



Applying for or renewing Medicaid or CHIP? If yes, you must fill out this form.

? 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.

Section 1

Your Tax Return

This form needs to be filled out, signed, and sent back with your application for benefits.

Each person listed in **Section H** of the **Your Texas Benefits** application needs to answer the questions below (Section 1). The people who should be included in Section H and who should answer the questions below are:

- Yourself.
- Your spouse.
- Your children age 18 and younger who live with you.
- Anyone you include on your tax return, even if they don't live with you.
- Anyone else age 18 and younger who you take care of and lives with you.

(You can still apply for health insurance even if you don't file a federal income tax return.)

Person 1: (main contact or head of household)

First name

Middle name

Last name

If married, name of spouse:

Do you plan to file a federal income tax return next year? Yes No

If yes, answer questions a to c. If no, skip to question c.

a. Will you file jointly with a spouse? Yes No

b. Will you claim any dependents on your tax return? Yes No

If yes, list name(s) of dependents:

c. Will you be claimed as a dependent on someone's tax return? Yes No

If yes, list the name of the tax filer:

How are you related to the tax filer?



More on page 2-A



Section 1

Your Tax Return

(continued)

Person 2:

First name **Middle name** **Last name**

If married, name of spouse:

Do you plan to file a federal income tax return next year? Yes No

If yes, answer questions a to c. If no, skip to question c.

a. Will you file jointly with a spouse? Yes No

b. Will you claim any dependents on your tax return? Yes No

If yes, list name(s) of dependents:

c. Will you be claimed as a dependent on someone's tax return? Yes No

If yes, list the name of the tax filer:

How are you related to the tax filer?

Does Person 2 live at the same address as Person 1? Yes No

If no, what is Person 2's address?

Person 3:

First name **Middle name** **Last name**

If married, name of spouse:

Do you plan to file a federal income tax return next year? Yes No

If yes, answer questions a to c. If no, skip to question c.

a. Will you file jointly with a spouse? Yes No

b. Will you claim any dependents on your tax return? Yes No

If yes, list name(s) of dependents:

c. Will you be claimed as a dependent on someone's tax return? Yes No

If yes, list the name of the tax filer:

How are you related to the tax filer?

Does Person 3 live at the same address as Person 1? Yes No

If no, what is Person 3's address?



Section 1

Your Tax Return
(continued)

Person 4:

First name **Middle name** **Last name**

If married, name of spouse:

Do you plan to file a federal income tax return next year? Yes No

If yes, answer questions a to c. If no, skip to question c. ← ↓ ← ↓

a. Will you file jointly with a spouse? Yes No

b. Will you claim any dependents on your tax return? Yes No

If yes, list name(s) of dependents:

c. Will you be claimed as a dependent on someone's tax return? Yes No

If yes, list the name of the tax filer:

How are you related to the tax filer?

Does Person 4 live at the same address as Person 1? Yes No

If no, what is Person 4's address?

Person 5:

First name **Middle name** **Last name**

If married, name of spouse:

Do you plan to file a federal income tax return next year? Yes No

If yes, answer questions a to c. If no, skip to question c. ← ↓ ← ↓

a. Will you file jointly with a spouse? Yes No

b. Will you claim any dependents on your tax return? Yes No

If yes, list name(s) of dependents:

c. Will you be claimed as a dependent on someone's tax return? Yes No

If yes, list the name of the tax filer:

How are you related to the tax filer?

Does Person 5 live at the same address as Person 1? Yes No

If no, what is Person 5's address?

If more than 5 people are applying for benefits, add more pages with the same facts.



Section 2

Tax deductions you claim

Tell us about things that can be deducted on a federal income tax return. If anyone has deductions, health coverage costs might be a little lower.

Tax deductions

Mark all that apply, give the amount, and how often you pay it. (You shouldn't include a cost that you already considered as part of your net self-employment.)

- Alimony paid \$ _____ How often? _____
- Student loan interest \$ _____ How often? _____
- Other deductions, such as educator expenses, health savings accounts, moving expenses, tuition and fees \$ _____ How often? _____ Type: _____

If you have any of these deductions, you will need to send us a copy of your last year's income tax return.

Section 3

Information about people applying for benefits

Information about people applying for benefits

1. Does a child applying for health care travel with a family member who is a migrant farm worker? Yes No
If yes, who?
2. Is a child in the Children with Special Health Care Needs program? Yes No
If yes, who?
3. Is anyone an American Indian or Native Alaskan? Yes No
If yes, you must fill out "Appendix B: American Indian or Alaska Native Family Member." It is attached to this form.
4. Was anyone in foster care when they were age 18 or older? Yes No
If yes, who? In which state?
5. Is anyone an unaccompanied refugee minor? This means a person is: (1) not living with a relative, (2) age 18 or younger, and (3) a refugee. Yes No
If yes, who?
6. Was anyone in the Unaccompanied Refugee Minor Resettlement Program at age 18 or older? Yes No
If yes, who? In which state?



Section 4

Money you get

Money you get

Fill out this section only if the amount of money you get changes or might change from month to month. If you don't expect changes to your monthly income, skip this question.

Your total income this year:

\$

Your total income next year (if you think it will be different):

\$

Section 5

Insurance offered through your job

Insurance offered through your job

1. Can anyone listed on this form get health insurance through a job? (Check yes even if the coverage is from someone else's job, such as a parent or spouse.) Yes No

If yes, fill out "Appendix A: Health coverage from job." ←

2. Did anyone have insurance through a job and lose it within the past 3 months? Yes No

If yes, who?

If yes, end date:

If yes, reason the insurance ended:

- Parent's job ended due to layoff or business closing.
- Change in parent's marital status.
- Medicaid benefits from another state ended.
- Parent's COBRA coverage ended.
- CHIP benefits from another state ended.
- Private health coverage ended.
- Other: _____

Section 6

Read and sign this form

A. Is anyone who is applying for health coverage in jail (incarcerated)? Yes No

If yes, who is in jail?

B. Renewing your health coverage in future years

To make it easier to find out if I can get help paying for health coverage in future years, I agree to allow the agency to use facts about money I get (income data), including information from tax returns. The agency will send me a notice, let me make any changes, and I can cancel (opt out) at any time.

I agree: Yes, the agency can get facts listed above and renew my health coverage without asking me for the next:

- 5 years (the maximum number of years allowed)
- 3 years
- Don't use information from tax returns to renew my coverage.
- 4 years
- 2 years
- 1 year

Sign here

/ /

Date (mm/dd/yyyy)

APPENDIX A



Health Coverage from Jobs

You **DON'T** need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

Tell us about the **job** that offers coverage.

Take the Employer Coverage Tool on the next page to the employer who offers coverage to help you answer these questions. You only need to include this page when you send in your application, not the Employer Coverage Tool.

EMPLOYEE Information

1. Employee name (First, Middle, Last)	2. Employee Social Security number ____-____-_____
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EMPLOYER Information

3. Employer name	4. Employer Identification Number (EIN) ____-____-_____	
5. Employer address	6. Employer phone number () -	
7. City	8. State	9. ZIP code
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above) () -	12. Email address	

13. **Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?**

Yes (Continue)

13a. If you're in a waiting or probationary period, when can you enroll in coverage? _____ (mm/dd/yyyy)

List the names of anyone else who is eligible for coverage from this job.

Name: _____ Name: _____ Name: _____

No (Stop here and go to Step 5 in the application)

Tell us about the **health plan** offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*? Yes No

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans):
If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? \$ _____

b. How often? Weekly Every 2 weeks Twice a month Once a month Quarterly Yearly

16. What change will the employer make for the new plan year (if known)?

Employer won't offer health coverage

Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? \$ _____

b. How often? Weekly Every 2 weeks Twice a month Once a month Quarterly Yearly

Date of change (mm/dd/yyyy): _____

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

EMPLOYER COVERAGE TOOL



Use this tool to help answer questions in Appendix A about any employer health coverage that you're eligible for (even if it's from another person's job, like a parent or spouse). The information in the numbered boxes below match the boxes on Appendix A. For example, the answer to question 14 on this page should match question 14 on Appendix A.

Write your name and Social Security number in boxes 1 and 2 and ask the employer to fill out the rest of the form. Complete one tool for each employer that offers health coverage.



EMPLOYEE Information

The **employee** needs to fill out this section.

1. Employee name (First, Middle, Last)	2. Social Security Number _____ - _____ - _____
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EMPLOYER Information

Ask the **employer** for this information.

3. Employer name	4. Employer Identification Number (EIN) _____ - _____ - _____	
5. Employer address (HHSC will send notices to this address)	6. Employer phone number () -	
7. City	8. State	9. ZIP code
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above) () -	12. Email address	

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

Yes (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?
_____ (mm/dd/yyyy) (Continue)

No (STOP and return this form to employee)

Tell us about the health plan offered by this employer.

Does the employer offer a health plan that covers an employee's spouse or dependent?

Yes. Which people? Spouse Dependent(s)

No

(Go to question 14)

14. Does the employer offer a health plan that meets the minimum value standard*?

Yes (Go to question 15) No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? \$ _____

b. How often? Weekly Every 2 weeks Twice a month Once a month Quarterly Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?

Employer won't offer health coverage

Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? \$ _____

b. How often? Weekly Every 2 weeks Twice a month Once a month Quarterly Yearly

Date of change (mm/dd/yyyy): _____

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

APPENDIX B



American Indian or Alaska Native Family Member (AI/AN)

Complete this appendix if you or a family member are American Indian or Alaska Native. Submit this with your application.

Tell us about your American Indian or Alaska Native family member(s).

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach.

	AI/AN PERSON 1	AI/AN PERSON 2
1. Name (First name, Middle name, Last name)	First Middle	First Middle
	Last	Last
2. Member of a federally recognized tribe?	<input type="checkbox"/> Yes If yes , tribe name _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes If yes , tribe name _____ <input type="checkbox"/> No
3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? <input type="checkbox"/> Yes <input type="checkbox"/> No
4. Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources: <ul style="list-style-type: none"> • Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties • Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations) • Money from selling things that have cultural significance 	\$ _____ How often? _____	\$ _____ How often? _____

APPENDIX C



Assistance with Completing this Application

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an “authorized representative.” If you ever need to change your authorized representative, contact HHSC. If you’re a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, middle name, last name)		
2. Address		3. Apartment or suite number
4. City	5. State	6. ZIP code
7. Phone number () -		
8. Organization name		9. Organization ID number (if applicable)
10. Which benefits can this person talk to us about? <input type="radio"/> SNAP food benefits <input type="radio"/> TANF cash help <input type="radio"/> Health-care (including Medicaid or CHIP)		

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.

11. Your signature	12. Date (mm/dd/yyyy)
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For certified application counselors, navigators, agents, and brokers only.

Complete this section if you’re a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)	
2. First name, middle name, last name, & suffix	
3. Organization name	4. Organization ID number (if applicable)