keep the amount of medical support and service payments allowed by law. I will work with HHSC to get these funds.

By signing below, I agree:

- To let HHSC and other state, federal, and local agencies check, share, and get facts about anyone on my benefits case (the household).
- To let other people, businesses, and organizations share facts they have about anyone on my benefits case (the household) with HHSC.
- The facts to be checked and shared include anything that helps decide: (1) who can get benefits, and (2) the amount of benefits.

My Answers Are True

Sign here to show your agree:

I certify under penalty of perjury that the information I have provided on this application is true and complete to the best of my knowledge. If it is not, I may be subject to criminal prosecution.

■ Person applying or their authorized representative

Sign here **Date (mm/dd/yyyy)** __ __ / __ __ / __ __ __ __

■ Parent, guardian, or power of attorney for the person applying:

Sign here (you must give proof of this right) **Phone** ( ) - **Date (mm/dd/yyyy)** __ __ / __ __ / __ __ __ __

■ Witness (only needed if anyone above signed with an "X" or other mark).

Sign here **Date (mm/dd/yyyy)** __ __ / __ __ / __ __ __ __

Printed name of witness

Ready to send this form to us? See "How to send it" at the bottom of page A.

Social Security number: __ __ __ - __ __ - __ __ __ __

Applying for or renewing Medicaid, CHIP, or Healthy Texas Women? If yes, you must fill out this form.

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.

Section 1

Your Tax Return

This form needs to be filled out, signed, and sent back with your application for benefits.

Are you afraid that giving us facts about someone could cause harm (physical or emotional) to you or your child?

If yes, you might not have to give us facts about that person. You might be able to get the "Family Violence Exemption."

Each person listed in **Section H** of the **Your Texas Benefits** application needs to answer the questions below (Section 1). The people who should be included in Section H and who should answer the questions below are:

- Yourself.
- Your spouse.
- Your children age 20 and younger who live with you.
- Anyone you include on your tax return, even if they don't live with you.
- Anyone else age 20 and younger who you take care of and lives with you.

(You can still apply for health insurance even if you don't file a federal income tax return.)

Person 1: (main contact or head of household)

First name | Middle name | Last name

If married, name of spouse:

Do you plan to file a federal income tax return next year? ..... ○ **Yes** ○ **No**

If yes, answer questions a to c. **If no**, skip to question c.

a. Will you file jointly with a spouse? ..... ○ **Yes** ○ **No**

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, list the name of tax filer:

How are you related to the tax filer?

More on page 2-A

Section 1

Your Tax Return

(continued)

Person 2:

First name | Middle name | Last name

If married, name of spouse:

Do you plan to file a federal income tax return next year? ..... ○ **Yes** ○ **No**

If yes, answer questions a to c. **If no**, skip to question c.

a. Will you file jointly with a spouse? ..... ○ **Yes** ○ **No**

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, list the name of tax filer: **How are you related to the tax filer?**

Does Person 2 live at the same address as Person 1?..... ○ **Yes** ○ **No**

If no, what is Person 2's address?

Person 3:

First name | Middle name | Last name

If married, name of spouse:

Do you plan to file a federal income tax return next year? ..... ○ **Yes** ○ **No**

If yes, answer questions a to c. **If no**, skip to question c.

a. Will you file jointly with a spouse? ..... ○ **Yes** ○ **No**

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, list the name of tax filer: **How are you related to the tax filer?**

Does Person 3 live at the same address as Person 1?..... ○ **Yes** ○ **No**

If no, what is Person 3's address?

Section 1

Your Tax Return

(continued)

Person 4:

First name | Middle name | Last name

If married, name of spouse:

Do you plan to file a federal income tax return next year? ..... ○ **Yes** ○ **No**

If yes, answer questions a to c. **If no**, skip to question c.

a. Will you file jointly with a spouse? ..... ○ **Yes** ○ **No**

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, list the name of tax filer: | **How are you related to the tax filer?**

Does Person 4 live at the same address as Person 1?..... ○ **Yes** ○ **No**

If no, what is Person 4's address?

Person 5:

First name | Middle name | Last name

If married, name of spouse:

Do you plan to file a federal income tax return next year? ..... ○ **Yes** ○ **No**

If yes, answer questions a to c. **If no**, skip to question c.

a. Will you file jointly with a spouse? ..... ○ **Yes** ○ **No**

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, list the name of tax filer: | **How are you related to the tax filer?**

Does Person 5 live at the same address as Person 1?..... ○ **Yes** ○ **No**

If no, what is Person 5's address?

If more than 5 people are applying for benefits, add more pages with the same facts.

Section 2

Tax deductions you claim

Tell us about things that can be deducted on a federal income tax return. If anyone has deductions, health coverage costs might be a little lower.

Tax deductions

Mark all that apply, give the amount, and how often you pay it.
(You shouldn't include a cost that you already considered as part of your net self-employment.)

○ 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, tuition and fees $ _____
How often? _____ Types _____

If you have any of these deductions, you will need to send us a copy of your last year's income tax return.

Section 3

Information about people applying for benefits

Information about people applying for benefits

1. Does a child applying for health care travel with a family member who is a migrant farm worker? ..... ○ **Yes** ○ **No**
   If yes, what is the name of that child or children?

2. Is a child in the Children with Special Health Care Needs program? ..... ○ **Yes** ○ **No**
   If yes, who?

3. Is anyone an American Indian or Native Alaskan? ..... ○ **Yes** ○ **No**
   If yes, you must fill out "Appendix B: American Indian or Alaska Native Family Member." It is attached to this form.

4. Was anyone in foster care when they were age 18 or older? ..... ○ **Yes** ○ **No**
   If yes, who? **In which state?**

5. Does any child on this application have a parent living outside of the home? ..... ○ **Yes** ○ **No**

6. 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 your letters about the program at a different address than what is listed on your application. Fill out the section below to use a confidential address and phone number:
   Mailing Address - Street.
   City:
   State:
   Zip:
   Phone number:

7. Women ages 15-44 are automatically tested for Healthy Texas Women (HTW) eligibility if they do not qualify for Medicaid or CHIP. Check the box below if you do not want to be tested for HTW.
   Name _____. I do not want to be tested for HTW. ○
   Name _____. I do not want to be tested for HTW. ○
   Name _____. I do not want to be tested for HTW. ○

Section 4

Money you get

Money you get

Fill out this section only if the amount of money you get changes or might change from month to month. If you don't expect changes to your monthly income, skip this question.

Your total income this year:

$ _____

Your total income next year (if you think it will be different):

$ _____

Section 5

Insurance offered through your job

Insurance offered through your job

1. Can anyone listed on this form get health insurance through a job? (Check yes even if the coverage is from someone else's job, such as a parent or spouse.)..... ○ **Yes** ○ **No**

If yes, you must fill out "Appendix A: Health coverage from job."

2. Did anyone have insurance through a job and lose it within the past 3 months?..... ○ **Yes** ○ **No**

If yes, who? _____

If yes, end date: _____

If yes, reason the insurance ended:

- ○ Parent's job ended due to layoff or business closing.
- ○ Parent's COBRA or ERS coverage ended.
- ○ Change in parent's marital status.
- ○ CHIP benefits from another state ended.
- ○ Medicaid benefits from another state ended.
- ○ Private health coverage ended.
- ○ Death of a parent.
- ○ The child has special health-care needs.
- ○ Medicaid benefits ended (for any reason).
- ○ Others _____

Section 6

Read and sign this form

A. Is anyone who is applying for health coverage in jail (incarcerated)? ..... ○ **Yes** ○ **No**

If yes, who is in jail? _____

B. Renewing your health coverage in future years

To make it easier to find out if I can get help paying for health coverage in future years, I agree to allow the agency to use facts about money I get (income data), including information from tax returns. The agency will send me a notice, let me make any changes, and I can cancel (opt out) at any time.

I agree: Yes, the agency can get facts listed above and renew my health coverage without asking me for the next:

- ○ 5 years (the maximum number of years allowed)
- ○ 4 years
- ○ 3 years
- ○ 2 years
- ○ 1 years
- ○ Don't use information from tax returns to renew my coverage.

_____

Sign here

☐☐ / ☐☐ / ☐☐☐☐

Date (mm/dd/yyyy)

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 page 9, Section L)

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 ☐ Twice a month ☐ Once 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 ☐ Twice a month ☐ Once 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)

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	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 you become 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 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 ☐ Twice a month ☐ Once 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 would the employee have to pay in premiums for this plan? **$**_____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once 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)

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? _____

APPENDIX C

Assistance with Completing this Application

You can choose an authorized representative.

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 for you 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));
  - 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)