TEXAS Health and Human Services Commission

Getting started:
Applying for children's health-care benefits

CHIP and Children's Medicaid

These programs offer health-care benefits for newborns and children age 18 and younger who live in Texas. With these programs, your child can get a wide range of services, including:

- Regular checkups
- Prescription drugs
- Dental care
- Eye exam and glasses
- Hospital care
- X-rays and lab tests

After you fill out this form, we will find out if your child can get CHIP or Children's Medicaid. We must first find out if each person applying for benefits can get Medicaid. If a person applying can't get Medicaid, we then find out if they can get CHIP.

If your child gets CHIP benefits, you might have to pay a yearly fee. You also might have co-pays for some services. Costs for CHIP depend on: (a) the amount of money a family makes, and (b) the number of people in the family.

CHIP for the unborn child (perinatal)

CHIP offers health-care benefits related to pregnancy. This is for pregnant women who can't get Medicaid or other CHIP benefits because: (a) of their immigration status, or (b) they make too much money. There are no fees or co-pays for these benefits.

How to apply

1. Fill out a form.

You can use this form or you can apply online or by phone.

Online: www.CHIPmedicaid.org

Phone: Call 1-877-543-7669 (1-877-KIDS-NOW).
If you have a hearing or speech disability, call 7-1-1 or any relay service.

2. Gather the items we need.

You will need to mail or fax us copies of items that apply to your case.
See the next page for a list of these items.

3. Sign and date the form.

We can't work on your case until you sign and date the form.

4. Send us the form you filled out and the items we need.

Mail: Use the pre-paid envelope that came with this form. Or mail it to:
HHSC, PO Box 14200, Midland, TX, 79711-4200

Fax: 1-877-542-5951

If you apply online, by phone, or by fax, you don't need to mail us this form.

Just mail or fax us the **items we need**.

All phone and fax numbers on this form are free to call.

Items we need

Send copies of these items. We only need items that apply to your case.

We need these 3 bulleted items for: (a) the children applying for benefits (not for their parents) and (b) for pregnant women who are U.S. citizens or legal immigrants applying for benefits related to the pregnancy.

- **Social Security number –** Social Security numbers (SSN) for each person applying for benefits. If a child doesn't have a SSN, send proof that you applied for one (Form SSA 2853 or Form SSA 5028). If you need help applying for an SSN or need proof that you applied for an SSN, call 1-800-772-1213.
- **Citizenship –** U.S. passport, Certificate of Naturalization, U.S. birth certificate, hospital record of birth (copies of the front and back), or Medicare card. If the person applying was born in Texas, we might be able to look up their birth record.
- **Immigration status –** Resident card (I-551), arrival/departure form (I-94), or papers from the U.S. Citizenship and Immigration Services. We need copies of the front and back of these forms.

Proof showing money coming into the home (income):

- **Proof of money from a job –** Pay check stub from the past 60 days showing the amount paid before taxes or deductions (gross pay), last tax return, or a statement signed and dated by the employer and showing the employer's name, address, and phone number. Your proof should show the amount you usually get paid.
- **Proof you work for yourself** (self-employment) **–** Last tax return or self-employment records.
- **Child support you get –** Child support check stub or receipt.
- **Social Security, Supplementary Security Income (SSI),** or **pension benefits –** Award letter or pay stub.
- **Veterans' benefits, workers' compensation,** or **unemployment –** Award letter or a pay stub.

Proof showing costs to take care of others (expenses):

- **Child support you pay –** Court papers that show what you must pay for child support (for example: divorce decree, court order, or district clerk record). Canceled checks or a statement from the Office of the Attorney General.
- **Child care or other costs you pay to take care of others –** Receipts, canceled checks, or a signed statement from the person you pay. A signed statement must show when and how much you pay.
- **Alimony you pay –** Copy of a canceled check or a signed and dated letter from the person you pay.

Other state benefit programs

SNAP food benefits, cash help for families (TANF), or Medicaid for adults

If you want to apply for these benefits you can:

- Visit www.YourTexasBenefits.com
- Call 2-1-1 or 1-877-541-7905. You can ask questions about benefits. You can find an HHSC benefits office near you.

Health Insurance Premium Payment program (HIPP)

If someone in your family can get health insurance through work and a family member gets Medicaid, call us at 1-800-440-0493. We might be able to pay the premiums for all family members. All family members might get health services through the private health insurance plan.

TEXAS Health and Human Services Commission

Form to apply:
CHIP, Children's Medicaid, and CHIP perinatal

Fill out and sign this form. Fax it to 1-877-542-5951
or mail it to HHSC, PO Box 14200, Midland, TX, 79711-4200.

Use black or blue ink only.

1 People who can fill out this form

- An adult age 18 or older who: (a) lives with and is in charge of the child applying for benefits, (b) lives with the pregnant woman applying for benefits for her unborn child, or (c) is pregnant.
- Anyone age 19 or younger who lives on their own.

Tell us about yourself (the person filling out this form)

Your Name _____ (First / Middle / Last) Case number (if you know it)

Have you ever applied for CHIP or Medicaid using another name? This can include using a maiden name or nickname. ☐Yes ☐No If yes, write the other name: _____ (First / Middle / Last)

Your Social Security number (if you have one) ___ – ___ – ___ Your date of birth (mm/dd/yyyy) ___ / ___ / ___

Home address _____ Apt. / Lot _____

City _____ State _____ ZIP _____ County _____

Do you live in Texas?..... ☐Yes ☐No Do you plan to stay in Texas?..... ☐Yes ☐No

Mailing address (if different) _____ Apt. / Lot _____

City _____ State _____ ZIP _____ County _____

Home phone _____ Other phone _____

Cell phone _____

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

Want to get case updates by email?... ☐Yes ☐No If yes, write your email address _____

2 Pregnant woman

Are you applying for benefits related to a pregnancy? ..... ☐Yes ☐No

If yes, tell us about the pregnant woman by filling out this section. If you are applying for more than one pregnant woman in your home, add more pages with the same facts.

A.

_____ / / – – (First name / Middle / Last / Date of birth (mm/dd/yyyy) / Social Security number (if she has one))

_____ / / (Pregnant woman's mother's maiden name / Due date (mm/dd/yyyy) / Number of babies expected / How is the pregnant woman related to you?)

B. Is this pregnant woman a U.S. citizen? ..... ☐Yes ☐No

If no, is she a legal immigrant? (If no, she might still be able to get benefits.) ..... ☐Yes ☐No

C. Does the pregnant woman have health insurance other than Medicaid or CHIP?..... ☐Yes ☐No

If yes, when does her health insurance coverage end? (If the coverage isn't ending, write "N.A.") ___ / ___ (Month / Year)

D. Tell us about the father of the unborn child:

_____ (First name / Middle / Last / Phone number / Relationship to pregnant woman)

_____ (Address / City / State / ZIP)

3 Parents and stepparents living with the children

List the parents and stepparents who live with the children. List them here even if they are listed somewhere else in this form.

First name Middle Last	Date of birth (mm/dd/yyyy)	Social Security number (SSN) Needed only for people applying for benefits.	Relationship to you

4 Children

If you are applying for benefits related to a pregnancy and there are no other children in the home, **skip this section**. Tell us about all children age 18 or younger living in your home even if: (a) they already get benefits, or (b) they don't want benefits.
If you have more than 4 children, add more pages with the same facts.
Note: Send proof showing citizenship or immigration status for children applying for benefits.

	Child 1	Child 2	Child 3	Child 4
A. Child's first name and middle name				
B. Child's last name				
C. Check one box for each child	☐ Applying for benefits. ☐ Not applying for benefits.	☐ Applying for benefits. ☐ Not applying for benefits.	☐ Applying for benefits. ☐ Not applying for benefits.	☐ Applying for benefits. ☐ Not applying for benefits.
D. Right now is the child covered by Medicaid or CHIP?	☐ Yes ☐ No If yes, in what state? ____	☐ Yes ☐ No If yes, in what state? ____	☐ Yes ☐ No If yes, in what state? ____	☐ Yes ☐ No If yes, in what state? ____
E. How is this child related to you? (Examples: daughter, son, grandchild, 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."				
F. Child's date of birth (mm/dd/yyyy)	/ /	/ /	/ /	/ /
G. Child's Social Security number	– –	– –	– –	– –
H. Child's gender	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
I. Is the child a U.S. citizen?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If no, is the child a legal immigrant? Children who are legal immigrants might be able to get CHIP or Medicaid.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If the child is a legal immigrant, what is the child's immigrant registration number?				
J. Child's mother's first name and middle initial				
K. Child's mother's maiden name				
L. Child's mother's last name				
M. Child's father's first name and middle initial				
N. Child's father's last name				
O. Is this child going to school this school year?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
P. Child's race (optional)				

5 Other health insurance

If you are applying for benefits related to a pregnancy and there are no other children in the home, **skip this section.**

	Child 1	Child 2	Child 3	Child 4
Does the child have health insurance other than CHIP or Medicaid?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Mark "No" if the child is only covered by worker's compensation, auto, accident or sports-related insurance, or Children with Special Health Care Needs coverage.	If yes, go to section A below. If no, go to section B below.			
A. Fill out this section if the child gets health insurance other than CHIP or Medicaid.				
Insurance company				
Name of employer				
Name of policy holder				
Policy number				
Group number				
Coverage start date (mm/dd/yyyy)	/ /	/ /	/ /	/ /
Insurance company phone number				
Date coverage ends (mm/dd/yyyy) If coverage is not ending, write "N/A"	/ /	/ /	/ /	/ /
B. Fill out this section if the child had health insurance in the past 3 months. Mark the box that says why the insurance ended.	☐ Parent's job ended due to layoff or business closing.	☐ Parent's job ended due to layoff or business closing.	☐ Parent's job ended due to layoff or business closing.	☐ Parent's job ended due to layoff or business closing.
	☐ Medicaid benefits ended.	☐ Medicaid benefits ended.	☐ Medicaid benefits ended.	☐ Medicaid benefits ended.
	☐ Parent's COBRA coverage ended.	☐ Parent's COBRA coverage ended.	☐ Parent's COBRA coverage ended.	☐ Parent's COBRA coverage ended.
	☐ CHIP benefits from another state ended.	☐ CHIP benefits from another state ended.	☐ CHIP benefits from another state ended.	☐ CHIP benefits from another state ended.
	☐ Change in parent's marital status.	☐ Change in parent's marital status.	☐ Change in parent's marital status.	☐ Change in parent's marital status.
	☐ Private health coverage ended.	☐ Private health coverage ended.	☐ Private health coverage ended.	☐ Private health coverage ended.
	☐ Other _____	☐ Other _____	☐ Other _____	☐ Other _____
Date coverage ended (mm/dd/yyyy)	/ /	/ /	/ /	/ /
C. Does this child have a parent whose job offers health insurance?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No

D. How much have you paid each month for health insurance? **Total amount each month $** _____

6 Help us serve you better

These questions will not be used to decide if your family can get benefits.

1. Is anyone in your home a member of a federally recognized Indian tribe? ☐Yes ☐No
   If yes, who: _____
2. Is anyone in your home an American Indian or a Native Alaskan? ☐Yes ☐No
   If yes, who: _____
3. Is anyone an unaccompanied refugee minor? This means a person is: (a) not living with a relative, (b) age 18 or younger, and (c) a refugee. ☐Yes ☐No
   If yes, who: _____
4. Is a child in your home in the Children with Special Health Care Needs program? ☐Yes ☐No
   If yes, who: _____
5. Does a child applying for benefits travel with a family member who is a migrant farm worker? ☐Yes ☐No
6. Are you or your spouse an active duty member of one of these military forces?
   • U.S. armed forces • Reserves • National Guard • State military forces ☐Yes ☐No
   If yes, who: _____

7 Money coming into the home (income)

Tell us about any type of money that parents, stepparents, and children living in your home get, such as:

• Money from jobs • Social Security (retirement, survivor and disability) • Child support • Alimony • Other

If you get any of these types of money, you need to send proof. Types of proof you can send are listed in the "Getting started - Items we need" section. If no one in your home gets money, write $0. If you do not enter an amount, it will cause a delay.

Name of person who gets money. If a child gets child support, list the child's name. First	Middle	Last	**Type of money.** For example, "Money from job."	**Name of person, company, or agency paying the money. Also give their address, phone number, or both.** If self-employed, write "Self."	**How often does this person get this money?**	**How much?** Amount you get before taxes and deductions are taken out.
					☐ Once a week ☐ Every 2 weeks ☐ Twice a month ☐ Once a month	$
					☐ Once a week ☐ Every 2 weeks ☐ Twice a month ☐ Once a month	$
					☐ Once a week ☐ Every 2 weeks ☐ Twice a month ☐ Once a month	$
					☐ Once a week ☐ Every 2 weeks ☐ Twice a month ☐ Once a month	$
					☐ Once a week ☐ Every 2 weeks ☐ Twice a month ☐ Once a month	$

8 Costs to take care of others

Tell us if anyone living with the child pays:

- Child care costs so someone in the home can: (a) work or (b) look for work.
- Care costs for a person with a disability so someone in the home can: (a) work or (b) look for work.
- Child support payments, medical bills, and health insurance that anyone in the home pays for a child outside the home.
- Alimony payments.

Type of cost. Child care, child support, alimony, disability care	**Who pays the cost?**	**Name of person who gets the care or support?**	**How often is the cost paid?**	**How much is paid each time?**	**Name, address, and phone number of the person you pay.**
			☐ Once a week ☐ Every 2 weeks ☐ Twice a month ☐ Once a month	$	
			☐ Once a week ☐ Every 2 weeks ☐ Twice a month ☐ Once a month	$	
			☐ Once a week ☐ Every 2 weeks ☐ Twice a month ☐ Once a month	$	
			☐ Once a week ☐ Every 2 weeks ☐ Twice a month ☐ Once a month	$	
			☐ Once a week ☐ Every 2 weeks ☐ Twice a month ☐ Once a month	$	

9 Things you own

If you are applying for benefits related to a pregnancy and there are no other children in the home, **skip this section**.

A. Tell us the value of items owned by the child and the child's parents and stepparents living in the home, such as:

• Money in bank accounts • Cash on hand • Bonds • Stocks • Certificates of deposit

If the child or child's parents or stepparents living in the home have these types of items, give facts below.

If no one has these types of items, write in $0. If you do not enter an amount, it will cause a delay.

Total value of all items: $ _____

B. Tell us about anyone in your family who is buying or owns a vehicle such as:
• Car • Truck • Sport utility vehicle (SUV) • Van • Motorcycle • Boat • Motor home
Don't list vehicles that are leased. If no one has a vehicle, write "None."

Make	Model	Year
Example: Ford	*F150*	*2005*

10 Unpaid medical bills from the past 3 months

If a child applying for benefits has unpaid medical bills, you might be able to get help paying them. The bills must be for services the child got in the past 3 months.

If you need help paying medical bills for a child, send:

- At least one unpaid medical bill for each month you list below.
- Proof of money (income) from each month you list below. Proof is needed for each parent, stepparent, and child who: (a) got money, (b) lived in the home, and (c) is related to a child applying for benefits.

Does a child applying for benefits have any unpaid medical bills from the past 3 months?..... ☐Yes ☐No

If yes, give facts below:

Name of the child.	Which months does the child have unpaid medical bills?

11 Person who has the right to act for you

If you want, you can give someone who isn't listed on this application the right to act for you. That person can be your authorized representative and, along with you, can:

- Give and get facts for this application form.
- Take any action needed for the application process. This includes appealing an HHSC decision.
- Take any action needed for you to get benefits. This includes reporting changes.

This person can't make decisions about your health plan. This person also can't ask for a child to be removed from the CHIP program.

Name _____
First Middle Last

Home address _____ Apt. / Lot _____

City _____ State _____ ZIP _____ County _____

Home phone _____ Other phone _____

12 Signing up to vote

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, PO Box 12060, Austin, TX 78711. Phone: 1-800-252-8683.

13 Legal information

Your right to be treated fairly

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 at HHSCivilRightsOffice@hhsc.state.tx.us or by:

Mail: HHSC Office of Civil Rights, 701 W. 51st St., MC W-206, Austin, TX 78751. Phone 1-888-388-6332. Fax (not toll-free): 1-512-438-5885

Social Security numbers

You only need to give the Social Security numbers (SSN) for people who want benefits. Your SSN is not needed if you are applying for your children only. Giving or applying for an SSN is voluntary; however, anyone who doesn't apply for an SSN or doesn't give an SSN cannot get benefits. If you do not have an SSN, we can help you apply for one if you are a U.S. citizen or a legal immigrant. You must be a U.S. citizen or a legal immigrant to get an SSN. You can get benefits for your children if they have an SSN and you do not. We will not give SSNs to the Bureau of Immigration and Customs Enforcement. 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. (7 C.F.R 273.6 for food benefits; 45 C.F.R 205.52 for TANF; and 42 C.F.R 435.910 for health care.)

Citizenship and immigration status

You can get benefits for your children who are U.S. citizens or legal immigrants even if you are not a U.S. citizen or a legal immigrant. You do not have to give your citizenship or immigration status to get benefits for your children. You only have to give the citizenship or immigration status of people who want benefits. If you are not a U.S. citizen or a legal immigrant, the only benefits you might be able to get are emergency Medicaid services. Getting long-term care (Medicaid for the Elderly and People with Disabilities) or cash help (TANF) could affect your immigration status and your chances of getting a Permanent Resident Card (green card). Getting other benefits will not affect your immigration status and/or your chances of getting a Permanent Resident Card. You might want to talk to an agency that helps residents with legal questions before you apply. If you are a refugee or have been given asylum, getting benefits will not affect your chances of getting a Permanent Resident Card or becoming a citizen.

14 Statement of understanding

Facts HHSC has about me

HHSC uses facts about people applying for benefits to decide:
(1) who can get benefits, and (2) the amount of benefits. HHSC checks facts with the federal Income and Eligibility Verification System. If any facts do not match, HHSC will check other sources (banks, employers, etc.). If anyone applying for benefits has an immigration registration number, HHSC must check with the U.S. Citizenship and Immigration Services' (USCIS) system. HHSC will not give anyone's facts to USCIS.

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

Keeping my facts private

HHSC will keep my facts private if they were collected:
- By HHSC staff or contracted provider staff.
- To find out if I can get state benefits.

HHSC can share facts about me:
- When needed for me to get state health care benefits.
- With phone and utility companies. They will find out if my bill amount can be lowered. HHSC will give them my name, address, and phone number.

Giving out facts about me

I agree to let Medicaid and CHIP health care providers (doctors, drug stores, hospitals, etc.) give out any facts about me to HHSC. This will allow the providers to be paid by Medicaid and CHIP.

If I give false information

If I choose not to tell the truth, I might:
- Be charged with a crime.
- Have to repay benefits.

The same is true if I let someone else use my medical card, Medicaid ID, or CHIP ID.

Medical and child support payments

Depending on my benefits case, the Attorney General (the state) might check that I am getting the right amount of child or medical support payments and coverage.
- If only my child gets Medicaid, I can decide if I want the state to help get any payments and coverage we should get, but do not get right now.
- If my child and I both get Medicaid, I must:
  - Help the state get any payments and coverage we should get, but do not right now. If I do not help the state, my child can get Medicaid, but I might not.
  - Identify who the child's other parent is.
  - Allow the state to keep any medical support payments.

If I get Medicaid, HHSC will keep medical service payments I can get from other sources, such as:
- My health insurance.
- Money I got because of injuries.
- Money collected for me or my children by the Office of Attorney General.

I must tell HHSC about these sources. If I do not, I am breaking the law.

HHSC will only keep the amount of medical support and service payments allowed by law. I will work with HHSC to get these funds.

15 People helping you

Did anyone help you fill out this form? ..... ☐ Yes ☐ No

Helper's name and organization (optional) _____

16 Signature

By signing below, I agree:
- To let HHSC and other state, federal, and local agencies check, share, and get facts about anyone on my benefits case (the household).
- To let other people, businesses, and organizations share facts they have about anyone on my benefits case (the household) with HHSC.
- The facts to be checked and shared include anything that helps decide: (1) who can get benefits, and (2) amount of benefits.

My answers are true: 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.

X

_____ _____

Signature (required) **Date** (mm/dd/yyyy) (required)

Before you send this form back to us, make sure to:

1. Answer every question that applies to your case.
2. Sign and date it.
3. Include the "Items we need" listed in the "Getting started" section.

Questions? Call 1-877-543-7669 (1-877-KIDS-NOW).

Agency Use Only: Voter Registration Status

☐ Already registered ☐ Client declined ☐ Agency transmitted ☐ Client to mail

☐ Mailed to client ☐ Other Agency staff signature: _____