Your Texas Benefits

How to apply for benefits for:
People age 65 and older
People with disabilities

Medicaid for the Elderly and People with Disabilities

Helps people who:

- Lost Supplemental Security Income (SSI) benefits.
- Need to be in a nursing home or other place of care.
  or
- Have a disability.

There might be a better form to use, if any of these apply to you:

- You no longer get SSI and you aren't applying for the Medicaid Buy-In Program. (H1200-EZ)
- You are applying only for a Medicare Savings Program. (H1200-EZ)
- You live in a state supported living center. (H1200-PFS)
- You live in a state hospital. (H1200-PFS)

To ask for these forms, call 2-1-1 or 1-877-541-7905.

TEXAS Health and Human Services

Medicare Savings Programs

Helps people who already get Medicare. Helps people pay Medicare costs. Costs can include Medicare premiums, co-pays, and deductibles .

These programs also are known as:

- Qualified Medicare Beneficiaries (QMB).
- Specified Low-income Medicare Beneficiaries (SLMB).
- Qualifying Individuals (QI-1).
- Qualified Disabled and Working Individuals (QDWI).

To apply for Medicare

You must apply for Medicare through a different agency - the Social Security Administration.
To learn more, visit www.Medicare.gov or call 1-800-633-4227

Medicaid Buy-In Program

Helps people who work and: (a) have a disability or (b) are age 65 or older. Some people might have to pay a monthly fee.

Medicaid Buy-In for Children is a different program. It is for families who have a child with a disability, but make too much money to get traditional Medicaid.
To get the form for that program, call 2-1-1 or 1-877-541-7905 and ask for Form H1200-MBIC

How to Apply

What to do:

1. Fill out this form.
2. Sign and date pages 19.
3. Send "Items we need" listed on page D.

How to send it in:

Mail: Texas Health and Human Services Commission,P O Box 149024, Austin, Texas, 78714-9024
OR to your local benefits office,
Call 2-1-1 to get the address.
Fax: 1-877-447-2839. If your form is 2-sided, fax both sides.
In person: At a benefits office.
Call 2-1-1 to find one near you.

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

Don't send this page with your form. Keep for your records. **Page A**

You can apply for benefits online

If you would rather apply for benefits online, go to **www.YourTexasBenefits.com**

This website also will allow you to:

- Find out if you should apply for benefits.
- Find a benefits office near you.

After you fill out an online form, you can check:

- The status of your form.
- Your interview time.
- Items we still need to get from you.
- If we got forms you sent to us.
- Benefit amounts (if you get benefits).

Helpful Tips

- Sign and date page 19.
- Send "Items we need." See Page D.
- Read the tips on the left side of the page. They can help you save time.
- If you need more room to answer any question, you can add more pages.

Save Time

These time saving tips will tell you if you need to fill out a section.

Texas Health and Human Services Commission (HHSC)

Questions about this form or about benefits

Call 2-1-1 or 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.

To learn more about benefits, you also can go to **www.hhsc.state.tx.us**

To apply for other state benefits

If you want to apply for SNAP food benefits, cash help for families (TANF), or Medicaid for children and families, you need a different form. To get that form, call 2-1-1 (after you pick a language, press 2). Or apply online at www.YourTexasBenefits.com

Report waste, fraud, and abuse

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

Getting long-term care services

If you are approved to get Medicaid, another state agency, the Department of Aging and Disability Services (DADS), might help with your case.
DADS staff will find out what long-term care services you can get To see a list of services, go to Form H1204, "Long Term Care Options." It came with this form. To learn more, call 2-1-1 (after you pick a language, press 2, and then press 1).

Notice: Your estate might have to pay the state back for services you get. To learn more, see page 19.

Legal Information

Your right to be treated fairly

If you think you have been treated unfairly (discriminated against) because of race, color, national origin,age, sex, disability, or religion, you can file a complaint.

Contact us at:
HHSCivilRightsOffice
@hhsc.state.tx.us or by:

- Mail:
  HHSC
  Office of Civil Rights
  701 W. 51 st St.
  MC W-206
  Austin, TX 78751
- Phone:
  1-888-388-6332
  1-877-432-7232 (TTY)
- Fax (not toll-free):
  1-512-438-5885

Citizenship and Immigration Status

- 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 Medicaid long-term care services could affect your immigration status and your chances of getting a Permanent Resident Card (green card).
- You might want to talk to an agency that helps immigrants with legal questions before you apply.

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.

(42 CFR §435.910)

Help you can get without filling out this form

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.

Reporting abuse

Do you think someone is being abused? If the abuse is in a nursing home or other place of care, call 1-800-458-9858. If the abuse is in a private home, call 1-800-252-5400.

How to file a complaint

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

Services in your area

Do you need help finding services? Call 2-1-1 or 1-877-541-7905. Pick a language, then press 1. Or visit www.211Texas.org

Learn about services in your area, such as:

- Food banks
- Senior services
- Housing
- Help after a disaster
- Help with gas, electric, and water bills
- Tax help
- Child care
- After-school programs
- Family violence programs
- Legal help

Alcohol and Drug Abuse Prevention Program

Do you or someone you know want to stop using alcohol or drugs? Call 1-877-966-3784 (1-877-9-NO DRUG). You can get help:

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

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).

Family Violence Program

Are you afraid for your children's or your safety? Call the hotline anytime at 1-800-799-7233 (1-800-799-SAFE). You can get help:

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

Items we need

Look below for the items to bring or send with this form. We only need **copies** of these items. Keep the originals for your records.

We only need items that apply to your case. For example, if you or your spouse don't have a bank account, we do not need bank statements.

- **Social Security number –** Social Security card or statement.
- **Citizenship –** U.S. passport, Certificate of Naturalization, U.S. birth certificate, hospital record of birth, or Medicare card. (If you are renewing benefits, we need this only if your status changed.)
- **Immigration status –** Registration card or papers from the U.S. Citizenship and Immigration Services. We need copies of the front and back of these forms. (If you are renewing benefits, we need this only if your status changed.)
- **Legal representative –** Power of attorney papers, guardianship order, court order, or similar court documents.
- **Money from a job –** The last 6 pay stubs or paychecks, a statement from employer or self-employment records.
- **Social Security, pension, veterans benefits, Supplemental Security Income (SSI), workers' compensation, unemployment, or other government benefits –** Award letter or pay stubs.
- **Child support you pay –** Divorce decree, court order, or district clerk record showing how much you pay.
- **Child support you get –** District clerk record. Or letter from parent who pays showing how much, how often, and the date it is usually paid. The letter must be dated and have the name, address, phone number, and signature of the parent who pays.
- **Loans, repayments, and gifts (includes someone paying bills for you) –** Loan agreement. Or statement from the person giving or repaying you money, or paying your bills. The statement must be dated and have that person's name, address, phone number, and signature.
- **Bank accounts –** Statements you received this month and the past 3 months.
- **Stocks, bonds, trusts, annuities –** Trust bond instrument, or current statements.
- **Real estate, oil, gas, mineral rights –** Current tax statements, division orders, deeds, promissory or mortgage note, or royalty statements.
- **Medical, dental, and private insurance costs –** Bills, receipts, statements, or canceled checks from this month and the past 3 months.
- **Insurance policies –** Life, burial, and health insurance policies showing the current value. We also might need your spouse or ex-spouse's job-related health insurance information and policies.
- **Continuing care retirement community –** Admission contract.

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

Your Texas Benefits

Please use dark ink. Please print. If you need more room, add pages.
Fill in the circles (◯) like this —>●

People age 65 and older
People with disabilities

Section A

You and Your Spouse

Try to fill out as much of the form as you can.

We need facts about you and your spouse.
We need to know about your spouse even if:

- Your spouse does not live with you.
  or
- Your spouse does not want benefits.

Save Time

We need facts only for a spouse who is living.

If you are not married, do not fill in the sections marked "Spouse."

	You **The Person applying for benefits**	**Spouse** **Your husband or wife**
What benefits are you applying for?	◯ Medicaid for the Elderly and People with Disabilities ◯ Medicare Savings Program ◯ Medicaid Buy-In Program	◯ None ◯ Medicaid for the Elderly and People with Disabilities ◯ Medicare Savings Program ◯ Medicaid Buy-In Program
First name		
Middle name		
Last name		
Social Security number	– –	– – only if you are applying for benefits
Birth date	month day year	month day year
Mailing address		
City		
State, Zip		
Home phone		
Cell or daytime phone	( ) -	( ) -
Home address		
City		
State, Zip		
County		
E-mail		

Agency Use Only

Date received: _____ Case/EDG number: _____

Section A

You and Your Spouse (continued)

Optional Questions

	You	Spouse
Live in Texas?	◯ Yes ◯ No	◯ Yes ◯ No
Plan to stay in Texas?	◯ Yes ◯ No	◯ Yes ◯ No
If you get money from Social Security or railroad retirement, list the number.	_____ Social Security claim number _____ Railroad retirement number	_____ Social Security claim number _____ Railroad retirement number
Gender	◯ Male ◯ Female	◯ Male ◯ Female
Hispanic or Latino?	◯ Yes ◯ No	◯ Yes ◯ No
Mark one or more:	◯ American Indian or Alaska Native ◯ Asian ◯ Black or African-American ◯ Native Hawaiian or Pacific Islander ◯ White	◯ American Indian or Alaska Native ◯ Asian ◯ Black or African-American ◯ Native Hawaiian or Pacific Islander ◯ White
Mark one:	◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed	◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Section B

Citizenship

	You	Spouse
Are you a U.S. citizen? If yes, go to Section C.	◯ Yes ◯ No If no, give facts below:	◯ Yes ◯ No If no, give facts below:
Are you a refugee or legally admitted immigrant?	◯ Yes ◯ No	◯ Yes ◯ No
If you have a sponsor, write their name.	_____ Sponsor's name	_____ Sponsor's name
Date you entered the U.S.	___ / ___ / ____ month day year	___ / ___ / ____ month day year
Are you registered with the U.S. Citizenship and Immigration Services?	◯ Yes ◯ No _____ If yes, immigrant registration number	◯ Yes ◯ No _____ If yes, immigrant registration number

Section C

Long - Term Care

Save Time

This section is only for people who are not in a nursing home or other place that gives nursing care.

Whether or not you get Medicaid, the Department of Aging and Disability Services (DADS) can see if you can get long-term care services. Services can include meals, nursing care, and help with dressing and bathing. (See Form H1204, "Long Term Care Options." It came with this form.)

	You	Spouse
Do you want DADS to find out if you can get long-term care services?	◯ Yes ◯ No	◯ Yes ◯ No
If yes, do you have intellectual or developmental disabilities?	◯ Yes ◯ No	◯ Yes ◯ No

Section D

People Helping 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 to get benefits. This includes reporting changes and renewing benefits.

By agreeing to act as your authorized representative, I agree 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).

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.

	You and your spouse
1. 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:	_____ **Name** _____ **Address** ( ) - **Phone**
This person is your:	◯ Guardian ◯ Power of Attorney ◯ Other Relationship: _____

Your authorized representative

If this person is filling out this application for you, they also must sign page 19.

_____ _____

The person who agrees to be your authorized representative must sign here. **Date**

You, the person applying for benefits

_____ _____

Sign here to show you agree to have the person listed above as your authorized representative. **Date**

Section D

People Helping You
(continued)

2. Do you have an executor or court appointed administrator? ..... ○ Yes ○ No

If yes, tell us about that person:

Name

Address

( ) -

Phone

Person helping you fill out this form

Is someone helping you or your spouse fill out this form? ..... ○ Yes ○ No

If yes, tell us about that person:

Name

Relationship or organization

Address

( ) -

Phone

Section E

Interview Help

You don't have to come to our office to be interviewed for these programs:

- Medicaid for the Elderly and People with Disabilities
- Medicare Savings Programs
- Medicaid Buy-In

We can interview you if you want to be interviewed.
Do you want to come to our office for an interview? ..... ○ Yes ○ No

If yes, give facts below:

1. When you come to our office, will you need special help or equipment? ..... ○ Yes ○ No

If yes, what do you need? _____

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

3. 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 _____

Section F

Your Home or Where You Live

Where you live

Where do you live?

You	Spouse
○ Nursing home.	○ Nursing home.
○ State supported living center.	○ State supported living center.
○ State hospital.	○ State hospital.
○ Group home for people with intellectual or developmental disabilities (ICF/MR).	○ Group home for people with intellectual or developmental disabilities (ICF/MR).
○ Continuing care retirement community.	○ Continuing care retirement community.
○ Your own home.	○ Your own home.
○ Rent house or apartment (including an assisted living facility).	○ Rent house or apartment (including an assisted living facility).
○ With someone else in their home.	○ With someone else in their home.
○ House paid for by someone else.	○ House paid for by someone else.
○ Other _____	○ Other _____

Section F

Your Home or Where You Live (continued)

If you live in a nursing home or other place of care, write the place name below.

Name of place	Name of place
Will you stay there for less than 6 months?	
○ Yes ○ No	○ Yes ○ No

Other people living with you

Tell us about everyone living with you. Do you and your spouse live together? ..... ○ Yes ○ No

If yes, you only need to list the people who live with both of you under "You."
If no, tell us about the people who live with each of you.

	You	Spouse
PERSON 1	Name of person living with you Relationship to you Birth date if a relative	Name of person living with you Relationship to you Birth date if a relative
PERSON 2	Name of person living with you Relationship to you Birth date if a relative	Name of person living with you Relationship to you Birth date if a relative
PERSON 3	Name of person living with you Relationship to you Birth date if a relative	Name of person living with you Relationship to you Birth date if a relative

Save Time

Fill out this page only if you live:

- **In your own home.**
- **In a rent house or apartment.**
- **With someone else in their home.**
- **In a house paid for by someone else.**

Housing costs

Tell us the costs you have for the home you live in or plan to return to. List the average amount each person pays every month.

	You pay:	Spouse pays:	If another person pays, list their name:
Rent or house payment	$	$	
Tax on home	$	$	
Water and sewer	$	$	
Electricity	$	$	

Natural gas or propane	$	$	
Phone	$	$	
Home insurance	$	$	
Food	$	$	

Section G
Medical Facts

Medicare

Do you get Medicare? ..... ○ Yes ○ No

	You	Spouse
If yes, mark the type you get.	○ Part A ○ Part B ○ Part D	○ Part A ○ Part B ○ Part D
If yes, what is your Medicare premium (monthly cost)?	$ _____	$ _____

Other health insurance

Do you or your spouse have health insurance other than Medicare, Medicaid, or CHIP? Include health insurance you had during the past year. ..... ○ Yes ○ No

If yes, give facts below:

POLICY 1

_____ _____
Name of insured person (first, middle, last) **Name of policy holder**

_____ _____
Insurance company **Insurance company address**

_____ / / / / _____
Policy number **Coverage start date** **Coverage end date** **Type of coverage**

$ _____ _____ **How often is the premium paid?**
How much is the premium? **Who pays the premium?** ○ Monthly ○ Quarterly ○ Yearly

Do you get this insurance through a job you have now or used to have? ○ Yes ○ No **If yes,employer's name** _____

POLICY 2

_____ _____
Name of insured person (first, middle, last) **Name of policy holder**

_____ _____
Insurance company **Insurance company address**

_____ / / / / _____
Policy number **Coverage start date** **Coverage end date** **Type of coverage**

$ _____ _____ **How often is the premium paid?**
How much is the premium? **Who pays the premium?** ○ Monthly ○ Quarterly ○ Yearly

Do you get this insurance through a job you have now or used to have? ○ Yes ○ No **If yes,employer's name** _____

Section G

Medical Facts
(continued)

Other facts

1. Do you or your spouse get Medicaid benefits from another state? ..... ○ Yes ○ No

If yes, which state? **When did you last get benefits?**

2. Do you or your spouse get or expect to get money from:
• a lawsuit • personal injury settlement • an accident liability claim? ○ Yes ○ No

If yes, list the name, address, and phone number of your attorney, insurance company, court, or person who has facts about the settlement.

Section H

Things You and Your Spouse are Paying for or Own (Resources)

Reminder:

If you need more room, add more pages.

Things you are paying for or own

Give facts about items you and your spouse own or are paying for.

1. Do you have checking accounts? ..... ○ Yes ○ No

If yes, give facts below:

ACCOUNT 1

Account number **Names on account**

$

Bank or company name and address **Value**

ACCOUNT 2

Account number **Names on account**

$

Bank or company name and address **Value**

2. Do you have savings accounts? ..... ○ Yes ○ No

If yes, give facts below:

ACCOUNT 1

Account number **Names on account**

$

Bank or company name and address **Value**

ACCOUNT 2

Account number **Names on account**

$

Bank or company name and address **Value**

Section H

Things You and Your Spouse are Paying for or Own
(continued)

3. Do you have certificates of deposit (CDs), money market accounts, or IRAs? ..... ○ Yes ○ No
If yes, give facts below:

ACCOUNT 1

Account number _____ **Names on account** _____

Bank or company name and address _____ **Value** $ _____

ACCOUNT 2

Account number _____ **Names on account** _____

Bank or company name and address _____ **Value** $ _____

4. Do you have savings bonds, stocks, or annuities? ..... ○ Yes ○ No
If yes, give facts below:

By law, you must tell us if you or your spouse has an interest in an annuity or similar instrument.

If you get Medicaid, the state of Texas becomes the remainder beneficiary of that instrument.

ACCOUNT 1

Account number _____ **Names on account** _____

Bank or company name and address _____ **Value** $ _____

If this is an annuity, is the state of Texas named the remainder beneficiary? ..... ○ Yes ○ No

ACCOUNT 2

Account number _____ **Names on account** _____

Bank or company name and address _____ **Value** $ _____

If this is an annuity, is the state of Texas named the remainder beneficiary? ..... ○ Yes ○ No

Section H

Things You and Your Spouse are Paying for or Own (continued)

5. Did you close an account (investment, annuity, bank, etc.) in the past 5 years? ..... ○ Yes ○ No

If yes, give facts below:

ACCOUNT 1

Name of closed investment or account _____ Account number _____ $ _____ Amount you received

Company name and address that handled investment or account _____ / / Date closed

ACCOUNT 2

Name of closed investment or account _____ Account number _____ $ _____ Amount you received

Company name and address that handled investment or account _____ / / Date closed

6. Do you have signature authority on someone else's account? ..... ○ Yes ○ No

If yes, give facts below:

Account owner's name _____ Account number _____ $ _____ Value

Bank or company name and address _____

7. Do you have a safe deposit box? ..... ○ Yes ○ No

If yes, give facts below:

Name and address of bank or company that keeps the safe deposit box _____

Item _____ $ _____ Value

Item _____ $ _____ Value

Save Time

This question is only for people in a nursing home or other place of care.

8. Do you have a patient trust fund? ..... ○ Yes ○ No

If yes

Name and address of the place that keeps this fund for you _____ $ _____ Value

Section H

Things You and Your Spouse are Paying for or Own (continued)

9. Do you have any cash on hand? ..... ○ Yes ○ No

If yes, how much cash: _____

10. Do you have life insurance? ..... ○ Yes ○ No

If yes, give facts below:

POLICY 1

_____
Insurance company name and address

_____ $ _____
Policy number **Face value**

POLICY 2

_____
Insurance company name and address

_____ $ _____
Policy number **Face value**

11. Do you have a burial space or plot? ..... ○ Yes ○ No

If yes:

_____ _____ $ _____
Name of cemetery **Number of spaces** **Value**

12. Do you have a pre-need burial contract? ..... ○ Yes ○ No

If yes:

_____ _____ $ _____
Funeral home name and address **Buyer or owner of contract** **Value**

13. Do you have promissory or mortgage notes? ..... ○ Yes ○ No

If yes, are they: ○ Negotiable ○ Non - negotiable **Value** $ _____

14. Do you have any trusts? ..... ○ Yes ○ No

If yes:

_____ $ _____
What kind? **Value**

15. Do you have any cars, trucks, boats, or other vehicles? ..... ○ Yes ○ No

If yes:

_____ _____ $ _____
Make / Model **Year** **Value**

_____ _____ $ _____
Make / Model **Year** **Value**

Section H

Things You and Your Spouse are Paying for or Own
(continued)

16. Do you have a home (including a mobile home)? ..... ○ Yes ○ No

If yes:

Address of the home	Amount of land	$ Current value

If you are not living in your home right now, do you plan to live in it again? ..... ○ Yes ○ No

Mark all that apply to the home:
○ **No one lives there** ○ **Someone lives there and they pay rent**
○ **Someone lives there and they don't pay rent** ○ **For sale**

Don't forget, give us a copy of the latest tax statement.

17. Do you have a life estate or remainder interest in property? ..... ○ Yes ○ No

18. Do you own or share ownership of any other land, lots, or houses? ..... ○ Yes ○ No

If yes:

Address or location	Amount of land	$ Current value

19. Do you have any oil, gas, mineral, or surface rights? ..... ○ Yes ○ No

If yes:

Address or location	Amount of land	$ Current value

20. Do you have any livestock (cows, horses, pigs, etc.) or poultry? ..... ○ Yes ○ No

If yes:

	Number	$ Current value		Number	$ Current value
○ **livestock**			○ **livestock**		
○ **poultry**			○ **poultry**		

21. Do you have any work equipment? ..... ○ Yes ○ No

If yes:

Type	$ Current value	Type	$ Current value

Section H

Things You and Your Spouse are Paying for or Own (continued)

22. Do you get any money or benefits now that you should have gotten in the past? ..... ○ Yes ○ No

Examples:
- You were awarded money from an estate 2 years ago, but you just started getting the money.
- You applied for SSI 3 years ago and they just decided that you should get benefits. You are now getting paid for benefits you should have gotten 3 years ago.

If yes:

_____ **Type of money or benefits**

$ _____ **Amount you were owed**

Save Time

Don't list items you use for daily living needs.

23. Do you have any personal property (fine china, silver, antiques, etc.) ..... ○ Yes ○ No

If yes:

_____ **Item** $ _____ **Current value**

_____ **Item** $ _____ **Current value**

24. Do you own or share ownership of anything not named in Section H? ..... ○ Yes ○ No

If yes:

_____ **Item** $ _____ **Current value**

_____ **Item** $ _____ **Current value**

Section I

Money or Property You or Your Spouse Sold, Traded, or Gave Away

Money or property you or your spouse sold, traded, or gave away

1. Did you sell, trade, or give away money (including income), property, or anything else in the past 5 years? ..... ○ Yes ○ No

If yes, give facts below:

ITEM 1

_____ **What did you sell, trade, or give away?**

$ _____ **Market value**

_____ **What did you get in return?**

_____ **Who did you sell, trade, or give it to?**

_____ **Date sold, traded, or given away**

ITEM 2

_____ **What did you sell, trade, or give away?**

$ _____ **Market value**

_____ **What did you get in return?**

_____ **Who did you sell, trade, or give it to?**

_____ **Date sold, traded, or given away**

2. Did you give up the right to get any money (including income) or an inheritance? ..... ○ Yes ○ No

If yes, explain: _____

3. Did you reduce the amount of benefits you get from any source? ..... ○ Yes ○ No

If yes, explain: _____

Section J

Money Coming into Your Home (Income)

Money you or your spouse might get from other programs

Are you waiting for an answer on an application for one of the programs listed below? ..... ◯ Yes ◯ No

If yes, mark the programs below:

You	Spouse
◯ Social Security.	◯ Social Security.
◯ Supplemental Security Income (SSI).	◯ Supplemental Security Income (SSI).
◯ Veterans benefits.	◯ Veterans benefits.
◯ Other benefits _____	◯ Other benefits _____

Money from jobs

Did you or your spouse get money in the past 3 months from: (a) working for someone else, (b) training, or (c) working for yourself? ..... ◯ Yes ◯ No

If yes, give facts below:

JOB 1

Who got the money: ◯ You ◯ Your spouse

_____ **Hours worked**

$ _____ **Amount paid** **before taxes and deductions are taken out**

/ / **Start date**

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

Are you still working at this job? ..... ◯ Yes ◯ No

How often are you paid?

◯ Daily ◯ Twice a month
◯ Once a week ◯ Once a month
◯ Every 2 weeks ◯ Other: _____

Did you work for yourself? ..... ◯ Yes ◯ No

_____

If no, list the person or place that paid the money.

JOB 2

Who got the money: ◯ You ◯ Your spouse

_____ **Hours worked**

$ _____ **Amount paid** **before taxes and deductions are taken out**

/ / **Start date**

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

Are you still working at this job? ..... ◯ Yes ◯ No

How often are you paid?

◯ Daily ◯ Twice a month
◯ Once a week ◯ Once a month
◯ Every 2 weeks ◯ Other: _____

Did you work for yourself? ..... ◯ Yes ◯ No

_____

If no, list the person or place that paid the money.

Section J

Money Coming into Your Home (continued)

Other money

Give facts about other money you or your spouse get.

You	Spouse
1. Do you get Social Security? ..... ○ Yes ○ No	
$ _____ **If yes, what is the monthly amount?**	$ _____ **If yes, what is the monthly amount?**
2. Do you get Supplemental Security Income (SSI)? ..... ○ Yes ○ No	
$ _____ **If yes, what is the monthly amount?**	$ _____ **If yes, what is the monthly amount?**
3. Do you get veterans benefits? ..... ○ Yes ○ No	
_____ **If yes, what is the claim number?** $ _____ **If yes, what is the monthly amount?**	_____ **If yes, what is the claim number?** $ _____ **If yes, what is the monthly amount?**

4. Did you, your spouse, parent, or deceased child ever serve in the armed forces? ..... ○ Yes ○ No
If yes, tell us about the person who served.
We will use these facts to find out if you can get their veterans benefits.

_____ **Name**

_____ **Service number**

Is this person related to: ○ You ○ Your spouse

_____ **What is their relationship to you?**

/ / **Service start date**

/ / **Service end date**

You	Spouse
5. Do you get railroad retirement? ..... ○ Yes ○ No	
$ _____ **If yes, what is the monthly amount?**	$ _____ **If yes, what is the monthly amount?**
6. Do you get civil service retirement payments? ..... ○ Yes ○ No	
_____ **If yes, what is the claim number?** $ _____ **If yes, what is the monthly amount?**	_____ **If yes, what is the claim number?** $ _____ **If yes, what is the monthly amount?**

Section J

Money Coming into Your Home (continued)

You	Spouse
7. Do you get any other retirement income? ..... ○ Yes ○ No	
_____ **If yes, what is the claim number?**	_____ **If yes, what is the claim number?**
$ _____ **If yes, what is the monthly amount?**	$ _____ **If yes, what is the monthly amount?**
8. Do you have payments or annuities from private insurance? ..... ○ Yes ○ No	
_____ **If yes, what is the company name?**	_____ **If yes, what is the company name?**
$ _____ **If yes, what is the monthly amount?**	$ _____ **If yes, what is the monthly amount?**
9. Do you get interest from any of the following sources? ..... ○ Yes ○ No • checking account • savings account • certificate of deposit (CD) • note payment • other	
$ _____ **If yes, what is the amount you get?**	$ _____ **If yes, what is the amount you get?**
_____ **If yes, how often?**	_____ **If yes, how often?**
10. Do you get dividends from stocks, bonds, or insurance? ..... ○ Yes ○ No	
$ _____ **If yes, what is the amount you get?**	$ _____ **If yes, what is the amount you get?**
_____ **If yes, how often?**	_____ **If yes, how often?**
11. Does anyone pay you rent? ..... ○ Yes ○ No	
$ _____ **If yes, what is the amount you get?**	$ _____ **If yes, what is the amount you get?**
_____ **If yes, how often?**	_____ **If yes, how often?**

Section J

Money Coming into Your Home (continued)

You	Spouse
12. Do you get any money from leases or royalties from oil, gas, mineral, or surface rights? ..... ○ Yes ○ No	
If yes, write the name of the company that pays you.	If yes, write the name of the company that pays you.
$ If yes, what is the amount you get?	$ If yes, what is the amount you get?
If yes, how often?	If yes, how often?
13. Do you get any money from farming? ..... ○ Yes ○ No	
$ If yes, what is the amount you get?	$ If yes, what is the amount you get?
14. Do you get the following types of money from anyone else or anywhere else? ..... ○ Yes ○ No • cash • gifts • payments you get for loaning money to someone else • bills paid for you • child support • training • other	
If yes, what type of money do you get?	If yes, what type of money do you get?
If yes, who do you get the money from and why?	If yes, who do you get the money from and why?
$ If yes, what is the amount you get?	$ If yes, what is the amount you get?

Section K

Medical Costs

Save Time

This section is only for people applying for the first time. If you are renewing benefits, you can skip this section.

Medical bills from the past 3 months

If you or your spouse can't pay medical bills from the past 3 months, Medicaid might pay them. We will look at the money you get and the things you own to find out if Medicaid might pay them. If you have paid them, you might be able to get paid back by your health care provider (doctor, hospital, clinic, etc.).

Do you have any medical bills for services from the past 3 months? ..... ○ Yes ○ No
If yes, give facts below:

Who got the services? ○ You ○ Your spouse **Type of Bill** ○ Doctor ○ Hospital ○ Medicine ○ Other

$ **Amount of bill** $ **Amount paid** / / **Date of service** (mm/dd/yy) **Who provided the medical service?**

Address of medical service provider

If yes, we need to know about the money you got (income) and things you were paying for or owned (resources) during those past 3 months.
Were they different from what you listed on this form? ..... ○ Yes ○ No

Section K

Medical Costs
(continued)

Save Time

Fill out this section only if you are in a:
- **Nursing home.**
- **State supported living center.**
- **State hospital.**
- **Group home (ICF/MR).**
- **Home and community-based waiver program.**

Medical costs you paid in the past year

Did you or your spouse pay any medical bills in the past year? ..... ◯ Yes ◯ No
If yes, give facts below:

Date paid	Amount paid	Who got the services?	Type of bill:
/ /	$	◯ You ◯ Your spouse	◯ Doctor ◯ Hospital ◯ Medicine ◯ Other
/ /	$	◯ You ◯ Your spouse	◯ Doctor ◯ Hospital ◯ Medicine ◯ Other
/ /	$	◯ You ◯ Your spouse	◯ Doctor ◯ Hospital ◯ Medicine ◯ Other
/ /	$	◯ You ◯ Your spouse	◯ Doctor ◯ Hospital ◯ Medicine ◯ Other

Section L

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

_____
Agency staff signature

Section M

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 N

Statement of Understanding

Read this section before signing.

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.

Asset Verification Consent

I know that my signature below and/or on the application lets the HHSC get facts about things I own (including money) from banks, credit unions, or other financial institutions so HHSC can decide if I can get Medicaid. HHSC can keep checking these facts until:

- HHSC denies my application for Medicaid; or
- I can't get Medicaid anymore; or
- I tell HHSC in writing that I do not want HHSC to check these facts any more.

If I do not let HHSC get facts about me from financial institutions, or I tell HHSC I do not want it to check these facts anymore, I know that HHSC may deny or stop my Medicaid.

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.

Giving Out Facts About Me

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

Medical 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.

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.

Reporting Changes

I agree to let HHSC know, within 10 days, about any changes to my case. This includes changes in facts I give on this form such as money I get, things I own or are paying for, where I live, or insurance I have (including health insurance premiums).

Notice:

Your estate might have to pay the state back for services you get.

Medicaid Estate Recovery Program:

If you get certain Medicaid long-term services, the state of Texas has the right to ask for money back from your estate after you die. In some cases, the state might not ask for anything back. The state will never ask for more money back than what it paid for your services.

The state can ask for money back from your estate only if:

1. you applied for and received certain Medicaid services on or after March 1, 2005; and
2. you were age 55 or older when you got the services.

To learn more about Texas Medicaid Estate Recovery Program, including frequently asked questions, please visit https://hhs.texas.gov/MERP. You also may email questions to merp@hhsc.state.tx.us.

If you have a problem or complaint you should first discuss it with the Texas Medicaid Estate Recovery Program. Many times they can explain specific policies or correct the problem immediately. If your problem or complaint is not resolved to your satisfaction, you can contact the HHS Office of the Ombudsman by calling 1-877-787-8999 or by making an online submission at https://hhs.texas.gov/ombudsman.

By signing below, I agree:

Did you...
1. **Include the "items we need" listed on page D.**
2. **Sign and date this page.**

- To let HHSC and other state, federal, and local agencies check, share, and get facts about me or my spouse.
- To let other people, businesses, and organizations share facts they have about me or my spouse 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: 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 below to show you agree:

You		Spouse	
Sign here	**Date** / /	**Sign here**	**Date** / /

If you are a parent, guardian, authorized representative, court appointed administrator, executor, or have power of attorney for this person, sign below:

Sign here (You must give proof of this right)	**Date** / /	**Sign here** (You must give proof of this right)	**Date** / /

Sign here if you are a witness (only needed if anyone above signed with an "X" or other mark). Date / /

Printed name of witness