

# TexCare Application Instructions

To apply, please fill out the application, sign it and attach copies of your proof of income and other information you may need to send. Mail the application and other proof to:

TexCare Partnership  
P.O. Box 149276  
Austin, TX 78714-9983

## Who can apply?

Parents **WHO LIVE WITH** their children can apply for their children who are ages 18 years or younger. A grandparent, relative or other adult **WHO LIVES WITH** the child and takes care of the child may also apply. If you are younger than 19 and living on your own, you can apply for yourself.

- 1 Complete the application using blue or black ink. If we may call you at work, please write that phone number as well.
- 2 Please fill out a column for every child **WHO LIVES WITH YOU**. You may only apply for children that live in your home. If more than four children live with you, please give us the information about the additional children on an extra sheet of paper. If you are younger than 19 and living on your own, you can apply for yourself.

### Line (c)

Please check the "Applying" box in each column under any child's name who needs health insurance. If you do not need health insurance for one of the children listed, please check the "Not Applying" box in the column under that child's name.

### Line (d)

Please tell us the relationship between you and each child. Examples of answers include "daughter," "grandchild," or "nephew." If you are not related to the child but take care of the child, write "Guardian."

### Line (g)

If you are applying for a non-citizen child who is a legal resident, please include proof of the child's immigration status (a copy of the front and back of the child's Resident Alien Card (I-551) from the Immigration and Naturalization Service (INS). We do not need information on the citizenship status of any adults in your family. We will not share any information you provide with the INS and the INS **CANNOT** use this application or the enrollment of your children in Medicaid or the Children's Health Insurance Program (CHIP) to deny you admission to the U.S., to harm your permanent resident status or to deport you.

### Line (h)

We must have a Social Security Number (SSN) for each child for whom you are applying for health insurance. If your child does not have a SSN, we can help you apply for one. Social Security Numbers are used to do computer matching with other agencies and contractors. The SSN cannot be used by the Internal Revenue Service (IRS) for tax purposes or by the INS.

### Line (n)

Please tell us the race for each child for whom you are applying for health insurance. This question is optional and used for statistical purposes only. If you choose to do so, please use Anglo, African-

American, American Indian, Asian/Pacific Islander or Hispanic.

- 3 Please fill out a column for each child who lives with you.

### Line (a)

Mark the box "Yes" if the child is currently covered by commercial health insurance. Please provide the name of the insurance company, name of the policy holder, the policy and group number and the insurance company's phone number. If your child is eligible for Medicaid you may be eligible for financial help for the insurance premium. Mark the box "No" if the child is not insured by commercial health insurance or is insured under an auto, worker's compensation, accident or sports-related insurance plan. If a child's health insurance ended in the past 90 days, please tell us why, when and how much was paid monthly for the insurance. We ask this because your child may qualify for CHIP immediately if certain conditions are met; but you must be able to drop your child's other insurance immediately before covering your child under CHIP. Your child cannot be covered by both CHIP and other health insurance, including Medicaid, at the same time. However, your child can be covered by Medicaid and other health insurance at the same time.

### Line (b)

Please tell us if health insurance is available for your child(ren) through your job/employer. Mark the box "Yes" if your job/employer offers health insurance for your child(ren). Mark the box "No" if your job/employer **does not** offer health insurance for your child(ren).

- 4 Please list all of the parents and step-parents **WHO LIVE WITH THE CHILDREN**, even if you already listed them in question 2. The purpose of this question is to find out the size of your family, which helps determine which program the child **MAY** be eligible for once the application process is complete.
- 8 Please answer these questions about **YOUR** assets if you are the child's parent or step-parent. If you are **NOT** the child's parent or step-parent please answer these questions about the **child's** assets. Your home and one vehicle (car, truck, etc.) do not count and do not need to be considered when answering these questions.
- 9 These questions are voluntary. If you leave them blank, your child may still be insured through Medicaid or CHIP.

### Line (a)

Please tell us if your child(ren) for whom you are applying has unpaid medical bills for the past 3 months. If your child(ren) has unpaid medical bills and is eligible for Medicaid the bills **MAY** be covered.

- 10 If you would like to have someone else contact us for you (as your representative), please check the box and provide us with their name, address and phone number.

### 11 + 12

Please read these sections carefully, then sign and date the application. By signing and dating the application, you are agreeing to all statements under "Rights & Responsibilities." All applications must be signed and dated.

Mail to:  
 TexCare Partnership  
 P.O. Box 149276  
 Austin, TX 78714-9983

# TexCare Partnership Application

Questions? Please call 1-800-647-6558

FOR OFFICE USE ONLY
CBO# _____

Use blue or black ink only.

**1** Your Name \_\_\_\_\_  
First Middle Initial (M.I.) Last

Home Address \_\_\_\_\_ Apt./Lot # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ County \_\_\_\_\_

Mailing Address \_\_\_\_\_ Apt./Lot # \_\_\_\_\_  
(if different from above)

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ County \_\_\_\_\_

Home Phone # (\_\_\_\_) \_\_\_\_\_ Work Phone # (\_\_\_\_) \_\_\_\_\_

If we need to contact you, what language do you prefer?  English  Spanish  Vietnamese  Other \_\_\_\_\_

**2** Tell us about all the children living in your home. Add an extra sheet of paper if needed. Children **MUST** live in **YOUR** home to apply.

	Child 1	Child 2	Child 3	Child 4
a. Child's first name and middle initial				
b. Child's last name				
c. Check the box for each child for whom you wish to apply for health insurance.	<input type="checkbox"/> Applying <input type="checkbox"/> Not Applying	<input type="checkbox"/> Applying <input type="checkbox"/> Not Applying	<input type="checkbox"/> Applying <input type="checkbox"/> Not Applying	<input type="checkbox"/> Applying <input type="checkbox"/> Not Applying
d. Relationship to you				
e. Date of birth (Mo./Day/Year)	____/____/____	____/____/____	____/____/____	____/____/____
f. Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
g. Is your child a U.S. citizen?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>If "NO," is child a legal resident?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Children who are legal residents may qualify for these health insurance programs. You must provide a copy of the front and back of the child's Resident Alien Card (I-551) with this application. This information is for <b>OUR</b> records only, will not affect the immigration status of you or your children and will not be shared with the INS.				
h. <b>CHILD'S</b> Social Security #				
i. Mother's first name and middle initial				
j. Mother's last name				
k. Father's first name and middle initial				
l. Father's last name				
m. Is this child enrolled in school?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
n. Race (optional, see instructions)				
o. Does child currently have Medicaid?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
p. Does child currently have CHIP?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

	Child 1	Child 2	Child 3	Child 4
<b>3</b> a. Does child currently have commercial health insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>IF "YES,"</b> please provide the following information for each child insured. Insurance Company Name: _____ Policy Holder: _____ Policy Number: _____ Group Number: _____ Phone: _____	_____	_____	_____	_____
Date the health coverage will end (Mo./Day/Year)	____/____/____	____/____/____	____/____/____	____/____/____
<b>IF "NO,"</b> but the child had health insurance in the past 90 days, please mark the box that states why the insurance was dropped and the date the insurance ended.	<input type="checkbox"/> Parent's job ended <input type="checkbox"/> Loss of Medicaid or CHIP eligibility <input type="checkbox"/> Change in parents' marital status <input type="checkbox"/> Parent's COBRA coverage ended <input type="checkbox"/> Other _____	<input type="checkbox"/> Parent's job ended <input type="checkbox"/> Loss of Medicaid or CHIP eligibility <input type="checkbox"/> Change in parents' marital status <input type="checkbox"/> Parent's COBRA coverage ended <input type="checkbox"/> Other _____	<input type="checkbox"/> Parent's job ended <input type="checkbox"/> Loss of Medicaid or CHIP eligibility <input type="checkbox"/> Change in parents' marital status <input type="checkbox"/> Parent's COBRA coverage ended <input type="checkbox"/> Other _____	<input type="checkbox"/> Parent's job ended <input type="checkbox"/> Loss of Medicaid or CHIP eligibility <input type="checkbox"/> Change in parents' marital status <input type="checkbox"/> Parent's COBRA coverage ended <input type="checkbox"/> Other _____
Date the health coverage ended (Mo./Day/Year)	____/____/____	____/____/____	____/____/____	____/____/____
b. Could the child get commercial health insurance through the parent's job/employer?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. If you or someone else in your family <b>WHO LIVES IN YOUR HOME</b> pays/paid for the health insurance coverage, what is/was the <b>TOTAL AMOUNT</b> paid for <b>ALL</b> the children per month?			<b>Total Amount \$</b> _____ /month	

**4** List all of the parents and step-parents **WHO LIVE WITH THE CHILDREN**, including those listed on the front of this application. Please list all the parents or step-parents even if you already listed them under question number 2.

First name	Middle initial	Last name	Relationship to child
			<input type="checkbox"/> Parent <input type="checkbox"/> Step-parent
			<input type="checkbox"/> Parent <input type="checkbox"/> Step-parent

**5 FAMILY INCOME** List all of your family's **CURRENT** income before taxes. Include wages, unemployment compensation, social security, child support or any other money you regularly receive. You must provide a **COPY** of proof for each type of income you list. The proof must reflect your family's **CURRENT** total income. This could be a copy of any one (or more) of the following: a paycheck stub issued in the last 60 days, your most recent tax return, your most recent social security statement, child support check, proof of self-employment or a letter from an employer telling us your current income and how often you get paid.

Name of person receiving money	Employer(s) name OR sources of income	How much?	How often?
First Middle initial Last		\$ _____	<input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 Weeks <input type="checkbox"/> Twice a Month <input type="checkbox"/> Monthly
		\$ _____	<input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 Weeks <input type="checkbox"/> Twice a Month <input type="checkbox"/> Monthly

**NOTE: Questions 6-8 ask for information that could LOWER the cost of your children's health insurance.**

**6** a. Of the family members who live in your home, is anyone pregnant?

No  Yes **IF "YES,"** please list her name and due date. \_\_\_\_\_ (M.L.) \_\_\_\_\_ Last \_\_\_\_\_ Due date (Mo./Day/Year)

b. Of the family members who live in your home, does anyone pay for childcare OR pay for disabled adult care in order for a family member to work or receive training?

No  Yes **IF "YES,"** please give us the following information. You must send proof of payments with this application to be able to reduce your total income.

Caregiver's or facility's name and phone number	First name of person who receives care	First name of person who pays for care	How much is paid for childcare AND disabled adult care?
Caregiver/facility _____ Phone: _____	First name _____	First name _____	How much? \$ _____
Caregiver/facility _____ Phone: _____	_____	_____	How often? <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 Weeks <input type="checkbox"/> Twice a Month <input type="checkbox"/> Monthly

**7** Of the family members who live in your home, does anyone pay child support and/or alimony to anyone outside your home?

No  Yes **IF "YES,"** you must send proof of how much and how often you pay this amount.

Child support \$ \_\_\_\_\_ How often?  Weekly  Every 2 Weeks  Twice a Month  Monthly

Alimony \$ \_\_\_\_\_ How often?  Weekly  Every 2 Weeks  Twice a Month  Monthly

**8** Your home and one vehicle (car, truck, etc) do not count as assets. If you **ARE** the child's parent or step-parent, answer the following questions based on you and your spouse's assets. If you are **NOT** the child's parent or step-parent, answer the following questions based on **THE CHILD'S ASSETS ONLY.**

a. Not counting your first vehicle, do you have another car, truck or other vehicle worth more than \$6,650?  Yes  No

b. Of the family members who live in your home, does anyone have more than \$2,000 in bank accounts, cash on hand or anywhere else?"  Yes  No

**9** Questions 9(a) and (b) are **VOLUNTARY.**

a. Does any child you are applying for have unpaid medical bills for the past 3 months? If your child(ren) has unpaid medical bills for the 3 months before you applied, the bills **MAY** be covered.  Yes  No

b. Do you want to be referred to the Office of the Attorney General (OAG) for help establishing paternity and obtaining medical or child support for your children?  Yes  No

**10 AUTHORIZED REPRESENTATIVE** (see instructions)

By checking this box, I give

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_

Street Address \_\_\_\_\_ Apt. No. \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_

permission to apply for benefits or get eligibility/enrollment information relating to my child(ren). I further give CHIP, Medicaid and their contractors permission to release this information to this person.

**11 YOUR RIGHTS & RESPONSIBILITIES**

**By signing below, I agree to the following:**

**I have the right to:**

- Be treated fairly and equally regardless of my race, color, religion, national origin, gender, age, political beliefs or disability consistent with state and federal law. If I believe I have not been treated fairly and equally, I may call the U.S. Dept. of Health and Human Services at 1-800-368-1019.
- Request information that the State of Texas obtains about me and my children through this application, and to review and correct any wrong information (with a few exceptions).
- Request a fair hearing in writing, in person or by phone from my local DHS office should I be denied Medicaid through this application process and I am not satisfied with the decision.

**I have the responsibility to:**

- Not purposely withhold information or give false facts, or let anyone use my child's health insurance identification or I could be required to pay the state or federal government for any benefit issued incorrectly, and my children's health insurance may be denied or ended.

**I further understand and agree that:**

- This application could lead to my child(ren)'s enrollment in either the Children's Health Insurance Program (CHIP) or Medicaid.
- CHIP, Medicaid and their contractors may verify any information that affects my child(ren)'s eligibility for insurance with other state and federal agencies.
- CHIP, Medicaid and their contractors may exchange information on this application and medical, health or other information relating to my child(ren)'s coverage with other agencies and contractors, including companies offering health insurance to my child(ren), to assist with application, enrollment, administration and quality assurance. The information provided on this application cannot be used by the IRS for tax purposes or by the INS.
- The State of Texas or its designee has the right to receive payments for services and supplies from insurance companies and other liable sources as reimbursement for medical services for my child(ren). My signature below authorizes assignment of medical payments.
- Each provider of medical services to my child(ren) may release any medical or other information necessary in order for the provider to be paid.

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**12** X

SIGNATURE (REQUIRED)

DATE (REQUIRED)