TEXAS Health and Human Services Commission

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

CHIP

CHIP offers health care for children, from birth to age 18, whose families earn too much to get Medicaid and can't afford private health insurance. To get CHIP, your financial assets must be limited in value. Assets can include cash, stocks, inventories, and real estate. You also must have income below limits based on the number of people in your family. CHIP enrollment fees and co-payments for doctor visits, prescriptions and other services are based on your family's income.

Children's Medicaid

Medicaid offers free health care for children, from birth to age 18, in families with low income. To get Medicaid, your financial assets must be limited in value and you must have income below certain limits. If your child can get Medicaid, you will not have to pay an enrollment fee or make co-payments for doctor visits, prescriptions or other services for that child.

CHIP perinatal coverage

CHIP perinatal coverage offers health care for unborn children of pregnant women who can't get Medicaid or other CHIP coverage because of their income or immigration status. For some pregnant women, CHIP perinatal coverage will not pay for the costs of labor with delivery. These women can add on Emergency Medicaid for these women. Before the baby's due date, we will send the pregnant woman Medicaid Form H3038 in the mail. The pregnant woman will need to have her doctor fill out Form H3038 after delivery.

Health Insurance Premium Payment (HIPP)

This program may pay the private health insurance costs for your family and not just for the family members who get Medicaid. The family will get services through the private health insurance plan. To learn more or to apply, call us toll-free at 1-800-440-0493 or write to the Texas Health and Human Services Commission, TMHP-HIPP, PO Box 201120; Austin, Texas 78720-1120.

Ways to Apply

If you want to apply for CHIP, Children's Medicaid, or CHIP perinatal coverage you can do one of the following:

- Apply online at www.chipmedicaid.org
- Call toll free 1-800-647-6558.
- Fill out the attached application and, along with the documents we need (see below), mail them to:
  HHSC
  P.O. Box 14200
  Midland, TX 79711-4200
- Fill out the attached application and, along with the documents we need (see below), fax them toll-free to 1-877-542-5951.

If you want to apply for these programs and other benefits such as SNAP food benefits, cash assistance, or Medicaid for an adult, you can do one of the following:

- Call 2-1-1 for information and to get the location of an HHSC benefit office.
- Visit www.yourtexasbenefits.com

Documents We Need

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

Income: We need proof of how much money each person living in your home is making. The proof must show what each person usually makes. The proof could be a copy of:

- Pay check stub from 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 a receipt for child care expenses, expenses to care for an adult with a disability, 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 CHIP perinatal coverage. 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 United States, to harm your permanent resident status, or to deport you. For each person applying, send a copy of **one** of these:

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

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

If you are pregnant and do not have a Social Security number or you are a non-citizen, you may still be approved for CHIP perinatal coverage. All statements given as proof must be signed and dated with the name, address, and phone number of each person giving the statement. If you send an original document and we can tell 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 coverage. We must first see if each person applying for benefits can be approved for Medicaid before we can see if they might be approved for CHIP. Federal law does not allow anyone who can be approved for Medicaid to enroll in CHIP or CHIP perinatal coverage.

To apply:

- Fill in, sign, and date the application. Make sure to fill in Social Security numbers for each person who is applying for benefits.
- Attach all of your proof of income, expenses and proof of citizenship or lawful permanent resident status for each person applying for benefits.
- Mail the finished application and documents of proof in the pre-paid printed envelope that came with the application.

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.
- State employees can only apply for the State Kids Insurance Program (SKIP). The SKIP application is available in the 'Insurance' section of the Employees Retirement System website at www.ers.state.tx.us.

1 Fill out the application using black or blue ink. If you are applying for your children we do not need your Social Security number. Each child applying for coverage must live in Texas.

2 Provide information for any pregnant woman applying for health care benefits for her unborn child.

Line (a)
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 (b)
We will need proof of U.S. citizenship or immigration status for each person who is applying for benefits. People who are lawful permanent residents may be approved for these health care benefit programs.

If you are a non-citizen you may still qualify for CHIP perinatal coverage.

Line (c)
Mark the box "yes" if the pregnant family member is currently covered by private health insurance and write in 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 (d)
List the name and address of the father of the unborn child.

3 If you are **only** applying for CHIP perinatal coverage, 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 another 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)
Tell us how each child living in your home is related to you. 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 applying for CHIP or Children's Medicaid. Children who are lawful permanent residents may be approved for these health care benefit programs.

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 coverage, **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. Write in the name of the insurance company, name of the policy holder and the policy group number. If the health insurance is ending write in the date it will end in the space provided.

Mark the box "No" if the child is not covered 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 covered 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 be approved for Children's Medicaid or CHIP. We ask this because if your child is eligible for Children's Medicaid, you may be able to get financial help for the child's private insurance premium.

5 The following questions do not affect your ability to get benefits. Your answers will be used to better coordinate your family's health care needs.

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 from jobs, Social Security (retirement, survivor, and disability), child support, alimony, and Temporary Assistance for Needy Families (TANF). You must send proof for each source of income. If you are not the parent or step-parent of any of the children, do not provide your income information.

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

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

We may take out the amount of these dependent care expenses, child support, or alimony when deciding if your children can get Medicaid. We may also take out the childcare expenses when deciding if your children can get CHIP or CHIP perinatal coverage.

We will accept copies of cancelled checks and/or a statement from the Office of the Attorney General if the child support is paid through that office. You can send us receipts from the childcare center, company providing disabled care or cancelled checks.

9 If you are **only** applying for CHIP perinatal coverage, **skip** this section. Otherwise, you must fill out this section. If you are the child's parent or stepparent, answer these questions about the assets of the family members who live in your home. If you are not the child's parent or stepparent, your home and other property do not count as assets. Only give us information about the child or children's assets.

Line (a)
For the parents and 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 TANF 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 children living in the home, please write the make, model and year for each vehicle your family has registered in their names or is buying. Please write "NA" in the table if your family does not have a vehicle 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 ask you for more information about your vehicles.

10 If the child applying for benefits has unpaid medical bills during the last three months, Medicaid MAY be able to pay those bills. Mark the box "Yes" if the child applying for benefits has unpaid medical bills from the last three months. Send copies of the unpaid medical bills. Make sure each bill shows the date of service. Also, send proof of each source income for every family member in your home for each of the past three months. If you mark the box "Yes" and the child who is applying can get Medicaid, we will contact you for more information.

11 If you would like for someone besides yourself and any parent or stepparent, listed in Section 1 or 4 to contact us as your representative, write in their information. You must name a person 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 (HHSC) 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 and expenses and proof of your children's citizenship or lawful 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. We cannot work on your application and your children cannot get health care coverage without your signature. Mail your application and documents using the pre-paid envelope. If you do not have this envelope, address your own envelope and mail the application and documents to:

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

Or, fax the application and documents 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

Fax toll free 1-877-542-5951

1

Use black or blue ink only.

Your Name _____ (First) (Middle Initial (M.I.)) (Last) Case No.

Your Social Security Number* _____ Your Date of Birth (mo/day/year) _____

Home Address _____ Apt/Lot # _____

City _____ State _____ Zip Code _____ County _____

Email _____

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

City _____ State _____ Zip Code _____ County _____

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

Cell Phone # ( ) _____

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

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

2

Is anyone in your household pregnant? ☐ 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 lawful 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 lawful permanent resident?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Children who are lawful permanent residents may be able to get these health care programs. See section 3g of the instructions.				
h. Child's Social Security number				
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)				

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

	Child 1	**Child 2**	**Child 3**	**Child 4**
a. Right now, does the child have health insurance other than CHIP or Medicaid?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If "YES," please fill in the following information for each child insured:				
Insurance Company Name:	____	____	____	____
Name of Employer:	____	____	____	____
Name of Policy Holder:	____	____	____	____
Policy Number:	____	____	____	____
Group Number:	____	____	____	____
Policy Begin Date:	____	____	____	____
Insurance Company Phone Number:	____	____	____	____
Date the health coverage will end (Month/Day/Year).	___ / ___ / ___	___ / ___ / ___	___ / ___ / ___	___ / ___ / ___
If "NO," but the child had health insurance in the past 90 days, please mark the box that says why the insurance was dropped and the date the insurance ended.	☐ Parent's job ended due to layoff or business closing ☐ Medicaid coverage ended ☐ Parent's COBRA or ERS coverage ended ☐ CHIP coverage from another state ended ☐ Change in parent's marital status ☐ Private health coverage ended ☐ Other	☐ Parent's job ended due to layoff or business closing ☐ Medicaid coverage ended ☐ Parent's COBRA or ERS coverage ended ☐ CHIP coverage from another state ended ☐ Change in parent's marital status ☐ Private health coverage ended ☐ Other	☐ Parent's job ended due to layoff or business closing ☐ Medicaid coverage ended ☐ Parent's COBRA or ERS coverage ended ☐ CHIP coverage from another state ended ☐ Change in parent's marital status ☐ Private health coverage ended ☐ Other	☐ Parent's job ended due to layoff or business closing ☐ Medicaid coverage ended ☐ Parent's COBRA or ERS coverage ended ☐ CHIP coverage from another state ended ☐ Change in parent's marital status ☐ Private health 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. Write in the amount of money you are paying each month for health insurance or write in what you have paid for health insurance in the last 90 days. **Total Amount $**__________/month

5 **The following questions do not affect your ability to get benefits. Your answers will be used to better coordinate your family's health care needs.**

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 applying for medical assistance travel with a parent or family member who works as a migrant farm worker? .... ☐ Yes ☐ No

5. Are you or your spouse an active duty member of the United States Armed Forces, Reserves, National Guard or state military? .... ☐ Yes ☐ No

   If **"YES,"** provide the name of that person: ____________________

6 List all the parents and stepparents **WHO LIVE WITH THE CHILDREN,** including those who are already listed on this application.

First Name	Middle Initial	Last Name	Relationship to Child
			☐ Parent ☐ Stepparent
			☐ Parent ☐ Stepparent
			☐ Parent ☐ Stepparent
			☐ Parent ☐ Stepparent

7 HOUSEHOLD INCOME

Please list the current income of the parents, stepparents, 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 you received in the last 60 days showing the amount paid before any deductions (gross income) or a letter from an employer. Proof can also include a cash assistance receipt, your most recent Social Security statement, or a child support check stub or receipt. If you are self-employed proof can be your most recent IRS tax return including Schedule C or Schedule C-EZ. If a person you list does not have any income, write $0. Note: If you send us the Schedule C-EZ also send documents that prove the business deductions you claimed on that form so we can use those same deductions when we look at your income for CHIP.

Name of the person who has income First Middle Initial Last	This is the employer's name or source of the income	How Often?	How Much?
		☐ 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

Write how much you pay for:

- **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?**	**Name of Person Who Receives Care/Support**	**How often do you pay?***	**How much do you pay each time?**	**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, if you are the child's parent or stepparent, answer the following questions about the assets of the family members who live in your home. Assets are things you own. If you are not the child's parent or stepparent, your home and other property do not count as assets. Only fill out information about the child or children's assets.

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 we cannot work on your application.

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. Do not list vehicles that are leased.

MAKE	MODEL	YEAR
Nissan	Sentra	1995

10 **OTHER INFORMATION** If the child applying for benefits has unpaid medical bills during the last three months, Medicaid MAY be able to pay those bills. Mark the box "Yes" if the child applying for benefits has unpaid medical bills from the last three months. Send copies of the unpaid medical bills. Make sure each bill shows the date of service. Also, send proof of each income for every family member in your home for each of the past three months. If you mark the box "Yes" and the child who is applying can get Medicaid, we will contact you for more information.

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

If "YES," list the name of the child.	If "YES," list the month of the bills.

Did anyone help you fill out this application? ☐ Yes ☐ No Helper's Name (Optional) _____

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 www.oag.state.tx.us/child/mainchil.htm. Click the Child Support tab under the banner at the top of the page.

11 **VOLUNTARY: AUTHORIZED REPRESENTATIVE** As the applicant or a person with legal authority to act for the applicant, I authorize the person listed in this section to represent the applicant who is applying for benefits in providing and receiving information in connection with the application, and in taking any other action to complete the application process (including any appeal). If the applicant is found eligible I further authorize the following person to continue to represent the applicant in relation to the receipt of benefits, including reporting changes.

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 the application, signed it and dated it, mail the application and your documents of proof. Please make sure you have included:

- ❑ Proof of your family's current income (Proof may include a copy of a pay check stub you received in the last 60 days showing the amount paid before any deductions (gross income) or a letter from an employer. Proof can also include a cash assistance receipt, your most recent Social Security statement, or a child support check stub or receipt. If you are self-employed proof can be your most recent IRS tax return including Schedule C.)
- ❑ 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)**