TEXAS Health and Human Services Commission

Application Information for Children's Health Insurance Program (CHIP), Children's Medicaid, and CHIP Perinatal

CHIP

CHIP covers children from birth through age 18 who do not qualify for Medicaid and cannot afford private health insurance. To qualify for CHIP, you must meet certain asset requirements and have income below limits based on your household size. CHIP enrollment fees and co-payments for doctor visits, prescriptions and other services are based on your family's income.

Children's Medicaid

Medicaid provides health insurance for children from birth through age 18 in families with low income. To qualify for Medicaid, you must meet certain asset requirements and have income below limits based on the ages of your children. If your child qualifies for Medicaid, you will not have to pay an enrollment fee or make co-payments for doctor visits, prescriptions or other services.

CHIP Perinatal

CHIP Perinatal provides health insurance to unborn children of pregnant women who are not eligible for Medicaid or traditional CHIP due to income or immigration status.

Ways to Apply

If you want to apply for CHIP, Children's Medicaid, or CHIP Perinatal **ONLY** you can:

- Call toll-free 1-800-647-6558
- Complete the attached application and mail it, along with required documents, to:
  HHSC
  P.O. Box 14200
  Midland, TX 79711-4200
- Complete the attached application and fax it toll free, along with the required documents, to 1-877-542-5951.

If you want to apply for these programs and other benefits such as **food stamps, financial assistance, or Medicaid for an adult,** you can:

- Dial 2-1-1
- Visit www.yourtexasbenefits.com
- Visit a local HHSC Benefits Office

Required Documents

When we review your application, we will need to see proof of:

Income

We need proof of how much money each person in your household is making. The proof must show each person's current income. The proof could be a copy of any one or more of the following:

- Pay check stub issued in the last 60 days showing the amount paid before any taxes or deductions (gross pay)
- Most recent IRS tax return including Schedule C (if you filed that form)
- Proof of self-employment
- Letter from an employer
- Cash assistance receipt
- Most recent Social Security statement
- Child support check stub or receipt

Expenses

We need proof of any expenses you report on your application. The proof can be receipts for child care expenses, disabled adult care expenses, child support payments or alimony payments.

U.S. Citizenship or Immigration Status

We need proof of U.S. citizenship or immigration status for each person applying for CHIP, Children's Medicaid, or Perinatal. The proof can be:

- Front and back of Permanent Resident Card (I-551) or
- Arrival/Departure Form (I-94) from the U.S. Bureau of Citizenship and Immigration Service (BCIS) or
- U.S. birth certificate or
- U.S. passport

Social Security Numbers

We need Social Security numbers for each person requesting coverage.*

If you do not have a Social Security Number or you are a non-citizen, you may still qualify for CHIP Perinatal. All statements provided as proof of your situation must be signed and dated with the name, address, and phone number of the person(s) providing the statement. If you send an original document and we determine you need it for your personal records, we will make a copy and return it to you.

* 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 Medicaid benefits. Therefore, any person who declines to apply for or provide a Social Security number may be found ineligible for benefits. The authority for this requirement is found in 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, 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 electronic 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.

TEXAS Health and Human Services Commission

Instructions to fill out this Application

This application is for Children's Health Insurance Program (CHIP), Children's Medicaid, and CHIP Perinatal. We must first determine if each person applying qualifies for Medicaid before they can be considered for CHIP. Federal law does not allow anyone who qualifies for Medicaid to enroll in CHIP or CHIP Perinatal.

To apply:

- Complete, sign, and date the application
- Attach all of your proof of income, expenses and proof of each applying person(s)' citizenship or legal permanent resident status
- Provide Social Security numbers for each person applying
- Mail the enclosed application and other proof in the self-addressed envelope provided (no stamp or postage required)

Who can apply?

- Any adult age 18 or older who lives with the children more than half of the time and is responsible for the care of the children
- Any children younger than 19 years of age, living on their own
- Any pregnant family member.

1 Complete the application using black or blue ink. Please provide the information requested.Your Social Security number is not required to process your children's application for children's health care coverage. Each person applying must live in Texas.

2 Please complete this information for any pregnant woman applying for health insurance benefits.

Line (b)
List the name(s) of any pregnant family member(s) in your household, including children for whom you are applying. Tell us the pregnant family member's mother's maiden name along with all other requested information.

Line (c)
We will need proof of U.S. citizenship or immigration status for each person who is applying for benefits. People who are legal permanent residents may qualify for these health insurance programs. Provide a copy of the front and back of the person's:
• Permanent Resident Card (1-551) or
• Arrival/Departure Form (1-94) or
• U.S. birth certificate or
• U.S. passport

We do not need information about the citizenship or immigration status for anyone not applying. We will not share any information you provide with the Bureau of Citizenship and Immigration Services (BCIS) and the BCIS cannot use this application or the enrollment of any person in any of these programs to deny you admission to the U.S., to harm your permanent resident status, or to deport you. **If you are a non-citizen you may still qualify for the CHIP Perinatal.**

Line (d)
Mark the box "yes" if the pregnant family member is currently covered by private health insurance and provide the date the coverage will end. If the private health insurance coverage is not ending, mark "N/A". Mark the box "no" if the pregnant family member is not covered by private health insurance.

Line (e)
List the name and address of the father of the unborn child.

3 If you are **ONLY** applying for CHIP Perinatal benefits, and there are no children in the household, **SKIP** this section. Otherwise please fill out a column for every child, **even if you are not applying for health care for that child.** You may only apply for children who live in your home. If more than four children live with you, please give us the information about the additional children on a separate sheet of paper and attach it to this application. If you are younger than 19 and do not live with your parents, you can fill out this section for yourself.

Line (c)
Please check the "Applying" box in each column under any child's name who needs health care coverage. If you do not need health care coverage 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 living in the home. Examples of answers include daughter, son, grandchild, or nephew. If you are not related to the child but the child lives with you, write "other." If you are applying for yourself, write "self."

Line (g)
We will need proof of U.S. citizenship or immigration status for each child who is applying for CHIP or Children's Medicaid. Children who are legal permanent residents may qualify for these health insurance programs. Provide a copy of the front and back of the child's:
• Permanent Resident Card (I-551) or
• Arrival/Departure Form (I-94) or
• U.S. birth certificate, or
• U.S. passport

We do not need information about the citizenship or immigration status for anyone not applying. We will not share any information you provide with the Bureau of Citizenship and Immigration Services (BCIS) and the BCIS cannot use this application or the enrollment of your children in Children's Medicaid or 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 for each child for whom you are applying for health care coverage. If the child does not have a Social Security number, mail us proof that you have applied for your child's Social Security number from your local Social Security office (copy of Form SSA 2853 or Form SSA 5028). If you need help applying for the child's Social Security number please call 1-800-772-1213. We will not give the Internal Revenue Service or the BCIS your child's Social Security number.

Line (j)
Enter each child's mother's maiden name. This will help us find proof of U.S. citizenship if your child was born in Texas.

Line (o)
This question is optional and used for statistical purposes and does not affect eligibility.

4 If you are **ONLY** applying for CHIP Perinatal benefits, **SKIP** this section. Otherwise 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 private health insurance. Please provide the name of the insurance company, name of the policy holder and the policy group number. If the health insurance is ending please provide the date it will end in the space provided.

Mark the box "No" if the child is not insured by private health insurance. Mark the box "No" if the child is only covered by auto, worker's compensation, accident or sports-related insurance, or Children with Special Health Care Needs (CSHCN) coverage.

If the child is not insured by private health insurance but had health insurance in the past 90 days, please mark the box that best states why the insurance was dropped and the date the insurance ended.

Line (b)
Your answer to this question will not affect your children's ability to qualify for Children's Medicaid or CHIP. We ask this because if your child is eligible for Children's Medicaid, you may be eligible for financial help for the child's private insurance premium.

5 The four questions in this section are optional and do not affect eligibility.

6 Please list all of the parents and step-parents **WHO LIVE WITH THE CHILDREN**, even if you already listed them in other parts of this application. If you are not the children's parent or step-parent you do not need to list yourself in this section.

7 Please list all of the parents, step-parents and children's gross income in this section. Gross income is money you are paid before taxes and deductions. Include income received from jobs, Social Security (retirement, survivor, and disability), child support, alimony, and Temporary Assistance for Needy Families (TANF). You must send proof of each income source. This may include a copy of a pay check stub issued in the last 60 days showing the amount paid before any deductions (gross pay), your most recent IRS tax return including Schedule C (if you filed that form), proof of self-employment, letter from an employer, cash assistance receipt, your most recent Social Security statement, child support check stub or receipt. If you are not the parent or step-parent of any of the children, do not provide your income information.

8 Please complete this section if any of the family members who live in the home pay:

- Childcare expenses
- Child support
- Alimony
- Disabled adult care

We may deduct the amount of these dependent care expenses, child support, or alimony to determine if you are eligible for Medicaid. These expenses are not deducted when determining CHIP or CHIP Perinatal eligibility.

We must have proof and will accept copies of canceled checks and/or a statement from the Office of the Attorney General if the child support is paid through their office. We will accept the following copies of your documentation as proof: receipts from the childcare center, company providing disabled care or canceled checks.

9 If you are **ONLY** applying for CHIP Perinatal benefits, **SKIP** this section. Otherwise, you must fill out this section. Please answer these questions about your household's assets if you are the children's parent or step-parent. If you are not the children's parent or step-parent, please answer these questions about the children's assets only. Your home and other property do not count as assets.

Line (a)
For the parents and/or the children that live in the home, please write in the total amount of money that was available on the last day of last month in checking, savings and/or Electronic Benefit Transfers (TANF account only) accounts; cash on hand; and accessible trust funds. Write "$0" if the family members who live in your home DO NOT have money in bank accounts, cash on hand, or anywhere else.

Line (b)
For the parents and/or children living in the home, please write the make, model and year for each vehicle your family has registered in their name or is buying. Please write "NA" in the table if your family does not have a vehicle registered in their name or is not buying a vehicle. You do not need to provide information for any vehicle you are leasing. Depending on your family's income, we may need to contact you to ask you more information about your vehicles.

10 If any applying persons are found to be eligible for Medicaid and have unpaid medical bills during the past three months and they qualify for Medicaid during that time, Medicaid may be able to pay those bills. Please mark the box "Yes" if the applying persons have unpaid medical bills from the past three months. Please send copies of the unpaid medical bills showing the date(s) of service for each of the past three months. Please send proof of each income source for all household members for each of the past three months. If you mark the box "Yes" and any applying person is eligible for Medicaid, you will be contacted for more information.

11 If you would like for someone besides yourself and any parent or step-parent, listed in Section 1 or 4 to contact us as your representative, please provide their information. You must name an individual and not an agency. It is important to understand that this person will have the same rights as you and may change anything on your application, including taking your children off Children's Medicaid or CHIP. They will also have the right to change your children's health plan and primary care provider. You are also giving the Texas Health and Human Services Commission and its contractors permission to release information to this person.

12 Please read this section carefully. By signing this application you are agreeing to the rights and responsibilities listed.

13 Review this section to make sure you include all of the necessary proof of your income, expenses and proof of your children's citizenship or legal permanent resident status. If you do not include all of the necessary proof with your application, we will contact you for the information.

14 Please sign and date the application and mail it to us in the postage-paid self-addressed envelope or you may fax it toll free to 1-877-542-5951. We cannot process your application and your family member(s) cannot be offered health care coverage without your signature.

15 Be sure to send your application in the envelope provided to:

HHSC
P.O. Box 14200
Midland, TX 79711-4200

or, fax it toll free to: 1-877-542-5951

TEXAS Health and Human Services Commission

Children's Health Insurance Program (CHIP), Children's Medicaid, and CHIP Perinatal Application

1 *Use black or blue ink only.*

Your Name _____
First Middle Initial (M.I.) Last

Your Social Security Number* _____ Your Date of Birth _____

Home Address _____ Apt/Lot # _____

City _____ State _____ Zip Code _____ County _____

Mailing Address _____ Apt/Lot # _____
(If different from above)

City _____ State _____ Zip Code _____ County _____

Home Phone # (_____) _____ Other Phone # (_____) _____

If we need to call you, what language do you prefer? ☐ English ☐ Spanish ☐ Vietnamese ☐ Other _____

**Your Social Security Number is not required to process your application if you are applying for your children only.*

2 **Are you applying for benefits for a pregnant family member?** . . . . . ☐ Yes ☐ No

a. Please provide the name(s) and due date(s) of any pregnant family member(s) in your household.

First | MI | Last | Date of Birth (Mo./Day/Year) | Social Security Number (if you have one)

Mother's Maiden Name | Due Date (Mo./Day/Year) | Number of Children Expected | Relationship to Applicant

b. Is the pregnant family member a U.S. Citizen? . . . . . ☐ Yes ☐ No

If no, is the pregnant family member a legal permanent resident? . . . . . ☐ Yes ☐ No

c. Does the pregnant family member have health insurance other than Medicaid or CHIP? . . . . . ☐ Yes ☐ No

If yes, when does your health care coverage end? (Write N/A if the coverage is not ending.) ___/___
Mo Year

d. List the name and address of the father of the unborn child.

First | MI | Last | Phone Number

Address (City, State, Zip)

3 If you are **ONLY** applying for CHIP Perinatal benefits, and there are no other children in the household, **SKIP** this section. Otherwise, tell us about **ALL** children living in your household. Add an extra sheet of paper if needed. Children **MUST** live in **YOUR** household 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 one box for each child	☐ Applying ☐ Not Applying	☐ Applying ☐ Not Applying	☐ Applying ☐ Not Applying	☐ Applying ☐ Not Applying
d. Child's relationship to you				
e. Child's date of birth (Mo./Day/Year)	___/___/___	___/___/___	___/___/___	___/___/___
f. Child's gender	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
g. Is the child a U.S. citizen?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If "No," is the child a legal permanent resident?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Children who are legal permanent residents may qualify for these health insurance programs. See section 3g of the instructions.				
h. Child's Social Security #				
i. Child's mother's first name and middle initial				
j. Child's mother's maiden name				
k. Child's mother's last name				
l. Child's father's first name and middle initial				
m. Child's father's last name				
n. Does this child go to school during the regular school year?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
o. Child's race (optional)				

FOR OFFICE USE ONLY

CBONumber

4 If you are **ONLY** applying for CHIP Perinatal benefits, **SKIP** this section.

	Child 1	Child 2	Child 3	Child 4
a. Does the child currently have health insurance other than CHIP or Medicaid?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If "YES," please provide the following information for each child insured:				
Insurance Company Name:	______	______	______	______
Name of Employer:	______	______	______	______
Policy Holder:	______	______	______	______
Policy Number:	______	______	______	______
Group Number:	______	______	______	______
Policy Begin Date:	______	______	______	______
Phone:	______	______	______	______
Date the health coverage will end (Mo./Day/Year).	____ / ____ / ____	____ / ____ / ____	____ / ____ / ____	____ / ____ / ____
If "NO," 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.	☐ Parent's job ended due to layoff or business closing ☐ Loss of Medicaid eligibility ☐ Parent's COBRA or ERS coverage ended ☐ Loss of CHIP eligibility from another state ☐ Change in parent's marital status ☐ Health care coverage ended ☐ Other	☐ Parent's job ended due to layoff or business closing ☐ Loss of Medicaid eligibility ☐ Parent's COBRA or ERS coverage ended ☐ Loss of CHIP eligibility from another state ☐ Change in parent's marital status ☐ Health care coverage ended ☐ Other	☐ Parent's job ended due to layoff or business closing ☐ Loss of Medicaid eligibility ☐ Parent's COBRA or ERS coverage ended ☐ Loss of CHIP eligibility from another state ☐ Change in parent's marital status ☐ Health care coverage ended ☐ Other	☐ Parent's job ended due to layoff or business closing ☐ Loss of Medicaid eligibility ☐ Parent's COBRA or ERS coverage ended ☐ Loss of CHIP eligibility from another state ☐ Change in parent's marital status ☐ Health care coverage ended ☐ Other
Date the health coverage ended (Mo./Day/Year).	____ / ____ / ____	____ / ____ / ____	____ / ____ / ____	____ / ____ / ____
b. Could the child get private health insurance through the parent's job/employer?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

c. If you have paid for private health insurance in the last 90 days or are currently paying for health insurance for any child you are applying for on this application, fill in the amount paid per month. **Total Amount $**__________/month

5 The next four questions are optional and do not affect eligibility.

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

   If **"YES,"** List the name of the individual: ______________________________

2. Is anyone in your household an unaccompanied refugee minor? .... ☐ Yes ☐ No

   If **"YES,"** List the name of the individual: ______________________________

3. Is anyone in your household a child enrolled in the Texas Department of State Health Services Children with Special Health Care Needs program? .... ☐ Yes ☐ No

   If **"YES,"** List the name of the individual: ______________________________

4. Do the children travel outside of Texas with a parent or family member who works as a farm worker or seasonal worker? .... ☐ Yes ☐ No

6 List all the parents and step-parents **WHO LIVE WITH THE CHILDREN,** including those listed previously on this application.

First Name	Middle Initial	Last Name	Relationship to Child
			☐ Parent ☐ Step-parent
			☐ Parent ☐ Step-parent
			☐ Parent ☐ Step-parent
			☐ Parent ☐ Step-parent

7 HOUSEHOLD INCOME

Please list the current income of the parents, step-parents, and children living in your household. Include income received from jobs, Social Security (retirement, survivor and disability), child support, alimony, and Temporary Assistance for Needy Families (TANF). You will need to send proof of each source of income. Proof may include a copy of a pay check stub issued in the last 60 days showing the amount paid before any deductions (gross pay), your most recent IRS tax return including Schedule C (if you filed that form), proof of self-employment, letter from an employer, cash assistance receipt, your most recent Social Security statement, child support check stub or receipt. If a person you list does not have any income, write $0.

Name of Person Receiving Money	Employer(s) Name **OR** Source(s) of Income	How Often?	How Much?
First Middle Initial Last		☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Monthly	$_____
		☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Monthly	$_____
		☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Monthly	$_____
		☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Monthly	$_____
		☐ Weekly ☐ Every 2 Weeks ☐ Twice a Month ☐ Monthly	$_____

8

Please list your household expense for the items below:

- **Child care expenses** that anyone in your household pays so that he or she can work, look for work or receive training
- Court ordered **child support payments** that anyone in your houshold pays for a child outside of the home
- **Alimony payment** that anyone in your household pays
- **Disabled adult care expenses** that anyone in your household pays so he or she can work, look for work or receive training

Type of Expense (Child Care, child support, alimony, dependent care)	**Who is Paying this Expense?**	**First Name of Person Who Receives Care/Support**	**How Often Paid?***	**How Much Paid?**	**Name, Address and Phone Number of the Person You Pay**

**** Weekly, Every Two Weeks, Twice a Month, Monthly***

9

If you are **ONLY** applying for CHIP Perinatal benefits, **SKIP** this section. Otherwise answer the following questions based on the **ASSETS OF THE APPLYING CHILD(REN)'S PARENTS LIVING IN THE HOUSEHOLD**. If no parents are in the household, answer the questions based on **THE CHILD(REN)'S ASSETS ONLY**. Depending on your family's income, we may need to ask you more information about the vehicles you own or are buying.

a. Enter the amount of money in bank accounts, cash on hand, or anywhere else. Write in $0 if you do not have money in bank accounts, cash on hand, or anywhere else. If you do not enter an amount your application will be delayed.

Total Amount $_____

b. Please write the make, model and year for each vehicle your family owns or is buying. Please write "NA" in the table below if your family does not own or is not buying a vehicle. If your vehicle does not work, do not list it. Do not list vehicles that are leased.

MAKE	MODEL	YEAR
Nissan	Sentra	1995

10 OTHER INFORMATION

If the applying persons have unpaid medical bills during the last three months, Medicaid **MAY** pay those bills. Please send copies of these unpaid medical bills showing the date(s) of service for each of the past three months. Please send proof of each income source for all household members for each of the past three months**.**

Does any person you are applying for have unpaid medical bills for the last 3 months? ☐ Yes ☐ No

Note: If you want the Office of the Attorney General to help you obtain child and medical support or help you establish paternity for your child, call 1-800-252-8014. You may also read and request services from the Child Support Program on the Internet at http://www.oag.state.tx.us/child/mainchil.htm

11 VOLUNTARY: AUTHORIZED REPRESENTATIVE

If you would like a person besides yourself and any other parent or step-parent, listed in Section 1 or 4, to contact us as your representative, write their name, address and phone number below. You may not name an agency as your authorized representative.

This person will have the same rights as you and the other parent or step-parent listed on this application to change anything on your children's account, including adding or taking your children off their health care coverage program and requesting an appeal. You also give HHSC and its contractors permission to release information to this person.

Name _____
First Middle Initial (M.I.) Last

Home Address _____ Apt/Lot # _____

City _____ State _____ Zip Code _____ County _____

Home Phone # _____ Other Phone # _____

12 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 HHSC Civil Rights Office
- 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 HHSC 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
- Information I provide in connection with this application is subject to verification by Medicaid, CHIP, the Office of the Inspector General for the Health and Human Services Commission (HHSC), their contractors and other state and federal agencies. My signature below authorizes the release of information relevant to such verification to Medicaid, CHIP, the Office of the Inspector General for HHSC, their contractors and other state and federal agencies. It also authorizes Medicaid, CHIP, the Office of the Inspector General for HHSC, their contractors and other state and federal agencies to contact employers, credit reporting agencies, health care insurance providers, or others with knowledge regarding my children's eligibility for Medicaid and CHIP and authorizes those contacted to release information relevant to my children's eligibility for Medicaid and CHIP
- Medicaid, CHIP, the Office of the Inspector General for HHSC, their contractors and other state and federal agencies may exchange information on this application and medical, health or other information relating to my children's coverage with other agencies and contractors, including companies offering health insurance to my children, to assist with application, enrollment, administration and quality assurance. The information provided on this application cannot be used by the Internal Revenue Service (IRS) for tax purposes or by the Bureau of Citizenship and Immigration Services (BCIS) to deny you admission to the U.S., to harm your permanent resident status or to deport you
- 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

13 REQUIRED DOCUMENTS

After you have filled out and signed and dated the application, please mail the application and other required documents in the self-addressed envelope provided (no stamp or postage required).

Please check to make sure you've included:

- ❑ Proof of your family's current income (a pay check stub issued in the last 60 days showing the amount paid before any deductions (gross pay), your most recent IRS tax return including Schedule C (if you filed that form), proof of self-employment, letter from an employer, cash assistance receipt, your most recent Social Security statement, or a child support check stub or receipt.)
- ❑ Proof of U.S. citizenship or immigration status for all children applying for coverage (copies of the front and back of the children's U.S. birth certificate, U.S. passport, Permanent Resident Card, I-551 or Arrival/Departure Form I-94)
- ❑ Proof of expenses for child care, disabled adult care, child support and/or alimony

Signature required: If you do not sign and date this application, your children cannot be offered health care coverage.

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.

14

X _____ _____

SIGNATURE (REQUIRED) **DATE (REQUIRED)**