HAMILTON HEALTHCARE SYSTEM

Hamilton Healthcare System has contracted with Cadre Health, to assist you in applying for medical assistance to pay for your medical bills, co-pays or deductible.

1.) **Please answer the 7 questions below.**
2.) **Sign the two forms from Medicaid to help assist with Medicaid program.**
3.) **If you qualify for Medicaid or the County Indigent Program a representative will be contacting, you within 24-48hours.**

*Hamilton Financial Assistance Program A, B, or C and Indigent is the last resort, you must be screened by Cadre Health, before being assisted on any Hospital programs.

Who can qualify?

To qualify, a child must be:

- Age 18 or younger (Children up to age 20 may be able to get Medicaid in some cases).
- A pregnant woman of any age can apply for CHIP perinatal services or Medicaid for her unborn child.
- A Texas resident.
- A U.S. citizen or legal permanent resident.

Who can apply?

- Any adult who lives more than half the time with an uninsured child may apply. This includes parents, stepparents, grandparents, other relatives, legal guardians, or adult brothers or sisters.
- Anyone age 19 or younger who lives on their own can apply.
- A pregnant woman of any age.

Family members (adults plus children)	MEDICAID		CHIP	
	Monthly family income*	Yearly family income*	Monthly family income*	Yearly family income*
1**	$1,415	$16,971	$2,138	$25,648
2	$1,931	$23,169	$2,918	$35,015
3	$2,408	$28,888	$3,639	$43,658
4	$2,904	$34,846	$4,389	$52,662
5	$3,401	$40,805	$5,139	$61,667
6	$3,897	$46,763	$5,890	$70,672
7	$4,394	$52,722	$6,640	$79,677
8	$4,890	$58,680	$7,391	$88,682

The following questions will help us determine if you qualify for Medicaid and any other assistance programs that may help you with your medical bills and other expenses. Please answer all questions.

Full Legal Name: _____ **Date: _____**

Date of Birth: _____ **Best Contact Number: _____**

*** 1. Assigned Sex at birth?**

- ○ **Male**
- ○ **Female**

*** 2. Marital Status**

- ○ **Single**
- ○ **Married**
- ○ **Divorced**
- ○ **Separated**

*** 3. Are you registered Native American or Alaskan Native?**

- ○ **Yes**
- ○ **No**

*** 4. Are you a veteran?**

- ○ **Yes**
- ○ **No**

*** 5. Do you have any dependent children under the age of 19 who reside in the home with you full-time?**

- ○ **1**
- ○ **2**
- ○ **3**
- ○ **4**
- ○ **5 or more**

*** 6. How many people are in your home?**

- ○ **1**
- ○ **2**
- ○ **3**
- ○ **4**
- ○ **5 or more**

*** 7. What is your monthly income?**

$_____

Agency Use Only: Voter Registration Status

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

Agency staff signature: _____

STEP 5 Read & sign this application

- I'm signing this application under penalty of perjury which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false or untrue information.
- I know that I must tell the Texas Health and Human Services Commission (HHSC) if anything changes (and is different than) what I wrote on this application. To report changes, I can go to YourTexasBenefits.com or call 2-1-1 or 1-877-541-7905. I understand that a change in my information could affect the eligibility for member(s) of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.
- I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed). If not,

_____ is incarcerated.

(name of person)

We need this information to check your eligibility for help paying for health coverage if you choose to apply. We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof.

Renewal of coverage in future years

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the agency to use income data, including information from tax returns. The agency will send me a notice, let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next

☐ 5 years (the maximum number of years allowed), or for a shorter number of years:

☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year ☐ Don't use information from tax returns to renew my coverage

If anyone on this application is eligible for Medicaid

- I am giving to HHSC the rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving to HHSC rights to pursue and get medical support.
- Does any child on this application have a parent living outside of the home? ☐ Yes ☐ No
- If yes, I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell HHSC and I may not have to cooperate.

Important Information for Former Military Service Members

Women and men who served in any branch of the United States Armed Forces, including Army, Navy, Marines, Air Force, Coast Guard, Reserves or National Guard may be eligible for additional benefits and services.
For more information, please visit the Texas Veterans Portal at https://veterans.portal.texas.gov.

My right to appeal

If I think HHSC has made a mistake, I can appeal its decision. To appeal means to tell someone at HHSC that I think the action is wrong and ask for a fair review of the action. I know that I can find out how to appeal by contacting HHSC at 2-1-1 or 1-877-541-7905 (after you pick a language, press 2). I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

Sign this application

The person who filled out Step 1 should sign this application. If you're an authorized representative you may sign here, as long as you have provided the information required in Appendix C.

Signature	Date (mm/dd/yyyy)

STEP 6 Mail or fax your filled out and signed application

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

Mail: HHSC
PO Box 149024
Austin, TX 78714-9968

Form H1205
Dec 2018

NEED HELP WITH YOUR APPLICATION? We can help you at no cost to you. Call us at 2-1-1 or 1-877-541-7905 (after you pick a language, press 2). If you have a hearing or speech disability, call 7-1-1 or any relay service.

CREASE AND TEAR AT PERFORATION

TEXAS
Health and Human Services

Form 6700
August 2017-E

Use and Release of Health Information Authorization

Section I

Name: _____ Date of Birth: _____

Medicaid ID No. (*if known*): _____ **OR** SS No.: _____

By signing this authorization form, you are giving Texas Health and Human Services (HHS) permission to release all or part of your Medicaid claims history, which includes health information.

Section II – To be completed by client

I authorize HHS to release the information indicated at the bottom of Part A to the person or agency named in Part A, for the purpose(s) stated in Part B. My information will remain available to the person or agency indicated until the expiration date stated in Part B.

Part A – Release of information: I understand that my Medicaid claims history contains protected health information.

Check one of the following:

- ☐ Release **all** of my Medicaid claims history
- ☐ Release **only** the claims related to the accident and/or injury
- ☐ Release **only** the parts of my Medicaid claims history that relate to:
  - the following health care provider: _____
  - other (please describe in detail the health information you authorize HHSC to release):

_____

Release my information to the following Person/Agency: _____

Part B – Purpose(s) of Release: _____

This release expires six months following the final disposition of the claim or upon disposition of Medicaid funds.

Part C – Signature: _____ Date: _____

(Client or Personal Representative's Signature)

If you are signing for the client, please describe your authority to act for the client on the following line:

_____

Note: *If the person requesting the release of my Medicaid claims history cannot sign his/her name, a witness to his/her mark (X) must sign below:*

Witness: _____ Date: _____

Section III: Notices to Client

- Once you authorize HHS to release your information, HHS is not responsible for any redisclosure of the information by the recipient.
- You can withdraw permission you have given HHSC to use or disclose health information that identifies you, unless HHSC has already taken action based on your permission. You must withdraw your permission in writing.
- With a few exceptions, you have the right to request and be informed about the information that the HHS releases. You are entitled to receive and review the information upon request. You also have the right to ask HHS to correct information that is determined to be incorrect (Government Code, Sections 552.021, 552.023, 559.004). If you would like HHSC to correct information about you that is incorrect, please contact the HHSC Privacy Office at 4900 N. Lamar Blvd., 4th Floor, Austin, Texas 78751.