Getting started:

Health care for children

**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 for benefits can’t get Medicaid, we 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-payments 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 perinatal benefits**

CHIP offers health-care benefits for unborn children of a pregnant woman. 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-payments 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 are deaf, hard of hearing, or speech impaired, 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. For example, if no one has a bank account, we do not need bank statements.

**Proof showing facts about people applying for benefits:**
We need these 3 items only for the children or pregnant woman applying for benefits, not their parents.

- **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** – Your proof of income should show us the amount you usually get paid. At least one pay stub from the past 60 days, self-employment records, or a signed statement from the employer. The statement must be dated and show the employer’s name, address, phone number, and signature.

- **Child support you get** – A letter from the past 60 days with the paying parent’s name, address, phone number, and signature.

- **Loans and gifts (includes someone paying bills for you)** – A statement from the past 60 days with that person’s name, address, phone number, and signature.

- **Social Security or pension benefits** – Award letter or pay stub from the past 60 days.

- **Veterans’ benefits, workers’ compensation, or unemployment** – Award letter or a pay stub from the past 60 days.

**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 from the past 60 days 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 from the past 60 days. 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 from the past 60 days.

**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:

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

**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.
Form to apply:
Children’s Health Insurance Program (CHIP)
Children’s Medicaid and CHIP perinatal

Ways you can apply:
• Go online at www.CHIPmedicaid.org
• Call 1-877-KIDS-NOW (1-877-543-7669)

If you are deaf, hard of hearing, or speech impaired, call 7-1-1, or any relay service.
• Fill out this form. Fax it to 1-877-542-5951. Or mail it to HHSC, PO Box 14200, Midland, TX, 79711-4200

People who can fill out this form
• An adult age 18 or older who:
  ○ Lives with the child applying for benefits,
  ○ Is in charge of that child’s care.
• Anyone age 19 or younger who lives on their own.
• A pregnant woman of any age applying for herself.

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

Your Name
First name Middle name Last name 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.

If yes, write the other name:
First name Middle name Last name

Your Social Security number Your date of birth (mm/dd/yyyy) / /

Home address Apt. / Lot
City State Zip County

Mailing address Apt. / Lot
City State Zip County

Home phone Other phone

If we need to call you, what language should we speak?

☐ English ☐ Spanish ☐ Vietnamese ☐ Other:

Do you want to get case updates by e-mail?

☐ Yes ☐ No If yes, write your e-mail address

Pregnant woman

Are you applying for benefits for a pregnant woman? ☐ 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 name Last name 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 Relationship to you / /

B. Is this pregnant woman a U.S. citizen?

☐ Yes ☐ No

If no, is she a legal immigrant?

☐ 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 "NA").

Month Year

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

First name Middle name Last name Phone number Relationship to pregnant woman

Address City State Zip

Use black or blue ink only.

H1014-03/31/2011
### 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.

<table>
<thead>
<tr>
<th>Name: First</th>
<th>Middle</th>
<th>Last</th>
<th>Date of birth (mm/dd/yyyy)</th>
<th>Social Security number (SSN)</th>
<th>Relationship to you</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Children

If you are a pregnant woman only applying for benefits for yourself 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.

<table>
<thead>
<tr>
<th>Child 1</th>
<th>Child 2</th>
<th>Child 3</th>
<th>Child 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Child’s first name and middle name</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Child’s last name</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Check one box for each child</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Applying for benefits.</td>
<td>Not applying for benefits.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. 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.”</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E. Child’s date of birth (mm/dd/yyyy)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F. Child’s Social Security number</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G. Child’s gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>H. Is the child a U.S. citizen?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>If no, is the child a legal immigrant? Children who are legal immigrants might be able to get CHIP or Medicaid.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>If the child is a legal immigrant, what is the child’s immigrant registration number?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I. Child’s mother’s first name and middle initial</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>J. Child’s mother’s maiden name</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>K. Child’s mother’s last name</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>L. Child’s father’s first name and middle initial</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M. Child’s father’s last name</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N. Does this child go to school?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>O. Child’s race (optional)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Child 1

- Applying for benefits.
- Not applying for benefits.

Child 2

- Applying for benefits.
- Not applying for benefits.

Child 3

- Applying for benefits.
- Not applying for benefits.

Child 4

- Applying for benefits.
- Not applying for benefits.
**Other health insurance**

If you are a pregnant woman only applying for benefits for yourself and there are no other children in the home, **skip this section.**

If right now is the child covered by Medicaid or CHIP?

- Yes
- No

If yes, in what state?

- [ ] Yes
- [ ] No

Does the child have health insurance other than CHIP or Medicaid?

- 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.

- Yes
- No

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.
- Medicaid benefits ended.
- Parent's COBRA or ERS coverage ended.
- CHIP benefits from another state ended.
- Change in parent's marital status.
- Private health coverage ended.
- Other

If coverage is not ending, write “N/A”

- Date coverage ended (mm/dd/yyyy)

**C.** Does this child have a parent whose job offers health insurance?

<table>
<thead>
<tr>
<th>Child 1</th>
<th>Child 2</th>
<th>Child 3</th>
<th>Child 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes</td>
<td>☐ Yes</td>
<td>☐ Yes</td>
<td>☐ Yes</td>
</tr>
<tr>
<td>☐ No</td>
<td>☐ No</td>
<td>☐ No</td>
<td>☐ No</td>
</tr>
</tbody>
</table>

If “Yes,” list their name:

**D.** How much have you paid each month for health insurance?

Total amount each month $ __________ / month

---

**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,” list their name:

2. Is anyone in your home an American Indian or a Native Alaskan? ............................................................... ☐ Yes ☐ No

If “Yes,” list their name:

3. Is anyone in your home a refugee age 17 or younger who doesn’t have parents or a legal guardian? ....... ☐ Yes ☐ No

If “Yes,” list their name:

4. Is a child in your home in the Children with Special Health Care Needs program? ........................................... ☐ Yes ☐ No

If “Yes,” list their name:

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,” list that person’s name:  

---

H1014-03/31/2011
### Money coming into the home

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 have any of these items, 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.

<table>
<thead>
<tr>
<th>Name of person who gets money. (If a child gets child support, list the child’s name.)</th>
<th>Type of money (For example, “Money from job.”)</th>
<th>Give name of person, company, or agency paying the money. Also give their address, phone number, or both. (If this person is self-employed, write “Self.”)</th>
<th>How often does this person get this money?</th>
<th>How much? (Give the amount you get before taxes and deductions are taken out.)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 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.

<table>
<thead>
<tr>
<th>Type of cost (Child care, child support, alimony, disability care)</th>
<th>Who pays the cost?</th>
<th>Name of person who gets the care or support?</th>
<th>How often is the cost paid?</th>
<th>How much is paid each time?</th>
<th>Name, address, and phone number of the person you pay</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Things you own

If you are a pregnant woman only applying for benefits for yourself 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: 

---

H1014-03/31/2011
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.”

<table>
<thead>
<tr>
<th>Make</th>
<th>Model</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example:</td>
<td>Ford</td>
<td>F150</td>
</tr>
</tbody>
</table>

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) that family members living in the home got for each month you list below. Each family member who got money during those months must send at least one check stub for each month you list below. Send copies only.

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?

Person who has the right to act for you
If you want, you can give someone the right to act for you (an authorized representative). That person 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 name Middle name Last name
Home address Apt. / Lot
City State Zip County
Home phone Other phone

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. Telephone: 1-800-252-8683
### 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 HHSCCivilRightsOffice@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 benefits with another agency.

### 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:
- With medical providers.
- With people that help get benefits.

**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 pay for Medicaid and CHIP.

**Medical and child support payments**
Depending on my benefits case, the Attorney General (the state) may decide that I am getting the right amount of child support payments. If I lose support payments and coverage we should get, but do not get right now.

If my child is getting Medicaid, I can decide if I want the state to help get any payments and coverage. If I do not lose support payments.

**Giving or receiving payments**
If I give false information

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

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

**Helper’s name and organization (optional)**

### Signature

By signing below, I agree:

1. To let HHSC and other state, federal, and local agencies check, share, and get facts about anyone on my benefits case (the household).
2. To let other people, businesses, and organizations share facts they have about anyone on my benefits case (the household) with HHSC.
3. 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.

### 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: