Office of Primary and Specialty Health
Application for Program Benefits

This form can be used to apply for health care assistance through the Primary Health Care Services Program, the Title V Fee-for-Service Program, and/or the Epilepsy Program.

Section I. Primary Applicant Information

Name (Last, First, Middle)       Sex
                                      ○ Male  ○ Female

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

Home Area Code and Phone Number

Mobile Area Code and Phone Number

Important Information for Former Military Services 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, visit the Texas Veterans Portal at https://veterans.portal.texas.gov.

Are you a veteran?  ○ Yes  ○ No

Communication Preferences

The following form fields are optional and do not affect eligibility.

Email:

Preferred method of contact (check all that apply):  □ Email  □ Phone  □ Mail
Preferred Spoken Language:  □ English  □ Spanish  □ Other
Preferred Written Correspondence: □ English  □ Spanish  □ Other

By checking this box, I authorize my health care provider to contact me via voice mail or text messaging to the mobile phone number listed above.

Section II. Household Information

Number of People in the Household – This number will include you and anyone who lives with you for whom you are legally responsible. Minors should include parent(s)/legal guardian(s):  

Household Members (including Primary Applicant)

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<tr>
<th>Name (Last, First, Middle)</th>
<th>Date of Birth</th>
<th>Sex</th>
<th>Race/Ethnicity</th>
<th>Relationship</th>
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Section III. Healthcare Information

Do you have an immediate medical need?........................................................................... ○ Yes ○ No

Do you, or does anyone in your household, have comprehensive health care coverage (this includes Medicare, Medicaid, Children’s Health Insurance Program (CHIP), veteran’s benefits, TRICARE, private insurance, etc.)? ○ Yes ○ No

If Yes, an authorized program representative will submit a claim for reimbursement from your insurer for any benefit, service or assistance that you have received.

Check all benefits that you receive:

☐ Children’s Health Insurance Program (CHIP) Perinatal   ☐ Supplemental Nutrition Assistance Program (SNAP)

☐ Women, Infants and Children (WIC) Program   ☐ Medicaid for Pregnant Women

☐ Healthy Texas Women (HTW)   ☐ None of these

Do you, or does anyone in your household, have any special circumstances?........................................................................... ○ Yes ○ No

If Yes, who?

Section IV. Acknowledgment

The statement I have made, including my answers to all questions, are true and correct to the best of my knowledge and belief. I agree to give eligibility staff any information necessary to prove statements about my eligibility. I understand that giving false information could result in disqualification and repayment.

Privacy Notification

With few exceptions, you have the right to request information that the state of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. (Government Code, Section 552.021, 552.023, 559.003 and 559.004.)

Acknowledgment

I understand that this application is a legal document and that by signing this form, I am stating that from my personal knowledge, all facts included are true and correct. I understand that giving false information could result in disqualification or reimbursement for the cost of services and that if I am approved to receive program services, I will be held accountable for complying with program policies, including maintaining eligibility and fulfilling all other beneficiary responsibilities.

Statement of Release of Information

I authorize the release of income and medical information to and by the Texas Health and Human Services Commission and the provider, as necessary, to determine eligibility and to coordinate, render and bill for services.

Coverage Attestation

I attest that I, the primary applicant, have no other health insurance coverage than what is listed in Section III, Health Care Information, of this application. I authorize the program to bill the coverage sources listed for any services provided.

Applicant Signature ___________________________ Date ____________

For Office Use Only

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<tr>
<th>Name of Applicant</th>
<th>Type of Determination</th>
<th>Client/Case No.</th>
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<tbody>
<tr>
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<td>○ New ○ Re-Certification</td>
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<th>Case Record Action</th>
<th>Eligibility Effective Date</th>
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<tr>
<td>○ Approved ○ Presumptive ○ Supplemental ○ Denied</td>
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