Case Number: 1010925375

07/21/2023

Mr. Shiva Prasad Kaphle
208 Moonlight DR
Euless TX 76039-3891

TEXAS
Health and Human Services

Need Help? Call 2-1-1
or for out of the state callers,
call 1-877-541-7905

Fax: 1-877-447-2839

Mail: Texas Health and Human Services
Commission
PO Box 149024
Austin Texas 78714-9024

If you have a hearing or speech disability,
call 7-1-1 or any relay service.

To find out if you can get or keep getting benefits, we need more facts from you:

You are getting this packet because either: (1) you applied for benefits, (2) you reported a change to your case, or (3) we must check your income to see if you can still get benefits.

Inside this packet you will find:

- A list of the items we need from you.
- A pre-paid envelope.

You also might find other forms you can fill out and send to us.

Send us the items by **07/31/2023**

If you need help, call us at 2-1-1 or 877-541-7905. After you pick a language, press 2. We can take your call Monday to Friday, 8 a.m. to 6 p.m. Central Time.

For help or questions about your Lone Star Card account, call 1-800-777-7328 (7EBT).

You still need to send us the items by this due date.

**If you don't send us your items by this date,
you might not get benefits or your benefits might end.**

There are 4 ways to send us the items we need:

Pick one of these ways to send the items back to us:

- **YourTexasBenefits.com:** You can upload your items online.
- **Your Texas Benefits Mobile App:** You can upload your items using the mobile app. The app is free to download in the Google Play and Apple iTunes stores.
- **Mail:** Mail this letter and the items we need in the pre-paid envelope that came in this packet.
- **Fax:** Fax this letter and the items we need to 1-877-447-2839.

Don't forget:

- Put your case number on everything you send us.
- If you send us a letter or statement showing proof of facts we need, make sure the person who writes it includes: (1) their name, (2) their address, (3) their phone number, (4) the date they wrote it, and (5) their signature.

Benefit programs affected and due date:

Program	EDG number	Due date
For Medical Assistance:	633471645	7/31/23

If you're afraid that giving us facts about someone could cause harm (physical or emotional) to you or your child:

If you're applying for or renewing Medicaid or CHIP benefits, you might not need to give us facts about that person. You might be able to get the "Family Violence Exemption."

Let us know if you're afraid to give facts about someone:

- **Phone:** Call 2-1-1 or 1-877-541-7905 (after picking a language, press 2).
- **Mail:** TEXAS HEALTH AND HUMAN SERVICES COMMISSION,P O Box 149024,
  Austin, Texas 78714-9024
- **In person:** At a benefits office. To find one near you, go to YourTexasBenefits.com or call 2-1-1 or 1-877-541-7905 (after picking a language, press 1).
- **Fax:** 1-877-447-2839.

LIST OF INFORMATION NEEDED AND/OR ACTION REQUIRED:

Name(s)	Program(s)	Information/Action Requested	Acceptable Verification/Proof
Gita Kaphle	Medicaid	Provide a completed Application for Prior Medicaid Coverage for unpaid medical bills. 3/1/2023	Form H1113, Application for Prior Medicaid Coverage
Gita Kaphle	Medicaid	Provide proof of unpaid bills or medical bills. 3/1/2023	Bills/Copy of unpaid Medical bills Provider's Statement Qualified Health Professional's Statement
Aaron Kaphle	Medicaid	Send proof that this person lives with their child or children in the same home. Proof must come from someone who isn't related.	Employee of adult supervised setting Form 1155 Request for Domicile Verification Form H1857 Landlord Verification Other - Non-relative Other acceptable School record with address/School Official contact

TEXAS
Health and Human Services

Texas Health and Human Services Commission
PO Box 149024
Austin Texas 78714-9024

Case Number:1010925375

The enclosed Missing Information form (Form 1020) includes a list of documents you need to send to us so we can determine your eligibility for services.

See page 1 to find out how to send us your forms.

El formulario adjunto de información faltante (Formulario 1020) incluye una lista de documentos que usted necesita enviarnos para que podamos determiner si usted reúne los requisitos para los servicios.

Vea la página 1 para saber cómo enviarnos sus documentos.

TEXAS
Health and Human
Services Commission

Application for Prior Medicaid Coverage

You might be eligible for Medicaid for three months before the month you applied for Medicaid.

The following conditions apply to three months prior eligibility:

- Medical services must have been given during the three months before the month you applied for assistance;
- You must provide proof that: (1) the bill(s) for these medical services are unpaid, OR (2) the medical services were provided by the Texas Department of State Health Services (DSHS); and
- You or a household member would have been eligible for Medicaid in the prior month.

If you use this form to show you have prior unpaid medical services, you must answer all questions, sign, and date at the bottom of page 2.

- This is your sworn statement of prior medical services.
- Use more sheets of paper if you need to. You must sign and date each sheet.
- If you have questions or need help with this form, call 2-1-1 or 1-877-541-7905 (after you pick a language press 2).

AGENCY USE ONLY	DATE OF APPLICATION	THIS APPLICATION APPLIES ONLY TO MEDICAL BILLS FOR SERVICES RECEIVED DURING THESE THREE MONTHS		
	06/19/2023	MAY 2023	APRIL 2023	MARCH 2023

1. Do you need help paying medical bills for the months listed above?..... ☐ Yes ☐ No
If Yes, you need to include the following people on this application:

If you plan to file taxes: We need to know about everyone on your tax return, including yourself.

If you don't plan to file a tax return: We need to know about family members who lived with you during the month(s) above, including yourself. (You don't need to file taxes to get health coverage. **)**

Name (Last, First Middle)	Relationship to You	Date of Birth (Month/Day/Year)	Plan to claim on federal income tax
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

2. If this application is for a child, did the child, child's parents, or the child's spouse (if applicable) own or buy anything during the month(s) listed above that they do not own or are not buying right now? (Examples: car, bank,account,etc.): ..... ☐ **Yes** ☐ **No**

If Yes, list the items below:

_____

_____

_____

_____

3. Did you or anyone you listed on page 1 of this application get any money during the three months listed above?..... ☐ **Yes** ☐ **No**

If Yes, list below all of the income during the month(s) listed above. (Examples: wages, Social Security, etc.):

Amount	Who Received	Type of Income	Date Received

4. List the unpaid medical bills that you and anyone you listed on page 1 have for medical care received during the month(s) listed on page 1 (Examples: hospital bills, doctor bills, drug bills, nursing home bills, etc.). If you received services from DSHS for Medicaid services provided during the month(s) listed, you must provide a statement from DSHS.

Patient's Name	Name & Address of Persons You Owe (Hospital, Doctor, Drugstore, etc.)	Date of Treatment

Remember ► You must provide proof of the facts given on these pages. There are 5 ways to send us the items we need:

- **YourTexasBenefits.com:** You can upload your items online.
- **Your Texas Benefits Mobile App:** You can upload your items using the mobile app.
- **Mail:** HHSC, PO Box 149024, Austin, TX 78714-9968.
- **Fax:** 1-877-447-2839.
- **In Person:** At a local benefits office. To find one near you, go to YourTexasBenefits.com or call 2-1-1 (after you pick a language, press 1).

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:** _____

Who must sign ► The form must be signed by the person applying for prior Medicaid coverage or their authorized representative.

By signing below, I agree that: The answers on this form are true and complete to the best of my knowledge. If they aren't, I know I might: (1) be charged with a crime, and (2) have to repay benefits.

Signature of Applicant or Authorized Representative _____ Date _____

If for some reason the applicant/recipient or authorized representative cannot sign their name, two witnesses must sign below.

Signature - Witness _____ Date _____ Signature - Witness _____ Date _____

In most cases, you can see and get facts HHSC has about you. This includes facts you give HHSC and facts HHSC gets from other sources (medical records, employment records, etc.). You might have to pay to get a copy of these facts. You can ask HHSC to fix anything that is wrong (Government Code, Sections 552.021, 552.023, 559.004). You do not have to pay to fix a mistake. To ask for a copy or fix a mistake, call 2-1-1 or 1-877-541-7905 (after you pick a language, press 2).

FOR DEPARTMENT USE ONLY	
Case name Mr. Shiva Prasad Kaphle	Case number 1010925375

TEXAS HEALTH AND HUMAN SERVICES COMMISSION
P O BOX 149027
AUSTIN, TEXAS 78714-9027

Date: 07/21/2023

Case number: 1010925375

TEXAS
Health and Human
Services Commission

Need help? Call 2-1-1 or 1-877-541-7905

Fax: 1-877-447-2839

Mail: TEXAS HEALTH AND HUMAN SERVICES COMMISSION
P O BOX 149027
AUSTIN, TEXAS 78714-9027

If you are deaf, hard of hearing, or speech impaired, call 7-1-1 or 1-800-735-2989.

All numbers are free to call.

MR. SHIVA PRASAD KAPHLE
208 MOONLIGHT DR
EULESS TX 76039-3891

Note to Mr. Shiva Prasad Kaphle :

This form is for your employer. They need to fill out the form and return it by 07/31/2023 . You must agree to let them give facts about you.
Fill out and sign this agreement:

I, (print your name) Ms. Gita Kaphle allow HHSC to give my Social Security number (SSN) to the employer listed on this form.
My SSN can be used to get facts about my employment. I also allow the employer listed on this form to give facts asked on this form to HHSC.

_____ _____

Sign here **Date**

Employer -- your help is needed:

We need proof that the following person is or was your employee.

Employee or former employee	Social Security number
Ms. Gita Kaphle	

Some employers might get tax refunds or tax credits for hiring people who get certain state benefits.
To learn more, go to TexasWorkforce.org/wotc or email the Texas Workforce Commission at wotc@twc.state.tx.us.

Employer -- please follow these steps:
This person lives in a home in which someone is applying for state benefits. We need to know the amount of money this person makes or made from this job.

1. Please fill out the “Proof of Employment” form on the next page.
2. If a question doesn't apply, mark it with "N/A."
3. Return the form by 07/31/2023
   To send this back to us, you can either: (a) give it to the employee listed above,
   (b) mail it in the pre-paid envelope, or (c) fax it to 1-877-447-2839.

T-01028-0748854267

Proof of Employment

To be filled out by the employer

Texas Health and Human Services Commission

Case number : 1010925375

1. Company or employer name: S&R Trading Corporation
2. Company or employer address - street, city, state, ZIP: _____
3. Employee name (as shown on your records): _____
4. Employee address (as shown on your records) - street, city, state, ZIP: _____
5. Is or was this person your employee? ☐ Yes ☐ No

If no: Stop here - sign and date the bottom of this form and return it.
If yes: Answer all the questions below. If a question doesn't apply, write "N/A."

6. Date hired: _____ 7. Date of first check: _____
8. What type of job does or did this person have? _____
9. This job is or was (mark all that apply): ☐ Full Time ☐ Part time ☐ Permanent ☐ Temporary
10. Average hours per pay period: _____
11. Rate of pay: $_____ per: ☐ Hour ☐ Day ☐ Week ☐ Month ☐ Job
12. How often paid: ☐ Daily ☐ Once a week ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Other: _____
13. Does or did this person get overtime pay? ☐ Yes - often ☐ Yes - rarely ☐ No - never
14. FICA or FIT withheld? ☐ Yes ☐ No
15. Is or was this person on leave without pay? ☐ Yes ☐ No

If yes: Start date of leave: _____ End date of leave: _____

16. Does this person have a profit sharing or pension plan? ☐ Yes ☐ No

If yes: What is the current value? $ _____

17. Does your company offer health insurance? ☐ Yes ☐ No

If yes: This person is: ☐ Not enrolled ☐ Enrolled with family members ☐ Enrolled for self only

If yes: Name of insurance company: _____

18. Do you expect any changes to the facts above within the next few months? ☐ Yes ☐ No

If yes: Explain what will change: _____

19. On this chart, list all money this person got from jobs or training (Need more room? Add pages with the same facts):

Date pay period ended	**Date received**	**Actual hours**	**Gross pay amount** (before taxes taken out)	**Other pay**(include tips, commissions and bonuses)	**EITC Advance amount**	**Total Pretax Contributions**

20. If you entered an amount in the "Other pay" column on the chart, tell us **when** and **how often** this person gets this other pay:

21. Does this person still work for you? ☐ Yes ☐ No

If no: Date separated: _____ Reason for separation: _____

Date of last check sent: _____ Gross amount of last check sent: $ _____

Employer - read, sign, and date:

I confirm that this information is true and correct to the best of my knowledge:

Employer -sign here | Date | Title | Phone number

T-01028-0748854267

Health and Human Services Commission
PO Box 149027
Austin TX 78714-9027

TEXAS
Health and Human
Services Commission

REQUEST FOR DOMICILE VERIFICATION

Case Number: 1010925375 **Date:** 07/21/2023

Contact Tel #
2-1-1 or 1-877-541-7905

Name of Client	Case No.
Aaron Kaphle	1010925375
Address	
208 Moonlight DR Euless TX 76039-3891	

The person listed above has told us that you are not related to them but are familiar with their family. To help us correctly evaluate the household's situation, we need your assistance.

Please complete the information requested on page 2 of this letter and return it to me in the postage paid envelope provided or fax to HHSC at **1-877-447-2839**. Please return it as soon as possible, but no later than

08/05/2023
(date)

Your help is greatly appreciated.

T-01155-0748854267

Case Number. 1010925375

DOMICILE VERIFICATION
(The form must be completed by a non relative who does not live with the client.)

Please list all of the persons living in the home, including the client named on the front of this form:

NAME	RELATIONSHIP TO CLIENT	NAME OF EMPLOYER
Name of Client		

I can verify the above information because I am:

☐ **A Neighbor** ☐ **An Employer** ☐ **A School Official** ☐ **A Clergy Person**

☐ **A Friend** ☐ **A Landlord** ☐ **A Child Care Provider** ☐ **Other (explain):** _____

How long have you known the family?
.....

Years	Months	Weeks

X _____ _____ **Name**
Signature **Date**

Address	Telephone

T-01155-0748854267

Health and Human Services Commission
PO Box 149027
Austin TX 78714-9027

TEXAS Health and Human Services Commission

PETICIÓN DE DOMICILE VERIFICATION

Núm. de Caso: 1010925375 **Fecha:** 07/21/2023

Contacta con Tel #
2-1-1 or 1-877-541-7905

Nombre del Cliente	Caso Núm.
Aaron Kaphle	1010925375
Dirección	
208 Moonlight DR Euless TX 76039-3891	

La persona cuyo nombre aparece arriba nos dijo que no hay parentesco entre ustedes, pero que usted conoce a la familia. Necesitamos su ayuda para poder evaluar la situación de la casa.

Por favor complete la información solicitada en la página 2 de esta carta y envíela en el sobre prepagado provisto o por fax a HHSC al **1-877-447-2839** .Por favor, devuélvala en cuanto pueda, a más tardar para

08/05/2023
(fecha)

Agradecemos mucho su ayuda

Núm de Caso. 1010925375

VERIFICACIÓN DE DOMICILIO
(Una persona que no es pariente del cliente y que no vive con él debe llenar esta forma.)

Por favor, haga una lista de todas las personas que viven en la casa. Incluya el nombre del cliente que hay al otro lado de esta forma.

NOMBRE	RELACIÓN CON EL CLIENTE	NOMBRE DEL EMPLEADOR
Nombre del Cliente		

Puedo verificar la información anterior porque yo soy:

☐ **Vecino** ☐ **Empleador** ☐ **Funcionario de la Escuela** ☐ **Clérigo**

☐ **Amigo** ☐ **Casero** ☐ **Cuidador de los Niños** ☐ **Otro (explique): _____**

¿Cuánto hace que conoce a esta familia? .....

Años	Meses	Semanas

X _____ _____ **Nombre**

Firma **Fecha**

Dirección	Teléfono

T-01155-0748854267

LANDLORD VERIFICATION

(This form must be completed by the client's landlord or a representative.)

Client Name:	**Case Number:**
Mr. Shiva Prasad Kaphle	1010925375

Please provide the tenant's complete residential address:

Street Address:	**Apt. No**.:	**City:**	**Zip:**
208 Moonlight DR		Euless	76039

1. Date tenant moved in: _____

2. How many people live in the house or apartment? _____

3. List the names of all people who live in the house or apartment. List their employer, if known:

Name of Person	**Working?**		**Employer**
	Yes	**No**	

4. Questions about the rent payment:

Amount of Rent:	**Tenant's Portion of Rent:**	**Person making payment**:
$	$	

How often paid?

☐ Weekly ☐ Every Two Weeks ☐ Twice a Month ☐ Monthly

Method of payment?

☐ Cash ☐ Check ☐ Money Order ☐ Other (explain):

Is the tenant current in paying the rent? ☐ Yes ☐ No

If "No," when was the last month rent was paid?

What is the total amount of past due rent?

$

5. Questions about the utilities:

Are all utilities included in rent?	☐ Yes ☐ No
Utilities the Tenant is responsible for paying (check all that apply):	☐ Gas ☐ Electric ☐ Telephone
Utility bills are paid directly to:	☐ Landlord ☐ Utility Company

Landlord or Representative Name (printed):	**Signature - Landlord or Representative**	**Date**
Business Address or Residential Address:		**Telephone:**