Application for Benefits – Medicaid Buy-In for Children

About this program:

Medicaid Buy-In for Children can help pay medical bills for children with disabilities.

This program helps families who make too much money to get traditional Medicaid.

To get benefits:

- The child must be age 18 or younger.
- The child must meet the same rules for a disability that are used to get Supplemental Security Income (SSI).
- If a parent's employer pays at least half of the annual cost of health insurance, the parent must sign up and keep that insurance.
- The family must meet income limits set by the program.
- The family might have to pay a monthly fee.

How to apply:

1. Fill out this form. You can ask a friend or family member to help you.
2. Answer each question on the form. If a question does not apply to you, write "none" for the answer.
3. Sign and date Page 6.
4. Send copies of the following items (don't send originals). We only need items that apply to your case.
    - **Proof of money from a job:** Pay stubs or earning statements.
    - **Proof of money not from a job (veterans benefits, Social Security income, etc.):** Award letters.
    - **Medical costs:** Bills or statements from health care providers (doctors, hospitals, drug stores, etc.) from the past 6 months.

How to send in your application and items we need:

Fax: 1-877-447-2839. If your form is 2-sided, fax both sides.

Mail: Health and Human Services Commission, P.O. Box 14600, Midland, TX 79711-4600.

After we get your form, we will check to see if you can get benefits. Someone might contact you if we need more information. We will let you know the decision within 45 days.

You can get free legal help if you need it. Call your local benefits office to find out where to get free legal help in your area.

Questions?

Call or visit an HHSC benefits office. To find an office near you, call 2-1-1 (toll-free).

2-1-1 also can answer questions about this program. When you call: (1) pick a language and then (2) pick option 2.

Texas Health and Human Services Commission

Form H1200-MBIC
March 2011

Application for Benefits – Medicaid Buy-In for Children

1. Child applying for benefits

1st child applying for benefits

First name	Middle initial	Last name	Social Security number	Is the child married? ☐ Yes ☐ No

Home address – street and number	City, state, and ZIP	County	Home phone

Mailing address (if different) – street and number	City, state, and ZIP	County	Cell phone

Birth date (mm/dd/yy)	Is the child: ☐ Male ☐ Female	Does the child live in Texas? ☐ Yes ☐ No	Does the child plan to stay in Texas? ☐ Yes ☐ No

Is the child a U.S. citizen? ☐ Yes ☐ No

If the child is not a U.S. citizen:
Is the child a refugee or legally admitted immigrant? ☐ Yes ☐ No
Is the child registered with the U.S. Citizenship and Immigration Services? ☐ Yes ☐ No
If yes, give immigrant registration number:

The child is: (mark one or more)
☐ American Indian or Alaska Native ☐ Asian ☐ Black or African-American
☐ Native Hawaiian or Pacific Islander ☐ White ☐ Hispanic or Latino

2nd child applying for benefits

First name	Middle initial	Last name	Social Security number	Is the child married? ☐ Yes ☐ No

Home address – street and number	City, state, and ZIP	County	Home phone

Mailing address (if different) – street and number	City, state, and ZIP	County	Cell phone

Birth date (mm/dd/yy)	Is the child: ☐ Male ☐ Female	Does the child live in Texas? ☐ Yes ☐ No	Does the child plan to stay in Texas? ☐ Yes ☐ No

Is the child a U.S. citizen? ☐ Yes ☐ No

If the child is not a U.S. citizen:
Is the child a refugee or legally admitted immigrant? ☐ Yes ☐ No
Is the child registered with the U.S. Citizenship and Immigration Services? ☐ Yes ☐ No
If yes, give immigrant registration number:

The child is: (mark one or more)
☐ American Indian or Alaska Native ☐ Asian ☐ Black or African-American
☐ Native Hawaiian or Pacific Islander ☐ White ☐ Hispanic or Latino

If more than 2 children are applying for benefits, add more pages.

For HHSC staff use only	☐ Application ☐ Redetermination	Date Form Received	Case number	MBIC EDG number	MBIC EDG number

2. Parents living with the child

Items marked "optional" can help us work your case better.

1st parent

First name	Middle initial	Last name	**Social Security number** (optional)

Do you live with the child? ☐ **Yes** ☐ **No**	**Are you:** ☐ Male ☐ Female	**Birth date** (optional)

The following questions are about the 1st parent's job and their job's health insurance.

Do you want this parent's employer to answer these questions? ☐ **Yes** ☐ **No**

If yes, give the attached "Employment Verification" (Form H1028-MBIC) to your employer. Ask your employer to fill out the form and send it to us. If you need another form, make a copy.

If no, please give facts below. If this parent has more than one job, add more pages.

Employer's name and address

Gross amount paid (before taxes are taken out) $	**How often are you paid?** (once a week, twice a month, etc.)	**Does your job have health insurance?** ☐ **Yes** ☐ **No**

Does the child applying for benefits get health insurance coverage through your job? ..... ☐ **Yes** ☐ **No**

If no, answer the following question, then go to the next section:

If your job has insurance and your child isn't on it, what is the next date you could enroll your child? .....

If yes, answer the next 6 questions:

1. **What date did insurance coverage start?**	4. **What is your policy number?**
2. **How much do you pay for the insurance?** $	5. **What is the insurance company's name?**
3. **Does your employer pay at least half of the premium** (this is usually a monthly payment)**?** ☐ **Yes** ☐ **No**	6. **What is the insurance company's address?**

2nd parent

First name	Middle initial	Last name	**Social Security number** (optional)

Do you live with the child? ☐ **Yes** ☐ **No**	**Are you:** ☐ Male ☐ Female	**Birth date** (optional)

The following questions are about the 2nd parent's job and their job's health insurance.

Do you want this parent's employer to answer these questions? ☐ **Yes** ☐ **No**

If yes, give the attached "Employment Verification" (Form H1028-MBIC) to your employer. Ask your employer to fill out the form and send it to us. If you need another form, make a copy.

If no, please give facts below. If this parent has more than one job, add more pages.

Employer's name and address

Gross amount paid (before taxes are taken out) $	**How often are you paid?** (once a week, twice a month, etc.)	**Does your job have health insurance?** ☐ **Yes** ☐ **No**

Does the child applying for benefits get health insurance coverage through your job? ..... ☐ **Yes** ☐ **No**

If no, answer the following question, then go to the next section:

If your job has insurance and your child isn't on it, what is the next date you could enroll your child? .....

If yes, answer the next 6 questions:

1. **What date did insurance coverage start?**	4. **What is your policy number?**
2. **How much do you pay for the insurance?** $	5. **What is the insurance company's name?**
3. **Does your employer pay at least half of the premium** (this is usually a monthly payment)**?** ☐ **Yes** ☐ **No**	6. **What is the insurance company's address?**

3. Brothers and sisters living with the child

Does a child applying for benefits have any brothers or sisters who are:
(a) age 21 or younger, and (b) living in the same home? ☐ Yes ☐ No

If no, skip this section.
If yes, **give facts below. Add more pages, if needed. Items marked "optional" can help us work your case better.**

☐ **Brother** ☐ **Sister**		
First name	Middle initial	Last name
Social Security number (optional)	**Birth date** (optional)	**Does this person have a job?** ☐ **Yes** ☐ **No**
If this person has a job, give employer's name and address:	**Gross amount paid** (before taxes are taken out) $	**How often paid?** (once a week, twice a month, etc.)
If age 18 to 21: **Is this person in school or training for a job?** ☐ **Yes** ☐ **No**	**If yes, when will this person finish?** You will need to send proof that this person is in school or training.	

☐ **Brother** ☐ **Sister**		
First name	Middle initial	Last name
Social Security number (optional)	**Birth date** (optional)	**Does this person have a job?** ☐ **Yes** ☐ **No**
If this person has a job, give employer's name and address:	**Gross amount paid** (before taxes are taken out) $	**How often paid?** (once a week, twice a month, etc.)
If age 18 to 21: **Is this person in school or training for a job?** ☐ **Yes** ☐ **No**	**If yes, when will this person finish?** You will need to send proof that this person is in school or training.	

☐ **Brother** ☐ **Sister**		
First name	Middle initial	Last name
Social Security number (optional)	**Birth date** (optional)	**Does this person have a job?** ☐ **Yes** ☐ **No**
If this person has a job, give employer's name and address:	**Gross amount paid** (before taxes are taken out) $	**How often paid?** (once a week, twice a month, etc.)
If age 18 to 21: **Is this person in school or training for a job?** ☐ **Yes** ☐ **No**	**If yes, when will this person finish?** You will need to send proof that this person is in school or training.	

☐ **Brother** ☐ **Sister**		
First name	Middle initial	Last name
Social Security number (optional)	**Birth date** (optional)	**Does this person have a job?** ☐ **Yes** ☐ **No**
If this person has a job, give employer's name and address:	**Gross amount paid** (before taxes are taken out) $	**How often paid?** (once a week, twice a month, etc.)
If age 18 to 21: **Is this person in school or training for a job?** ☐ **Yes** ☐ **No**	**If yes, when will this person finish?** You will need to send proof that this person is in school or training.	

4. Other health insurance

The following question is about health coverage **other than** Medicaid, Medicare, or your job's insurance:

Does anyone pay now, or has anyone paid in the past year, for health coverage for the child applying for benefits? ☐ **Yes** ☐ **No**

If yes, tell us the following:

Name of insurance company	**Policy number**	
Address of insurance company	**Coverage start date**	**Coverage end date**

5. Medical Bills

Medicaid sometimes can pay for medical services you got 3 months before you applied.

Does the child applying for benefits have medical bills for services they got in the past 3 months?..... ☐ **Yes** ☐ **No**

If yes, send:
(1) Copies of medical bills from the past 3 months.

(2) Proof of money you got (income) from the past 3 months.

6. Money not from a job

Tell us about any other types of money you get. If you need more room, add more pages.
Attach proof of the money you get (award letters or earning statements). We might not count some of the money you get.

	Money the child applying for benefits gets:		**Money the parents, and brothers and sisters age 21 or younger, who live with the child get:**		
Type of money	**Monthly amount** (before taxes are taken out)	**Who pays the money?**	**Monthly amount** (before taxes are taken out)	**Who pays the money?**	**Who gets the money?**
Social Security	$		$		
Veterans benefits	$		$		
Railroad retirement	$		$		
Civil service	$		$		
Pension	$		$		
Annuity	$		$		
Interest	$		$		
Farm income	$		$		
Mineral / Royalty	$		$		
Gifts	$		$		
Other income not from a job	$		$		

7. Authorized representative

An authorized representative can act for the person applying for benefits by:

- Giving and getting facts related to the application.
- Taking any action needed to complete the application process. This includes appealing an HHSC decision.
- Taking any action related to getting benefits. This includes reporting changes.

If the child applying for benefits has an authorized representative, tell us about that person:

Name of authorized representative
Mailing address
Phone ( )

8. Signing up to vote

The following is for anyone age 17 years and 10 months or older:

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, P.O. Box 12060, Austin, TX 78711. Telephone: 1-800-252-8683

Agency Use Only: Voter Registration Status

☐ Already registered ☐ Client declined ☐ Agency transmitted
☐ Client to mail ☐ Mailed to client ☐ Other

Signature–Agency Staff

9. Legal information

Discrimination

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 by:

- **E-mail** – HHSCivilRightsOffice@hhsc.state.tx.us.
- **Mail** – HHSC Civil Rights Office, 701 W. 51st St., Suite 104, MC W-206, Austin, TX 78751.
- **Phone (toll-free)** – 1-888-388-6332 or 1-877-432-7232 (TTY). **Fax** – 1-512-438-5885.

You also can contact the U.S. Department of Health and Human Services (HHS).

- **Mail –** HHS, Office for Civil Rights - Region VI, 1301 Young St., Room 1169, Dallas, TX 75202.
- **Phone** – 1-800-368-1019 (toll-free) or 1-214-767-8940 (TTY). **Fax** – 1-214-767-4032.

Social Security Numbers

You only need to give the Social Security numbers (SSN) for people who want 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. 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.

We will not give your SSN to the Bureau of Citizenship and Immigration Services. 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. You won't have to give SSNs for any family members who are not eligible because of immigration status and who are not asking for benefits. (42 C.F.R. 435.910)

10. Statement of understanding

Facts HHSC Has About You

In most cases, you can see and get facts HHSC has about you. This includes facts you give HHSC and facts HHSC gets from other sources (medical records, employment records, etc.). You might have to pay to get a copy of these facts. You can ask HHSC to fix anything that is wrong. You do not have to pay to fix a mistake. To ask for a copy or to fix a mistake, you can call 2-1-1 or your local HHSC benefits office.

- I have been advised and understand that this application or redetermination will be considered without regard to race, color, religion, creed, national origin, age, sex, disability or political belief.
- I have been advised and understand that I may request a review of the decision made on my application or redetermination for benefits and may request a fair hearing, orally or in writing, concerning any action or inaction affecting receipt or termination of assistance.
- If my case is selected for review, I give my consent for HHSC to obtain information from any source to verify the statements I have made.
- I understand that HHSC may give my name, address and phone number to telephone and electric utility companies to help them determine if I qualify for a reduction in my bills.

11. Penalty statement

- My answers to all of the questions, and the statements I have made, are true and correct to the best of my knowledge and belief.
- I understand that if I obtain or assist another person in obtaining, medical assistance by fraudulent means, I may be charged with a state or federal offense; and I may also be held liable for any repayment of benefits fraudulently obtained.
- I will let HHSC know within 10 days of any changes that could affect my eligibility. This includes changes in income, living arrangement or insurance (including health insurance premiums).

12. Sign and date the form

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 here if you are applying for benefits. Or if you are the authorized representative. If the child applying for benefits is age 17 or younger, a parent must sign.

Date

If the person above signed with an "X" or other mark, we need the signature of 2 witnesses:

Sign here if you are a witness

Date

Sign here if you are a witness

Date