TEXAS Health and Human Services Commission

Application for Assistance

Instructions: There are various ways to apply for assistance. You can:

- Call 2-1-1 to apply over the phone or to get help in applying.
- Go online at: www.yourtexasbenefits.com to apply.
- Complete and fax this application to: 1-877-HHSC-TEX or 1-877-447-2839
- Complete and mail this application to: HHSC
  P.O. Box 14600
  Midland, Texas 79711-4600

Last Name ________ **First Name** ________ **MI** ___

Social Security Number : ___ - __ - ____ **Date of Birth** (MM/DD/YYYY)**:** __ / __ / ____

Home address: ____________________
(street address, apt. #, city, county, state, zip)

Home phone number: (___) ___ – ____
(area code, phone number)

Mailing address: ____________________
(if different from home address)

You can apply for services by filling out, signing and returning only this page. However, we encourage you to fill out this entire application now because we may be able to determine your benefits sooner. Benefits for food stamps will be provided from the date it is received by Health and Human Services Commission (HHSC). If you submit just this page, you will need to provide more information before we can decide if you qualify for benefits. Answer the questions marked for the program(s) for which you want to apply. Please fill out this application in **dark** ink. If there is not enough room for all your information on this application, include that information on additional pages.

Program	Description	Check To Apply
Food Stamps	Helps people buy food. If you qualify, we may be able to process your application in one day. Benefits will be provided from the date of application.	☐ Apply
Medical Assistance Provides help in the payment of medical bills, including doctors, hospitals, and medicines.	Medical Assistance for Children	☐ Apply
	Medical Assistance for Pregnant Women	☐ Apply
	Medicaid for low income adults who are caring for a child living in the home (TANF-level Medicaid)	☐ Apply
	Medicaid for the Elderly and People with Disabilities (including payment for care in nursing facilities, other institutional settings, or for people who have lost SSI benefits)	☐ Apply
Temporary Assistance for Needy Families	Helps families with children meet their basic needs with monthly cash assistance or a one time annual payment.	☐ Apply
Medicare Savings Programs	Helps with Medicare premium(s), co-payments, and deductibles.	☐ Apply
If you mark "Yes" for one or both of the programs below, Department of Aging and Disability Services staff will contact you.		
Long Term Services and Supports Provides assistance at home and access to community-based services allowing those who qualify to live in the community. This assistance can include meals, nursing care and help with tasks like dressing and bathing.	Check if you are interested in receiving Long Term Services and Supports for people with **mental retardation**.	☐ Yes
	Check if you are interested in receiving Long Term Services and Supports for people who are **elderly or have disabilities other than mental retardation**.	☐ Yes

Food Stamps: You may qualify for emergency Food Stamps if any of the following apply to you:

1. ☐ Yes ☐ No Is anyone in your home a migrant worker or a seasonal farm worker?
2. ☐ Yes ☐ No Does your household have $100 or less available and do you expect your income this month to be less than $150?
3. ☐ Yes ☐ No For this month, is the money you have and the money you expect to receive this month, less than the total of the following expenses that will be due for this month? If so, enter the bill amounts that are due:

Rent / mortgage: ________ Water: _______ Gas: _______ Electricity: _______ Sewage: _______ Phone: ______

Medical Assistance for Pregnant Women:

☐ Yes ☐ No Is anyone in your household pregnant?

If yes, who: ____________________

Due Date: ____________________ Number of Babies Expected: ____________________

X ____________________ ____________
Signature of Applicant or Authorized/Designated Representative Date

Applicant SSN: ________ Applicant Initials: ________

Section A: Information about Members of Your Household – All Programs

Complete the following for all of the members of your household. If you reside in a nursing facility, facility for the mentally impaired, adult foster care, or continuing care retirement communities, also include information about your spouse who does not live with you.

Persons 1-5	Head of Household	Person 2	Person 3	Person 4	Person 5
First Name					
Middle Name					
Last Name					
That person's relationship to you	Self				
Check (✓) to apply for the following programs					
Food Stamps					
Medical Assistance					
Temporary Aid to Needy Families (TANF)					
Medicare Savings Program (MSP)					
Social Security Number					
Date of Birth					
Gender					
Are you Hispanic or Latino?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
What is your race? (Select one or more)	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White
Marital status*					
U.S. Citizen	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Texas resident	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Last Name of Child's Father					
First Name of Child's Father					
Child's Father is	☐ In Home ☐ Out of Home ☐ Deceased	☐ In Home ☐ Out of Home ☐ Deceased	☐ In Home ☐ Out of Home ☐ Deceased	☐ In Home ☐ Out of Home ☐ Deceased	☐ In Home ☐ Out of Home ☐ Deceased
Child's Father's Social Security Number					
Child's Father's Date of Birth					
Last Name of Child's Mother					
First Name of Child's Mother					
Maiden Name of Child's Mother					
Child's Mother is	☐ In Home ☐ Out of Home ☐ Deceased	☐ In Home ☐ Out of Home ☐ Deceased	☐ In Home ☐ Out of Home ☐ Deceased	☐ In Home ☐ Out of Home ☐ Deceased	☐ In Home ☐ Out of Home ☐ Deceased
Child's Mother's Social Security Number					
Child's Mother's Date of Birth					

*** Marital status = Married, Single, Divorced, Separated, Widowed**

Applicant Initials: ____

Applicant SSN: ____

Section B: Telephone Interview for TANF, Food Stamps, and Medicaid for Caretakers of minor children. If any of the reasons below apply to you, you may request a telephone or a face-to-face interview in your home. Check any of the following that apply and, list the phone number where you can be reached: (________) ___________________________.

- ☐ I live more than 30 miles away from the local HHSC Benefit Office.
- ☐ I cannot come to the local HHSC Benefit Office because of bad weather.
- ☐ My work or training schedule conflicts with the local HHSC Benefit Office hours.
- ☐ I (and my household) is (are) elderly or disabled with no earned income.
- ☐ I am ill.
- ☐ I do not have transportation.
- ☐ I am a victim of family violence.
- ☐ I must take care of a household member.

Section C: General Information All Programs

1. What is the primary language spoken in your household? ______________________________

2. We can provide an interpreter at no cost to you. If you need an interpreter indicate the type below:

☐ Spanish ☐ Vietnamese ☐ American Sign Language (ASL) ☐ Other ______________________________

3. ☐ Yes ☐ No Is anyone in your household disabled?

If yes, who: ______________________________

4. ☐ Yes ☐ No Does anyone in your household receive TANF, Food Stamps, or Medicaid from another state?

If yes, who: ____________________ State: __________ Month last received: __________

5. ☐ Yes ☐ No Do you have a physical or mental condition that requires special accommodations?

If yes, what: ______________________________

Military Service for you or a family member

6. a. ☐ **Yes** ☐ **No** **Are you or your spouse an active duty member of the United States Armed Forces, Reserves, or National Guard or of the State Military Forces?**

If yes, provide the name of that person: ______________________________

b. ☐ **Yes** ☐ **No** **Are you or your spouse a veteran? If yes, provide the VA Claim Number:** ______________________________

c. ☐ **Yes** ☐ **No** **Do you have a parent, spouse, or deceased child who was a veteran?**

If yes, provide the name of that person: ______________________________

Start date and end dates of service: ______________________________

7. ☐ Yes ☐ No Has anyone in your household ever received Supplemental Security Income (SSI)?

If yes, who: ______________________________

8. ☐ Yes ☐ No If you are in a nursing facility, do you intend to return to your own home or stay in the facility for less than six months?

9. ☐ Yes ☐ No If you are not living in your own home, do you intend to return to your own home?

If yes, what is the date you expect to return to that home? ______________________________

☐ Yes ☐ No If yes, is anyone living in that home while you are not living there?

Food Stamps and TANF Only

10. ☐ Yes ☐ No Is anyone in your household fleeing from any law enforcement agency on any felony charges, or in violation of probation or parole according to a court?

If yes, who: ______________________________

11. ☐ Yes ☐ No Has anyone in your household had a felony conviction for conduct occuring on or after August 22, 1996, involving the possession, use, or distribution of a controlled substance?

If yes, who: ______________________________

12. ☐ Yes ☐ No Is there anyone in your household who is living in a group home, homeless shelter, drug treatment center, shelter for battered women, or other institution? If yes, who: ______________________________

Type Institution: ____________________ Institution Name: ____________________

13. ☐ Yes ☐ No Are you or anyone in your household disqualified from participating in the TANF or Food Stamp Program?

TANF Only

14. ☐ Yes ☐ No Are you applying for One Time Temporary Assistance for Needy Families (OTTANF)? OTTANF provides a one-time lump sum cash payment for families in crisis.

15. ☐ Yes ☐ No Would you like to request a One Time TANF Grandparent Payment? This is a special payment given to a grandparent who meets certain qualifications and cares for a child receiving TANF.

Applicant SSN: __________ Applicant Initials: __________

Section D: Citizenship Status -- All Programs

1. Identify Non-US Citizens

List anyone in your household who is not a United States citizen.					
Name (last, first, middle name)	**Date entered the US**	**From which country?**	**Registered?**	**Alien Registration Number**	**Refugee**
			☐ Yes ☐ No		☐ Yes ☐ No
			☐ Yes ☐ No		☐ Yes ☐ No
			☐ Yes ☐ No		☐ Yes ☐ No
			☐ Yes ☐ No		☐ Yes ☐ No

2. ☐ Yes ☐ No If anyone in your household is a refugee or legally admitted alien, do they have a sponsor?

If yes, provide the name of the sponsor. ______________________________

Section E: Education

Food Stamps, Medical Assistance, TANF

List anyone in your household under age 60 who IS in school.					
Name of student (last, first, middle name)	**Name of school**	**Current grade**	**Type of school ***	**Part time or full time**	**Expected graduation date**
				☐ Part ☐ Full	
				☐ Part ☐ Full	
				☐ Part ☐ Full	
				☐ Part ☐ Full	
				☐ Part ☐ Full	

*** Grades 1-12, technical / vocational, college**

Section F: Medical Coverage - All Programs

1. ☐ Yes ☐ No Is anyone in your household receiving Medicare?

If yes, who: ____________________ Medicare #: ______________ Medicare premium paid $ __________

Part A: ☐ Yes ☐ No Part B: ☐ Yes ☐ No Part D: ☐ Yes ☐ No

If yes, who: ____________________ Medicare #: ______________ Medicare premium paid $ __________

Part A: ☐ Yes ☐ No Part B: ☐ Yes ☐ No Part D: ☐ Yes ☐ No

2. ☐ Yes ☐ No Does anyone in your household need assistance in one of the following settings?

☐ Nursing Facility ☐ Continuing Care Retirement Communities ☐ State school
☐ ICF/MR (Group facility for persons with mental retardation) ☐ State Hospital

If yes, who:	Name / address of institution:	Admission date:

3. ☐ ***Yes*** ☐ ***No*** ***Does anyone in your household currently have medical coverage other than Medicare or Medicaid? If yes, list below.***						
Name of person with coverage	**Name of insurance carrier**	**Policy number**	**Premium amount**	**Coverage begin date**	**Coverage end date**	**Type of coverage**

4. ☐ Yes ☐ No Does someone pay this premium for anyone listed in the above question?

Name of the person who pays the premium: ______________________________

Applicant Initials: ________

Applicant SSN: ________

5. ☐ Yes ☐ No Does anyone in your household have any unpaid or reimbursable medical bills for the past three months?

If yes, who: ______________________________

These questions do not affect your family's ability to get benefits. Your answers will be used to better coordinate your family's health care:

6. ☐ Yes ☐ No Do the children applying for medical assistance travel with a parent or a family member who is a migrant farm worker?
7. ☐ Yes ☐ No Is a child in your household enrolled in the Department of State Health Services, Children with Special Health Care Needs program?

If yes, who: ______________________________ Admission date: ______________

Name / address of institution: ______________________________

8. ☐ Yes ☐ No Is anyone in your household a member of a federally recognized tribe?

If yes, who: ______________________________ What tribe? ______________

Section G: Resources/Assets - All Programs

1. ☐ Yes ☐ No Does anyone in your household own or is buying a car, truck, boat, motorcycle or other vehicle? If so, list below.

Name of owner	Year	Make / Model	If jointly owned by someone outside the home, list name	Vehicle registered?	Used to transport a disabled person?	Amount owed	Monthly vehicle payment
				☐ Yes ☐ No	☐ Yes ☐ No	$	$
				☐ Yes ☐ No	☐ Yes ☐ No	$	$
				☐ Yes ☐ No	☐ Yes ☐ No	$	$

2. ☐ Yes ☐ No Does anyone in your household have assets? If so, list below. Include business assets.

Assets include, but are not limited to:

- **Cash on hand**
- **Checking/Draft accounts**
- **Savings/Share accounts**
- **Cash or items in a safe deposit box**
- **Certificates of Deposit (CD)**
- **Money market accounts**
- **Savings bonds, stocks, mutual funds, or annuities**
- **Home, mobile home, other real estate**
- **Life insurance policy**
- **Pre-need burial contract**
- **Burial space/plot**
- **Tools/Equipment, livestock, or crops**
- **Oil, Gas, Mineral, Surface Rights**
- **Trust funds**
- **IRA, KEOGH, 401K, or deferred compensation accounts**
- **Mortgage, land contract, or other notes payable to anyone in the household**
- **Life estate**
- **Patient trust fund**
- **Tax shelter account**
- **Holiday club accounts**

Asset	Name(s) on account, policy, deed, title (include joint ownership)	Name and address of bank, credit union, savings and loan, insurance company, cemetary, or funeral home.	Account number	Balance amount / value of asset / market value
				$
				$
				$
				$
				$
				$
				$
				$

Applicant SSN: ______ Applicant Initials: ______

3. **Medical Assistance**
☐ Yes ☐ No If you or your spouse own an annuity, is the state named the remainder beneficiary?

4. **Medical Assistance, Medicare Savings Program, Community Care Only**
☐ Yes ☐ No Has anyone in your household closed any financial investments or bank accounts within the last five years?

5. **All Programs**
☐ Yes ☐ No Has anyone in your household sold, traded, transferred or given away any money or any other property within the last five years?

Section H: Earned Income - All Programs

1.☐ Yes ☐ No Did anyone in your household receive money from work during the last three months? If so, list below. Be sure to include money from training and self employment.

Name of person working or receiving money	Name/address of employer or source of income	Employer area code and phone number	Gross amount received (before deductions)	*How often paid?	Hours worked	Start date	Last payment date
		( )	$				
		( )	$				
		( )	$				
		( )	$				

Section I: Other Income - All Programs

1. ☐ Yes ☐ No Does anyone in your household have any other income? If so, list below.

Unearned income includes, but is not limited to:

- SSI / Social Security (RSDI)
- Child Support received
- Cash / Gifts / Loans
- Veteran's / Railroad retirement
- Unemployment / Workers' compensation
- Interest / Dividends
- Money from oil, gas, mineral rights
- Pensions / Retirement
- Civil service annuity / Military allotment
- Annuities / Payment from private insurance
- Utility Assistance
- Payments from a trust / Royalties
- Payment from promissory note
- Alimony
- Room and board
- Stipends
- Sick benefits
- Reparation payment
- Farm income / Rent received
- Home care for the elderly

Name of person receiving this money (If child support, list child)	Type or source of income	Person, company, or agency paying this money	Social Security / VA claim numbers	Amount received	*How often paid?	Date received
				$		
				$		
				$		
				$		
				$		

Applicant SSN: ________ Applicant Initials: ________

2. ☐ Yes ☐ No Does anyone in your household have a pending application for Social Security, SSI, or Unemployment Compensation Benefits?

If yes, who: ______________________ Type of Benefit: ______________________

who: ______________________ Type of Benefit: ______________________

Section J: Expenses

1. All Programs

☐ Yes ☐ No Does anyone in your household have any dependent care expenses? If so, list below.

- **Child care expenses that anyone in your household pays so that person can work, look for work, go to school, or receive training.**
- **Court ordered child support payments that anyone in your household pays for a child outside of the home.**
- **Alimony payments that anyone in your household pays.**
- **Dependent care for disabled/incapacitated adult that anyone in your household pays.**
- **Cost of transportation to and from day care that anyone in your household pays.**

Type of expense	Who is paying this expense?	Who is obligated to pay this expense?	* Amount and how often paid?	Payment date	Name, address, and phone number of person you pay	For court ordered child support only, name of child for whom support is paid (provide copy of court order)
			$			
			$			
			$			

*** Daily, weekly, every two weeks, semi-monthly, monthly, quarterly, semi-annually, annually, or one time only**

2. Food Stamps, Medical Assistance, Medicare Savings Program, Community Care

☐ Yes ☐ No Does anyone in your household have any shelter or utility expenses? If so, list below. **Shelter expenses apply to the home you live in and/or your home you do not currently occupy but you intend to return to.**

- **Rent**
- **House payment**
- **Mandatory home owner fees**
- **Taxes on home**
- **Insurance on home**
- **Natural gas or propane**
- **Coal/Wood**
- **Fuel oil or kerosene**
- **Water/Sewer**
- **Electricity**
- **Trash removal**
- **Phone**

Type of expense	Who is obligated to pay this expense?	Monthly/Yearly amount	Paid to who (include name, address, and phone number)?	Do you share expense?	Name of person sharing expense
		$		☐ Yes ☐ No	
		$		☐ Yes ☐ No	
		$		☐ Yes ☐ No	
		$		☐ Yes ☐ No	
		$		☐ Yes ☐ No	

3. ☐ Yes ☐ No Are any of the utility expenses used for heating or cooling (excluding cooling by fan only)?

4. ☐ Yes ☐ No Does someone provide shelter to anyone in the household at no cost?

Applicant SSN: ______________ Applicant Initials: ______________

5. Food Stamps and Medical Assistance Only

☐ ***Yes*** ☐ ***No Does anyone over age 60 or disabled in your household pay medical expenses? If so, list below.***

Name of person with bill(s)	*How often paid?	Payment amount / Total owed	Who provided service?	Type of bill (doctor, hospital, prescriptions, etc.)	Date of service
		$			
		$			
		$			
		$			

*** Daily, weekly, every two weeks, semi-monthly, monthly, quarterly, semi-annually, annually, or one time only**

Section K: Voter Registration

Applying to register or declining to register to vote does not affect the amount of assistance that this agency provides. If you decline to register to vote, this decision will remain confidential and will only be used for voter registration purposes. If you believe that someone has interfered with your right to register to vote, to decline to register to vote, or your right to privacy in deciding whether to register; you may file a complaint with the Elections Division of the Secretary of State, P. O. Box 12060, Austin, TX 78711.

If you would like help with 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 and put it in the mail yourself. If you do not check the box below, you will be considered to have decided not to register to vote at this time.

If you are not registered to vote where you live now, would you like to apply to register to vote today?

☐ Yes ☐ No ☐ Already Registered

Help Completing Form

If someone helped in completing this form, please, give his/her name.

Name: ______________________ Phone:(________)______________________

Address:______________________

Legal Guardian

☐ Yes ☐ No Does anyone in your household have a legal guardian? If yes, provide the following information about that person.

Name of person: ______________	Name of person: ______________
Name of guardian: ______________	Name of guardian: ______________
Guardian Address ______________ ______________	Guardian Address: ______________ ______________
Guardian Phone:	Guardian Phone:

Designation of Authorized Representative (Optional)

As the applicant or a person with legal authority to act for the applicant, I authorize, ______________________, (name)

______________________, and (_____)______________, to represent the applicant who is (address) (phone) applying for benefits in providing and receiving information in connection with the application, and in taking any other action to complete the application process (including any appeal). If the applicant is found eligible, I further authorize the following person to continue to represent the applicant in relation to the receipt of benefits, including reporting changes.

Applicant Initials: ______

Applicant SSN: ______

STATEMENT OF UNDERSTANDING - Your signature below acknowledges the following:

Reporting Changes: I agree to report, within 10 days, all changes that may affect my eligibility.

Information we have about you: I understand, with a few exceptions, that I have the right to request and to know about information that the Texas Health and Human Services Commission (HHSC) obtains about me. I understand that upon request, you are entitled to receive and review the information. I also have the right to ask HHSC to correct information that is determined to be incorrect. (Government Code Sections 552.021, 552.023, 559.004).

By applying for TANF: Federal law and state law provide that the legal rights to child support and spousal maintenance must be assigned to the State of Texas for all persons receiving cash assistance. I understand that this means that while I receive or anyone on my application receives cash assistance, the State has the right to keep support or spousal maintenance collections, including collections for support or spousal maintenance that was owed before cash assistance was paid. I understand that when I and the persons on my application stop receiving cash assistance that the State may still keep certain collections received for support or spousal maintenance that were owed before and during the time I received Cash Assistance. The child support and spousal maintenance collections will be used to pay back the State for cash assistance paid to me or anyone on my application. I also understand that I have a right to claim Good Cause for non-cooperation with Child Support Enforcement if establishing or enforcing support would bring harm to me or any child in my custody. If I am a victim of family violence and think that collecting child support might endanger me or my children, I may not be required to cooperate with the child support requirement. I may claim Good Cause by telling my HHSC advisor (or designated representative) or Child Support worker the facts justifying Good Cause and signing the Claim of Good Cause at any time I am receiving cash assistance.

I understand that if I intentionally give wrong or misleading information, I could be prosecuted for a state or federal crime, found guilty or receive deferred adjudication, be sentenced to community supervision or up to 10 years in prison, be required to repay benefits, and be permanently disqualified from receiving TANF. I understand that if I commit an intentional program violation I will be disqualified from receiving financial assistance for up to 12 months for the first violation, and permanently for a second violation.

By applying for Medicaid: I understand that to the maximum extent allowed by state and federal law, HHSC will keep any medical payments made by other health insurance and any cash medical support collected for me or my child by the Office of the Attorney General (OAG). I understand that the filing of this application and the acceptance of Medicaid benefits results in the automatic assignment to HHSC of any right any recipient has to any third-party recovery. I agree to fully cooperate with HHSC in recovery of these funds.

I agree to authorize each provider of Medicaid services to release any medical or other information about me or my eligible family members in order for providers to be paid by Medicaid.

I understand that by applying for Medicaid for my child, I agree to give information about any parent who is not living with the child. If my child and I receive Medicaid, my case will be referred to the Office of the Attorney General for child support services. If only my child receives Medicaid, I understand that a referral to the OAG for child support services is voluntary. If my case is referred to the Office of the Attorney General, I agree to cooperate in establishing paternity and support for my child.

I acknowledge that if I give wrong or misleading information or let someone else use my Medical Card Identification Form, I could be prosecuted and/or be required to pay back to the State or Federal Government any benefits issued incorrectly.

By applying for the Food Stamp Program: I acknowledge that any member of my household who breaks the following rules may not get Food Stamps benefits for one year for the first offense, two years for the second offense, or permanently for the third offense; may be fined up to $250,000 or jailed up to 20 years, or both; may be barred from the Food Stamp program as ordered by the court; may lose deductions; and may be prosecuted under other state or federal laws:

- **Making false or misleading statements, orally or in writing, or hiding information to get benefits the household should not get.**
- **Using or having in your possession improperly obtained Food Stamp benefits, Lone Star Card(s), or other program access device(s).**
- **Trading or selling Food Stamp benefits, Lone Star Card(s), or other program access device(s)**

Verification: I understand that information I provide in connection with this application may be verified by HHSC and other state and federal agencies. My signature below authorizes release of this information and indicates that I agree that this information may be used to determine if the people in my household qualify for benefits.

Important Information You Should Know Before You Apply:

Annuities: You must disclose if you and/or your spouse have an interest in an annuity or similar instrument. If you are determined eligible for Medicaid, the state becomes the remainder beneficiary of the instrument.

Medicaid Estate Recovery Program Statement: I understand that my estate may be required to repay the cost of certain long-term care services and any related hospital and prescription drug services after my death unless my situation or family meets certain exceptions. (For questions about estate recovery, call 1-800-458-9858 or e-mail: merp@dads.state.tx.us)

Immigration: You will be asked to provide information about the citizenship or immigration status for all persons (including yourself) for whom you want assistance. If any of these persons do not want to give us information about his/her citizenship or immigration status, he/she will not be eligible for benefits. Other family or household members may still receive benefits, if they are otherwise eligible. You can apply for and get benefits for eligible household members even if your household includes other members who are not eligible because of immigration status. For example, immigrant parents may apply for benefits for their U.S. citizen or qualified legal immigrant children, even though the parents may not qualify for benefits. You will not have to provide immigration status information or documents for any household members who are not eligible because of immigration status and who are not asking for benefits. If you or members of your household use the Medicaid, Children's Health Insurance Program (CHIP), or Food Stamps program, it will not affect you or your household members' immigration status. Also, it will not affect you or your household members' ability to get a green card. The exception is if you receive long-term institutional care, such as nursing home care. The use of TANF might create problems with getting a green card, especially if the benefits are your household's only income. Talk to any agency that helps immigrants with legal questions before you apply. Refugees and persons granted asylum can use any benefits, including cash assistance; without hurting their chances of getting a green card or U.S. citizenship.

Race/Ethnicity and Gender: You will be asked to provide information about the race/ethnic background and gender of yourself and all persons for whom you want assistance. This information is voluntarily given and is used to make sure that benefits are provided without regard to race, color, gender, or national origin. It will not affect the household's eligibility or benefit amount.

Health and Hospitalization Information: According to state law a recipient of Medicaid automatically gives HHSC his or her right to financial recovery from personal health insurance, other recovery sources and money received as a result of personal injuries, to the extent HHSC has paid for medical services. This allows HHSC to recover the costs of medical services paid by the Medicaid program. Any applicant or recipient who knowingly withholds information regarding any sources of payment for medical services violates state law.

Social Security Numbers: You will be asked to provide the Social Security numbers for all people, including yourself, for whom you want assistance. If any of these people do not have a Social Security number, we can help you apply for one. Providing or applying for a Social Security number is required as a condition of eligibility for benefits as required by Section 1137 of the Social Security Act. The authority for these requirements is as follows: for food stamp benefits, 7 C.F.R. 273.6; for TANF benefits, 45 C.F.R. 205.52; and for medical assistance benefits, 42 C.F.R. 435.910. We will not share your Social Security number with the Bureau of Citizenship and Immigration Services. You will not have to provide Social Security numbers for any family members who are not eligible because of immigration status and who are not asking for benefits. Social Security numbers are used to verify eligibility, to conduct computer matching with other agencies (such as the Texas Workforce Commission, the Social Security Administration, the Internal Revenue Service and credit reporting agencies) and other matching sources, and to recover benefits you were not entitled to receive. We may share Social Security numbers with phone and electric companies to help them determine if you qualify for a reduction in your bills or with others to help you receive benefits based on need.

Discrimination: In accordance with Federal law and U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. Under the Food Stamp Act and USDA policy, discrimination is also prohibited on the basis of religion or political beliefs. If you feel you have been discriminated against, you may contact HHSC Civil Rights office by writing Texas Health and Human Services Commission, Civil Rights Office, 701 W. 51st St., Suite 104, Austin, TX 78751 or call (888) 388-6332 (voice), (512) 438-2960 (TDD), (877) 432-7232 (TTY), or (512) 438-5885 (fax). You may also file a complaint by contacting USDA or HHS. Write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410 or call (800) 795-3272 (voice) or (202) 720-6382 (TTY) Write HHS, Director, Office for Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TTY). USDA and HHS are equal opportunity providers and employers.

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.

Signature of Applicant or Authorized Representative ____________ Date ____________

Signature of person with legal authority to act for applicant (evidence must be provided) ____________ Date ____________

Phone Number of person with legal authority: (______)________________

Signature of witness, if above is signed with an "X" ____________ Date ____________

Print Name of witness: ____________

Applicant Initials: ____________

Applicant SSN: ____________

Other programs available to Texans:

Family Violence Program services are available to those who have been physically, emotionally or sexually abused by a partner, former partner, a family member or another person living in the home. Services include: 24-hour crisis hotline, 1-800-799-SAFE (7233) or TTY at 1-800-787-3224; 24-hour shelter; emergency medical care; counseling; emergency transportation; legal assistance; information about educational arrangements for children; and job training and information about employment opportunities.

Family Planning Program services are available to low-income Texans who are of child-bearing age. The cost of services depends on the individual's income and can range from free to low cost. Services include: complete health checkup, including health history review and physical exam; medical followup visits and birth control supplies; referrals for prenatal care and other health care; birth control approved by the Federal Drug Administration; and health education. To find a clinic near you, call 2-1-1.

Adult Education and Family Literacy Program helps adults and out-of-school youths learn to read and write English; earn a high school diploma or GED and get the skills for a job or to advance their careers. For more information, call 1-800-441-READ (7323).

Alcohol and Drug Abuse Prevention Program provides crisis counseling and prevention resources to Texas communities. For more information about substance abuse services near you, call 1-877-9-NO DRUG (1-877-966-3784).

Texas Workforce Network operates centers around the state to help people who are seeking work. Services include job placement, assistance with resume and application preparation, access to computers, printers, copiers and help with workforce necessities like childcare, transportation or other job-related expenses. To find a Texas Workforce Center near you, call 2-1-1.

Women, Infants and Children (WIC) Nutrition Program helps low-income pregnant women, new mothers and young children eat well, learn about nutrition and stay healthy. Services include nutrition classes, healthy foods (such as milk, infant formula and juice) and immunizations. For information, call 1-800-942-3678.

Applicant SSN: ____________ Applicant Initials: ____________

Documents To Send With Your Application

TEXAS Health and Human Services Commission

Food Stamps	Temporary Assistance for Needy Families (TANF)	Medical Assistance	Medicaid for the Elderly and People with Disabilities	**DOCUMENTS NEEDED TO SHOW PROOF** Send documents that are check marked under the program(s) for which you are applying. You only need to send documents that apply to your situation. For example, if you are applying for food stamps, but do not have a bank account, we do not need bank statements.
✓	✓	✓	✓	**Identity –** Valid driver's license or Department of Public Safety ID card. **Note:** If you have a representative, your representative will need to provide proof of his or her identity, plus proof of your identity.
✓	✓	✓	✓	**Social Security –** Social Security card/statement from the Social Security Administration for each person.
	✓	✓	✓	**Citizenship –** U.S. passport, Certificate of Naturalization, U.S. birth certificate, hospital record of birth or Medicare card.
✓	✓	✓	✓	**Qualified Alien/Eligible Non-Citizenship Status –** Alien registration card, documentation from the Bureau for Citizenship and Immigration Services (formerly INS).
✓	✓	✓	✓	**Legal Representative –** Power of attorney, guardianship order, court order or similar court documents.
✓	✓	✓	✓	**Earnings –** Pay stubs, copy of checks, a statement from employer or self-employment records.
✓	✓	✓	✓	**Social Security, Pension, Veterans Administration, Supplemental Security Income, Workers' Compensation or Unemployment Benefits –** Award letter or pay stubs.
✓	✓	✓	✓	**Child Support Obligations –** Divorce decree, court order or copy of district clerk record.
✓	✓	✓	✓	**Child Support Payment –** Copy of district clerk record or letter from parent who pays showing any child support amounts and dates paid, including the person's name, address, telephone number, signature and date.
✓	✓	✓	✓	**Loans, Gifts, Contributions –** Promissory note, loan agreement, statement from person providing the money that includes the person's name, address, telephone number, signature and date.
✓	✓	✓	✓	**Bank Accounts –** Current statements for all accounts.
✓	✓	✓	✓	**Stocks, Bonds, Trusts, Annuities –** Trust agreement, annuity contract, stock certificate, bond instrument or current statements.
✓	✓	✓	✓	**Real Estate, Oil, Gas, Mineral Rights –** Current tax statements, division orders, deeds or royalty statements.
✓		✓	✓	**Medical Expenses –** Medical bills, receipts or statements from the provider.
	✓	✓	✓	**Insurance Policies –** Copies of life, burial and health insurance policies; statements from the insurance provider showing the current value. We may also need your spouse or ex-spouse's job-related health insurance information and policies
✓			✓	**Rent/Mortgage –** Copies of checks or check stubs, statement from mortgage lender or landlord. Also, if you rent your home, please provide the name, address and telephone number of your landlord.
✓			✓	**Utilities –** Your most recent utility bills showing your name and current address.
✓		✓		**Dependent Care Expenses –** Copies of check or check stubs showing when and how often you pay. Include a signed and dated statement from the person you pay showing that person's address and telephone number, as well as when and how often you pay.
✓		✓		**Pregnancy –** Medical records confirming the pregnancy, or call 2-1-1 and request Form H3037, Report of Pregnancy, or ask for more information about how you can provide proof.
	✓			**Birth of Children –** Legal birth certificate, hospital certificate or baptismal certificate. We also must have proof that the child lives with you, such as a signed statement from your landlord or a non-relative neighbor that includes his or her name, address and telephone number.
	✓			**Child Immunizations –** Provide immunization records or proof of immunizations for each TANF child under the age of six. If you believe you are exempt from this requirement because of your religious or conscientious beliefs, call 2-1-1 for the information we will need.

We will contact you if we need more information or if you need to take any action.
Call 2-1-1 if you have questions.