

## Women's Health Program Medicaid Application

The Women's Health Program provides an annual exam, health screenings and contraceptives for 12 months.

Please complete the following information for the WOMAN who is applying for benefits.

Name (Last, First, MI)		Applicant's Maiden Name		<b>Agency Use Only</b> Date Received
Date of Birth (mm/dd/yyyy)	Social Security Number	Applicant's Mother's Maiden Name		
Home Address – Street		City, Texas		ZIP Code
County				

Complete if different from your home address or if you have a preferred address for receiving letters with confidential information:

Mailing Address – Street		City	State	ZIP Code	County
Please provide a telephone number where you can discuss confidential information. Area Code and Telephone Number		Driver's License or ID Number	In which county <u>and</u> state were you born?		Ethnicity (optional) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic

Race (optional)  
 American Indian/Alaska Native   
 Black/African American   
 White   
 Asian   
 Native Hawaiian/Pacific Islander   
 Unknown

Are you a U.S. citizen? .....  Yes     No (If yes, provide proof)   
Are you pregnant? .....  Yes     No

Are you a legal immigrant? .....  Yes     No (If yes, provide proof)   
Are you sterile, infertile or unable to get pregnant due to medical reasons? .....  Yes     No

Does anyone in your household currently receive WIC? .....  Yes     No (If yes, provide proof)

Do you have health insurance that covers family planning services? .....  Yes     No

- If yes, will filing a claim on your health insurance cause physical, emotional or other harm from your spouse, parents or other person? ...  Yes     No
- If yes, explain your situation below. If needed, attach additional pages and include your name and Social Security number.

Do you have CHIP or Medicare Part A or B? .....  Yes     No

Complete the information below for all other members of your household. DO NOT re-enter the woman's information listed above. Attach additional pages if you have more than four additional people living in your home. (\*See page 2 for more information.)

Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	Social Security Number*	Sex*	Race*	Relation to Applicant

List all of your household's income here. Be sure to include money you receive from training or work; cash, gifts, loans or contributions from parents, relatives or others; child support; and unemployment or government checks. Please provide proof of money received by each person.

Name of Person Receiving the Money or Income	Name of Employer, Person or Agency that Provides the Money or Income	How often is the money or income received? (weekly, every other week, twice per month, monthly)	Amount Received

List all of your household's expenses for childcare, dependent care for disabled adults, alimony, court-ordered child support or the cost of transportation to and from day care. Please provide proof of the money you pay for these expenses to receive this deduction.

How much do you pay?	How often do you pay? (weekly, every other week, twice per month, monthly)	Name, address and telephone number of person you pay

Information you provide in connection with this application is subject to verification by the Texas Health and Human Services Commission (HHSC) and other state and federal agencies. Your signature indicates that you agree that information provided in this application may be used to determine eligibility for yourself for the Women's Health Program administered by HHSC.

"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. I understand that this is not an application for full Medicaid coverage. However, I understand that I may qualify for other Medicaid services and I can apply at any time."

_____ Signature — Applicant	_____ Date Signed	_____ Signature — Witness (Required if applicant signed with an "X")	_____ Date Signed
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**Citizenship:** To show proof of U.S. citizenship you can send copies of a U.S. passport, a Certificate of Naturalization or a Certificate of U.S. Citizenship. If you do not have one of those documents, you can provide copies of a birth certificate and current driver's license with photo or I.D. card with photo. For people born in Texas, HHSC may be able to get the birth certificate electronically and you will not need to provide it. Call 211 to learn about other documents that are accepted as proof of citizenship. You do not have to provide information about citizenship for any household member who is not asking for benefits.

**Immigration:** Documents that can be provided to show proof of immigration status include an alien registration card or documentation from the Bureau for Citizenship and Immigration Services (formerly INS). You do not have to provide information about immigration status for any household member who is not asking for benefits. You can apply and get benefits for eligible family members, even if your family includes other members who are not eligible because of immigration status. If you or members of your family use Medicaid, the Children's Health Insurance Program (CHIP) or food stamps, it will not affect you or your family members' immigration status or ability to get a green card. If you or your family members use long-term institutional care, such as a nursing home, immigration status could be affected. Talk to an agency that helps immigrants with legal questions before you apply. Refugees and people granted asylum can use any benefits, including cash assistance, without hurting their chances of getting a green card or U.S. citizenship.

**Social Security Numbers:** You will be asked to provide Social Security numbers (SSNs) for all individuals, including yourself, for whom you want assistance. If any of these people do not have an SSN, we can help you apply for one. Before receiving benefits, you must provide or apply for an SSN. Any person who declines to apply for or provide an SSN may be found ineligible. The authority for these requirements is as follows: for food stamp, 7 CFR §273.6; for TANF, 45 CFR §205.52; and for medical assistance, 42 CFR §435.910. We will not share your SSN with the Bureau of Citizenship and Immigration Service (formerly INS). You will not have to provide SSNs for any family members who are not eligible because of immigration status and who are not asking for benefits. SSNs are used to verify eligibility, 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 also share SSNs with telephone and electric utility 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.

**Race, Ethnicity and Gender:** You will be asked to provide information about the race/ethnic background and gender for you and all individuals for whom you want assistance. This information is voluntary and is used to make sure that benefits are provided without regard to race, color or national origin. It will not affect your eligibility or benefit amount.

**Discrimination:** In accordance with federal law and U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age or disability. Under the Food Stamp Act and USDA policy, discrimination is also prohibited on the basis of religion or political beliefs. If you feel you have been discriminated against, you may contact HHSC Civil Rights by: writing to HHSC, Director, HHSC Civil Rights Office, 701 W. 51st St., Suite 104, MC W-206, Austin, TX, 78751; calling 1-888-388-6332 (voice) or 1-512- 438-2960 (TDD); or faxing 1-512- 438-5885. You may also file a complaint by contacting USDA or HHS. Write USDA, Director, Office of Civil Rights, 1400 Independence Ave., S.W., Washington, D.C. 20250-9410 or call 1-800- 795-3272 (voice) or 1-202- 720-6382 (TTY). Write HHS, Director, Office for Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call 1-202- 619-0403 (voice) or 1-202-619-3257 (TTY). USDA and HHS are equal opportunity providers and employers.

**WIC:** Documents we accept as proof of receiving WIC include: WIC Verification of Certification letter or active WIC voucher/EBT Shopping List.

**Household income:** Documents we accept as proof of income or money received by the household include: pay stubs; copy of checks; a statement from employer; self-employment records; statement from the person providing the money that includes the person's name, address, telephone number, signature and date.

**Household expenses:** Documents we accept as proof of household expenses include: copies of checks; check stubs; statement from the person you pay that includes the person's name, address, telephone number, signature, date, as well as when and how often you pay; copy of district clerk record.

**Questions:** Call us toll free at **211** Monday through Friday, 8 a.m. to 8 p.m. Central time.

**Provider use only:**

Did the applicant complete all questions, and sign and date the form? .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Proof of U.S. citizenship/immigration status.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Identification.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Current proof of all household income (within last 60 days).....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is the applicant at least 18 through 44 years of age?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does the applicant or anyone in the household have verification of Children's Medicaid or WIC? .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**Copy all verification documents and fax them with the front page of this application to 1-866-993-9971.**