



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.



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?	<input type="radio"/> Medicaid for the Elderly and People with Disabilities <input type="radio"/> Medicare Savings Program <input type="radio"/> Medicaid Buy-In Program	<input type="radio"/> None <input type="radio"/> Medicaid for the Elderly and People with Disabilities <input type="radio"/> Medicare Savings Program <input type="radio"/> Medicaid Buy-In Program																								
First name	_____	_____																								
Middle name	_____	_____																								
Last name	_____	_____																								
Social Security number	<table border="1"> <tr> <td> </td><td> </td><td> </td><td>-</td><td> </td><td> </td><td>-</td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>				-			-						<table border="1"> <tr> <td> </td><td> </td><td> </td><td>-</td><td> </td><td> </td><td>-</td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table> <p>only if you are applying for benefits</p>				-			-					
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Birth date	<table border="1"> <tr> <td> </td><td> </td><td>-</td><td> </td><td> </td><td>-</td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table> <p>month day year</p>			-			-							<table border="1"> <tr> <td> </td><td> </td><td>-</td><td> </td><td> </td><td>-</td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table> <p>month day year</p>			-			-						
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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?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Plan to stay in Texas?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> 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	<input type="radio"/> Male <input type="radio"/> Female	<input type="radio"/> Male <input type="radio"/> Female
Hispanic or Latino?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Mark one or more:	<input type="radio"/> American Indian or Alaska Native <input type="radio"/> Asian <input type="radio"/> Black or African-American <input type="radio"/> Native Hawaiian or Pacific Islander <input type="radio"/> White	<input type="radio"/> American Indian or Alaska Native <input type="radio"/> Asian <input type="radio"/> Black or African-American <input type="radio"/> Native Hawaiian or Pacific Islander <input type="radio"/> White
Mark one:	<input type="radio"/> Married <input type="radio"/> Single <input type="radio"/> Divorced <input type="radio"/> Separated <input type="radio"/> Widowed	<input type="radio"/> Married <input type="radio"/> Single <input type="radio"/> Divorced <input type="radio"/> Separated <input type="radio"/> Widowed

Section B

Citizenship

	You	Spouse
Are you a U.S. citizen? If yes, go to Section C.	<input type="radio"/> Yes <input type="radio"/> No If no, give facts below:	<input type="radio"/> Yes <input type="radio"/> No If no, give facts below:
Are you a refugee or legally admitted immigrant?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> 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?	<input type="radio"/> Yes <input type="radio"/> No If yes, immigrant registration number _____	<input type="radio"/> Yes <input type="radio"/> 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?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
If yes, do you have intellectual or developmental disabilities?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> 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
<input type="radio"/> Nursing home. <input type="radio"/> State supported living center. <input type="radio"/> State hospital. <input type="radio"/> Group home for people with intellectual or developmental disabilities (ICF/MR). <input type="radio"/> Continuing care retirement community. <input type="radio"/> Your own home. <input type="radio"/> Rent house or apartment (including an assisted living facility). <input type="radio"/> With someone else in their home. <input type="radio"/> House paid for by someone else. <input type="radio"/> Other _____	<input type="radio"/> Nursing home. <input type="radio"/> State supported living center. <input type="radio"/> State hospital. <input type="radio"/> Group home for people with intellectual or developmental disabilities (ICF/MR). <input type="radio"/> Continuing care retirement community. <input type="radio"/> Your own home. <input type="radio"/> Rent house or apartment (including an assisted living facility). <input type="radio"/> With someone else in their home. <input type="radio"/> House paid for by someone else. <input type="radio"/> 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?	
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> 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 <input type="text"/> / <input type="text"/> / <input type="text"/> Does this person receive public assistance benefits such as SNAP, SSI or TANF? <input type="radio"/> Yes <input type="radio"/> No	_____ Name of person living with you _____ Relationship to you Birth date if a relative <input type="text"/> / <input type="text"/> / <input type="text"/> Does this person receive public assistance benefits such as SNAP, SSI or TANF? <input type="radio"/> Yes <input type="radio"/> No
PERSON 2	_____ Name of person living with you _____ Relationship to you Birth date if a relative <input type="text"/> / <input type="text"/> / <input type="text"/> Does this person receive public assistance benefits such as SNAP, SSI or TANF? <input type="radio"/> Yes <input type="radio"/> No	_____ Name of person living with you _____ Relationship to you Birth date if a relative <input type="text"/> / <input type="text"/> / <input type="text"/> Does this person receive public assistance benefits such as SNAP, SSI or TANF? <input type="radio"/> Yes <input type="radio"/> No
PERSON 3	_____ Name of person living with you _____ Relationship to you Birth date if a relative <input type="text"/> / <input type="text"/> / <input type="text"/> Does this person receive public assistance benefits such as SNAP, SSI or TANF? <input type="radio"/> Yes <input type="radio"/> No	_____ Name of person living with you _____ Relationship to you Birth date if a relative <input type="text"/> / <input type="text"/> / <input type="text"/> Does this person receive public assistance benefits such as SNAP, SSI or TANF? <input type="radio"/> Yes <input type="radio"/> No

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	\$	\$	

Do other people in the household pay for, or provide you with, all your meals? Yes No

Section G
Medical Facts

Medicare
Do you get Medicare? Yes No

	You	Spouse
If yes, mark the type you get.	<input type="radio"/> Part A <input type="radio"/> Part B <input type="radio"/> Part D	<input type="radio"/> Part A <input type="radio"/> Part B <input type="radio"/> 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 much is the premium? Who pays the premium?

How often is the premium paid?
 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)

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 much is the premium?	Who pays the premium?		How often is the premium paid?
_____	_____		<input type="radio"/> Monthly <input type="radio"/> Quarterly <input type="radio"/> Yearly
Do you get this insurance through a job you have now or used to have? <input type="radio"/> Yes <input type="radio"/> No			_____
			If yes, employer's name

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.

1. Do you have checking accounts?

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

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

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.

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

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? <input type="radio"/> Yes <input type="radio"/> 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? <input type="radio"/> Yes <input type="radio"/> 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

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

Save Time

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



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

		\$ _____
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

		\$ _____
Address or location	Amount of land	Current value

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

<input type="radio"/> livestock _____ \$ <input type="radio"/> poultry Number Current value	<input type="radio"/> livestock _____ \$ <input type="radio"/> poultry Number Current value
--	--

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		Current value

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

If yes:

_____	\$	_____	\$	_____
Item		Current value		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
<input type="radio"/> Social Security. <input type="radio"/> Supplemental Security Income (SSI). <input type="radio"/> Veterans benefits. <input type="radio"/> Other benefits _____	<input type="radio"/> Social Security. <input type="radio"/> Supplemental Security Income (SSI). <input type="radio"/> Veterans benefits. <input type="radio"/> 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:

Who got the money: You Your spouse

JOB 1	_____	\$ _____	before taxes and deductions are taken out
	Hours worked	Amount paid	
	/ /	/	
	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.

Who got the money: You Your spouse

JOB 2	_____	\$ _____	before taxes and deductions are taken out
	Hours worked	Amount paid	
	/ /	/	
	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? <input type="radio"/> Yes <input type="radio"/> No	
\$ _____ If yes, what is the monthly amount?	\$ _____ If yes, what is the monthly amount?
2. Do you get Supplemental Security Income (SSI)? <input type="radio"/> Yes <input type="radio"/> No	
\$ _____ If yes, what is the monthly amount?	\$ _____ If yes, what is the monthly amount?
3. Do you get veterans benefits? <input type="radio"/> Yes <input type="radio"/> 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? <input type="radio"/> Yes <input type="radio"/> No If yes, what is their relationship to you? _____	
You	Spouse
5. Do you get railroad retirement? <input type="radio"/> Yes <input type="radio"/> No	
\$ _____ If yes, what is the monthly amount?	\$ _____ If yes, what is the monthly amount?
6. Do you get civil service retirement payments? <input type="radio"/> Yes <input type="radio"/> 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? <input type="radio"/> Yes <input type="radio"/> 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? <input type="radio"/> Yes <input type="radio"/> 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? <input type="radio"/> Yes <input type="radio"/> 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? <input type="radio"/> Yes <input type="radio"/> 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? <input type="radio"/> Yes <input type="radio"/> 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? <input type="radio"/> Yes <input type="radio"/> No	
_____ If yes, write the name of the company that pays you. \$ _____ If yes, what is the amount you get? _____ If yes, how often?	_____ If yes, write the name of the company that pays you. \$ _____ If yes, what is the amount you get? _____ If yes, how often?

13. Do you get any money from farming? <input type="radio"/> Yes <input type="radio"/> 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? <input type="radio"/> Yes <input type="radio"/> 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, who do you get the money from and why? \$ _____ If yes, what is the amount you get?	_____ If yes, what type of money do you get? _____ If yes, who do you get the money from and why? \$ _____ 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? <input type="radio"/> You <input type="radio"/> Your spouse		Type of Bill <input type="radio"/> Doctor <input type="radio"/> Hospital <input type="radio"/> Medicine <input type="radio"/> 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:

/ /	\$	Who got the services? <input type="radio"/> You <input type="radio"/> Your spouse
Date paid	Amount paid	Type of bill: <input type="radio"/> Doctor <input type="radio"/> Hospital <input type="radio"/> Medicine <input type="radio"/> Other

/ /	\$	Who got the services? <input type="radio"/> You <input type="radio"/> Your spouse
Date paid	Amount paid	Type of bill: <input type="radio"/> Doctor <input type="radio"/> Hospital <input type="radio"/> Medicine <input type="radio"/> Other

/ /	\$	Who got the services? <input type="radio"/> You <input type="radio"/> Your spouse
Date paid	Amount paid	Type of bill: <input type="radio"/> Doctor <input type="radio"/> Hospital <input type="radio"/> Medicine <input type="radio"/> Other

/ /	\$	Who got the services? <input type="radio"/> You <input type="radio"/> Your spouse
Date paid	Amount paid	Type of bill: <input type="radio"/> Doctor <input type="radio"/> Hospital <input type="radio"/> Medicine <input type="radio"/> 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
- Eligibility and Enrollment matters
- 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: _____

<input type="checkbox"/> 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)
<input type="checkbox"/> By Text message	Cell phone number: _____ (Carrier message and data rates may apply)
<input type="checkbox"/> By e-mail	E-mail address: _____

If you choose to provide this information, you will be responsible for notifying your MCO or health plan provider of any changes to your contact information. You can opt out of being contacted by telephone, text message, or email by notifying your MCO or health plan provider.



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@hsc.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
<p>_____/_____/_____ Date</p>	<p>_____/_____/_____ Date</p>
<p>Sign here</p>	<p>Sign here</p>

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

<p>_____/_____/_____ Date</p>	<p>_____/_____/_____ Date</p>
<p>Sign here (You must give proof of this right)</p>	<p>Sign here (You must give proof of this right)</p>

_____/_____/_____
Date

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

Printed name of witness