How To Get Your Harris Health Plan

There is no cost to make a Harris Health Financial Assistance Application. If you are asked to pay, please call 713-566-6277.

Fill out the form called "Application for Financial Assistance." Be sure you, your husband or wife, and ALL children who live with you, between 18 and 26 years old, sign and date the form.

• **Mail to** Harris Health Financial Assistance Program P.O. Box 300488, Houston, TX 77230 **OR**	• **Drop off at the nearest Eligibility Center**

Harris Health System has pharmacy staff who can sign you up for patient assistance programs to get free medicines from drug companies. You will be asked to sign the Medication Assistance Program (MAP) Consent and Authorization Form (Form #283233) that tells Harris Health to share your personal health information and sign any forms that are needed for you to get free medicine.

Please make and give Harris Health copies of:

This information, papers and signatures are needed for Harris Health Financial Assistance and Drug Replacement Programs, but may not be for other Department of State Health Services programs you may be eligible for like Expanded Primary Health Care Program (EPHC).

1. Identification for you and your husband or wife

You need a copy of **one** proof with a picture on it:

- ☐ State issued driver license
- ☐ State issued ID card
- ☐ Current student ID
- ☐ Passport with picture
- ☐ Current employee job badge
- ☐ Foreign consulate ID card
- ☐ U.S. Immigration documents

If you do not have a picture ID, you need a copy of **two** proofs:

- ☐ Birth certificate (not for married women)
- ☐ Marriage license
- ☐ Hospital or birth records
- ☐ Adoption papers or records
- ☐ Current Harris County voter card
- ☐ Current check stub
- ☐ Other federal document showing your name and address in Harris County
- ☐ Social Security card
- ☐ Medicaid card
- ☐ Medicare card

2. Address with your name or your husband or wife's name

You need a copy of one proof dated within the last 60 days:

- ☐ Utility bill
- ☐ Check stub
- ☐ Mortgage coupon
- ☐ Credit card statement
- ☐ Business mail
- ☐ Medicaid or Medicare letter
- ☐ School record for children under age 18
- ☐ Certification documents or benefit checks from Social Security Administration or Texas Workforce Commission
- ☐ Certification documents from Supplemental Nutrition Assistance Program (SNAP), also called Food Stamps
- ☐ Letter from recognized social services agency
- ☐ Statement from a licensed child care provider
- ☐ Harris Health System-Residence Verification Form filled out by a non-related person not living in your house

Or

You need a copy of one proof dated within the last year:

- ☐ Lease agreement
- ☐ Property tax document
- ☐ Department of motor vehicle record
- ☐ Automobile insurance document
- ☐ Harris County voter card
- ☐ Printout from IRS of most current year's tax filing
- ☐ Automobile registration

3.Gross income for the past 30 days for you, your husband or wife and children over the age of 18 who are living with you

- ☐ Cash income
- ☐ Dividends and royalties
- ☐ Rental property
- ☐ Alimony
- ☐ Workmen's compensation
- ☐ Military pay and allowances
- ☐ Current check stubs
- ☐ Child support documents
- ☐ Social Security award letter
- ☐ Retirement award letter
- ☐ Current IRS 1040/1040A tax return (all pages) if self-employed
- ☐ Veteran Affairs letter or check
- ☐ Unemployment benefit record
- ☐ Harris Health System- Statement of Self Employment Income Form if no tax return is filed
- ☐ Harris Health System- Statement of Wage Verification Form (for cash and personal check wages only)
- ☐ Harris Health System- Statement of Support Form if no income

4. Proof of how you are related to the children living with you who depend on you for support

- ☐ Birth certificate
- ☐ Baptismal record
- ☐ Proof of full time school enrollment for students aged 18 to 26
- ☐ Social Security award letter with dependent's names
- ☐ Baby's Popras forms
- ☐ U.S. Immigration applications with dependents'names
- ☐ Divorce decree or child support document
- ☐ Death certificate for previous household members
- ☐ School documents or insurance documents showing names of both parent and child
- ☐ Birth fact record or hospital armband for infants less than 90 days old

5. Immigration Status for you, your husband or wife and all your children who depend on you for support

You must show current or expired documents from the U.S. Citizenship and Immigration Services.

6. Health Care Coverage for you, your husband or wife and all your children who depend on you for support

Please show current proof of Medicaid, CHIP, CHIP Perinatal, Medicare, or health insurance.

7. If you have Medicare

You must fill out a Medicare Asset Form and show proof of your current resources and liabilities (all pages of bank statements, credit card bills, loans, etc.).

You must fill out papers for CHIP, CHIP Perinatal, Medicaid, TANF (Temporary Assistance for Needy Families), SSI (Supplemental Security Income) or Title V benefits if you can have these programs.

Harris Health's Financial Assistance Program is not an insurance plan. Harris Health does not provide health insurance coverage under the Federal Health Insurance Marketplace Exchange.

HARRISHEALTH SYSTEM

APPLICATION FOR FINANCIAL ASSISTANCE

This is an Official Government Record. False or incomplete information given on this form may result in criminal action being taken under Sections 31.04, 37.04, 37.10, or other portions of the Texas Penal Code.

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Name: ______________________ **Maiden Name:** ______________________

Home Address: ______________________ **Apt #:** __________ **County:** ______________

City: ______________________ **State:** __________ **Zip Code:** ______________

Home Telephone #: ______________ **Work Telephone #:** ______________ **Patient Identifier #:** ______________

Marital Status: ☐ **Single** ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widowed** ☐ **Common Law**

Household Members:

Last Name	First	Relationship	Date of Birth	Social Security #	Race	Ethnicity	Sex	Employed	Legal	
		SELF			☐ White ☐ Black ☐ Asian ☐ Other ☐ Unknown/No answer ☐ American Indian ☐ Alaska Native ☐ Pacific Islander	☐ Hispanic/ Latino ☐ Not Hispanic/ Latino	☐ M ☐ F	☐ Yes ☐ No	☐ US Citizen ☐ Legal Resident ☐ Undocumented	☐ Work Permit ☐ Sponsored ☐ Visa
					☐ White ☐ Black ☐ Asian ☐ Other ☐ Unknown/No answer ☐ American Indian ☐ Alaska Native ☐ Pacific Islander	☐ Hispanic/ Latino ☐ Not Hispanic/ Latino	☐ M ☐ F	☐ Yes ☐ No	☐ US Citizen ☐ Legal Resident ☐ Undocumented	☐ Work Permit ☐ Sponsored ☐ Visa
					☐ White ☐ Black ☐ Asian ☐ Other ☐ Unknown/No answer ☐ American Indian ☐ Alaska Native ☐ Pacific Islander	☐ Hispanic/ Latino ☐ Not Hispanic/ Latino	☐ M ☐ F	☐ Yes ☐ No	☐ US Citizen ☐ Legal Resident ☐ Undocumented	☐ Work Permit ☐ Sponsored ☐ Visa
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					☐ White ☐ Black ☐ Asian ☐ Other ☐ Unknown/No answer ☐ American Indian ☐ Alaska Native ☐ Pacific Islander	☐ Hispanic/ Latino ☐ Not Hispanic/ Latino	☐ M ☐ F	☐ Yes ☐ No	☐ US Citizen ☐ Legal Resident ☐ Undocumented	☐ Work Permit ☐ Sponsored ☐ Visa

Household Income: (includes all gross income in the family)

Name of person working or getting money	Source of Income/Company Name	How Often? (Weekly, Bi-weekly, twice a month, monthly)	Amount

Is anyone pregnant? ☐ No ☐ Yes, who? ______________________ Expected Due Date: ______________

Does anyone have health insurance? ☐ No ☐ Yes, who? ______________________

Name of Insurance Company: ______________________ Member #: ______________

Have you or a member of your household applied for any Social Security benefits? ☐ No ☐ Yes, who? ______________ When? __________

Is any adult you have listed on this form not working? ☐ No ☐ Yes, who? ______________ Last day worked: ______________

Name of Company: ______________________

You must report any changes of name, address, marital status, legal status, income, household members, and health care coverage right away. Failure to report these changes may mean you lose your assistance from Harris Health System and may be responsible to pay the costs of care from Harris Health System. Harris Health System has the right to ask for more information.

I certify under penalty of law that the information I have given to Harris Health System is true and complete to the best of my knowledge. My signature authorizes the release of information to Harris Health System vendors, contractors, state and federal agencies, or patient assistance programs to review records for auditing purposes.

I have read the "Statement of Applicant's Rights and Responsibilities" on Page 2 - Back ☐ Yes ☐ No

You, your husband or wife and all children 18 to 26 years old who live in your house must sign and date to get a Harris Health Plan with prescriptions

Your signature:	**Date:**
Signature of your husband or wife if married or common law:	**Date:**
Signature of your child 18 to 26 years old who lives in your house:	**Date:**
Signature of your child 18 to 26 years old who lives in your house:	**Date:**
Witness signature (if any line is signed with an "X"):	**Date:**

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HARRISHEALTH SYSTEM

STATEMENT OF APPLICANT'S RIGHTS AND RESPONSIBILITIES

By signing this application for assistance, I affirm the following:
The information on the application and its attachments is true and correct. This application is a legal document. Deliberately omitting information or giving false information may cause the Provider to terminate services to a member of my household/family or me.
If I omit information, fail or refuse to give information, or give false or misleading information about these matters, I may be required to reimburse the State for the services rendered if I am found to be ineligible for services. I will report changes in my household/family situation that affect eligibility during the certification period (changes in income, household/family members, and residency).
I authorize release of all information, including but not limited to, income and medical information, by and to the Texas Department of State Health Services (DSHS) and Provider in order to determine eligibility, to bill, or to render services to my household/family or me.
I understand I may be asked by Provider to provide proof of any of the information provided in this application.
Health insurance coverage, including but not limited to individual or group health insurance, health maintenance organization membership, Medicaid, Medicare, Veterans Administration benefits, TRICARE, and Worker's Compensation benefits, must be reported to Provider. Benefits from health insurance may be considered the primary source of payment for health care received. I hereby assign to Provider any such benefits. I also assign payment for benefits and services received from and through Provider directly to the service providers.
I understand that, to maintain program eligibility, I will be required to reapply for assistance at least every twelve months.
I am a bona fide resident of Texas or a dependent. I physically live in Texas, maintain living quarters in Texas, and do not claim to be a resident of another state or country, or am a dependent of a bona fide Texas resident.
Some programs provide care through program-approved providers. I understand that, to receive benefits from such programs, treatment must be received through those program-approved providers.
I understand that criteria for participation in the program are the same for everyone regardless of sex, age, disability, race, or national origin.
I understand I have the right to file a complaint regarding the handling of my application or any action taken by the program with the HHSC Civil Rights Office at 1-888-388-6332.
I understand that I will receive written documentation concerning the services for which my household/family or I is eligible or potentially eligible.
With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 522.023 and 559.004)
I understand and agree that the program does not provide payment for inpatient care. I understand that I must make my own arrangement for hospital care and that I am responsible for the cost of the care.