TEXAS
Health and Human
Services Commission

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 Grandparent:** Helps grandparents caring for a child who gets TANF.

Medicaid and CHIP

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

People who can get health-care benefits are:

- Children age 18 or younger.
- Pregnant women.
- Adults who either: (1) are caring for a child in their home, (2) were in foster care at age 18 or older, (3) were in the Unaccompanied Refugee Minor's Resettlement Program at age 18 or older, or (4) are a refugee.

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 18.
3. Send "Items we need." See pages C and D.

How to send it:

Mail: HHSC, PO Box 14600, Midland, TX 79711-4600

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

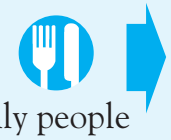
If you think anyone is misusing HHSC benefits, call 1-800-436-6184.

Helpful Tips

- There are tips in the left side of each page. They can help you save time.
- Sign and date pages 1 and 18.
- 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 with low income might be able to get free services in the Texas Women's Health Program. To learn more, 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

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 3 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 3 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

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 –** One pay stub or paycheck from the last 60 days, a statement from your employer, or self-employment records.
- **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.

If you are applying for

Medicaid for a Pregnant Woman or an Adult

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 3 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.
- **Bank accounts** – The most current statement for all accounts. (We don't need this if you are applying only for Medicaid for Pregnant Women.)

If you need help getting these items, let us know. Don't send this page with your form. Keep for your records.

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 18 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

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 based on your answers to these questions. Answer them for everyone living in your home.

1. Is anyone a migrant worker or seasonal farm worker? ..... ○ Yes ◉ No
2. Is the total amount of cash, checking, or savings that everyone has today $100 or less?..... ◉ Yes ○ No
3. Do you expect the total amount of money everyone will get this month to be less than $150? (Include all money you get, such as from jobs, child support, social security, and unemployment.)..... ◉ Yes ○ No
4. Is the amount of your housing bills more than the amount of money everyone expects to get this month? ("Amount of money"= the total of all money you get, such as from jobs, child support, social security, and unemployment.) ..... ◉ Yes ○ No

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

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

You also need to sign page 18.

More on page 2

TEXAS Health and Human Services Commission

Section C

Pregnant Women

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

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

If yes, who?

Due date (mm/dd/yy) ___ / ___ / ___ **Number of babies expected** ___

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

First name **Last name**

Section D

Military Service

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

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? ENGLISH

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)

Email

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

If yes, give your facts below:

Section G
Person 1

Mark the benefits Person 1 is applying for:

- ○ **SNAP Food Benefits**

TANF Cash Help for Families:

- ○ TANF
- ○ One-Time TANF
- ○ One-Time TANF Grandparent

Medicaid or CHIP for:

- ○ Children
- ○ Adult caring for a child
- ○ Adult not caring for a child
- ○ Pregnant women

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

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 14600, Midland, TX 79711-4600

In person: Call 2-1-1 to find an HHSC benefits office near you.

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

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 Grandparent

Medicaid or CHIP for:

- ○ Children
- ○ Adult caring for a child
- ○ Adult not caring for a child
- ○ Pregnant women

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

Mark the benefits Person 3 is applying for:

- ○ **SNAP Food Benefits**

TANF Cash Help for Families:

- ○ TANF
- ○ One-Time TANF
- ○ One-Time TANF Grandparent

Medicaid or CHIP for:

- ○ Children
- ○ Adult caring for a child
- ○ Adult not caring for a child
- ○ Pregnant women

Person 2: 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 ○ Native Hawaiian or Pacific Islander ○ Asian ○ 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 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 ○ Native Hawaiian or Pacific Islander ○ Asian ○ 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 Grandparent

Medicaid or CHIP for:

- ○ Children
- ○ Adult caring for a child
- ○ Adult not caring for a child
- ○ Pregnant women

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 ○ Native Hawaiian or Pacific Islander ○ Asian ○ 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

If you are applying for Medicaid or CHIP:

You also must fill out the attached form titled "Applying for or renewing Medicaid or CHIP?"

Mark the benefits Person 5 is applying for:

- ○ **SNAP Food Benefits**

TANF Cash Help for Families:

- ○ TANF
- ○ One-Time TANF
- ○ One-Time TANF Grandparent

Medicaid or CHIP for:

- ○ Children
- ○ Adult caring for a child
- ○ Adult not caring for a child
- ○ Pregnant women

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 ○ Native Hawaiian or Pacific Islander ○ Asian ○ 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

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

Section I

More Facts About Children Age 18 or Younger

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

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 a 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, 5, and 6 only if anyone is applying for TANF cash help or SNAP food benefits.

3. Has anyone: (1) been charged with or convicted of a felony and is fleeing the police, or (2) broken a rule of their probation or parole? ..... ○ Yes ◉ No

If yes, who?

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

If yes, who?

5. 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?

6. 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, or CHIP.

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.

POLICY 1

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

POLICY 2

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

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 for Pregnant 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**

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**

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

Section M

Things Anyone is Paying for or Owns (continued)

Skip this section if you are applying only for Medicaid for Pregnant 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

Did anyone get money in the past 3 months from:
(a) working for someone else (b) training, or (c) working for themselves?..... ○ Yes ◉ No
If yes, give facts below.

JOB 1

Name of person who got the 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 still 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.

JOB 2

Name of person who got the 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 still 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.

JOB 3

Name of person who got the 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 still 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.

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 RCA

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)

Person, company, or agency paying the money

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

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)

Person, company, or agency paying the money

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

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)

Person, company, or agency paying the money

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

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)

Person, company, or agency paying the money

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

Section O

Housing Costs

This section is only for people applying for SNAP food 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 $ _____	○ Water and sewer $ _____	○ Phone $ _____
○ Tax on home $ _____	○ Electricity $ _____	○ Home insurance $ _____
	○ Natural gas/propane $ _____	○ 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** / /

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

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

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** / /

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

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

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** / /

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

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

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

Social Security number: ___ - ___ - ____

Section Q

Medical Costs

This section is only for people applying for Medicaid, CHIP, 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

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

Social Security number: | | | - | | - | | | | |

Section T

A Person Who Can Act for You

Don't forget to sign page 18.

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 for you to get benefits. This includes reporting changes.

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 U

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 against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

If you wish to file a Civil Rights program complaint of discrimination with USDA, complete the *USDA Program Discrimination Complaint Form*, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov.

Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish).

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 number by State); found online at http://www.fns.usda.gov/snap/contact_info/hotlines.htm.

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 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (800) 537-7697 (TTY)

You also can contact the Texas HHSC Civil Rights Office.
Write to: HHSC Office of Civil Rights, 701 W. 51st St., MC W206, Austin, Texas 78751. Or call toll-free 1-888-388-6332 or 1-877-432-7232 (TTY).

USDA and HHS are equal opportunity providers and employers.

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 V

Statement of Understanding

Read Section V before signing page 18.

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.
- Never use or have Lone Star Cards or other devices if they don't belong to them.

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.**

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 W

Statement of Understanding

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.

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.

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.**

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 you 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.

Applying for or renewing Medicaid or CHIP? 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.

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 18 and younger who live with you.
- Anyone you include on your tax return, even if they don't live with you.
- Anyone else age 18 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 the tax filer: **How are you related to the tax filer?**

TEXAS Health and Human Services Commission

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 the 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 the 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 the 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 the 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?_____
- ○ Student loan interest $_____ How often?_____
- ○ Other deductions, such as educator expenses, health savings accounts, moving expenses, tuition and fees $_____ How often? _____ Type: _____

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, who?

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. Is anyone an unaccompanied refugee minor? This means a person is: (1) not living with a relative, (2) age **18 or younger**, and (3) a refugee. ..... ○ Yes ◉ No
   If yes, who?

6. Was anyone in the Unaccompanied Refugee Minor Resettlement Program at age **18 or older**? ..... ○ Yes ◉ No
   If yes, who? **In which state?**

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, 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 coverage ended.
- ○ Change in parent's marital status.
- ○ CHIP benefits from another state ended.
- ○ Medicaid benefits from another state ended.
- ○ Private health coverage ended.
- ○ Other: _____

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 year
- ◉ 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 will the employee have to pay in premiums for that 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 (HHSC will send notices to this 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 the employee be 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 didn't 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 will the employee have to pay in premiums for that 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.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact HHSC. If you're a legally appointed representative for someone on this application, submit 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)

10. Which benefits can this person talk to us about?

❍ SNAP food benefits ❍ TANF cash help ❍ Health-care (including Medicaid or CHIP)

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.

11. Your signature	12. 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)