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(Client Name and Address)


HHSC Staff
Office Address and Telephone No.

**Application Letter**

You may wish to apply for Medicaid benefits because:

- You reside in a long-term care facility (nursing facility, state supported living center, or private ICF-MR facility).
- You received both Social Security and Supplemental Security Income (SSI) benefits prior to denial of your SSI.
- You are enrolled in Part A Medicare and desire assistance in paying premiums, deductibles, and co-insurance on Medicare-covered services. (Qualified Medicare Beneficiary program).
- You are enrolled in Part A Medicare and desire assistance in paying all or part of the Part B Medicare premium (Specified Low-income Medicare Beneficiary or Qualifying Individuals programs).

If you wish to apply for assistance through the medical assistance program (Medicaid), you may complete the enclosed application form and return it to the office at the address shown above. Questions on the application form apply only to the applicant and the applicant's spouse, if any. An envelope is enclosed for your use. For state supported living center residents, information on the form should be for the period beginning

If you receive certain long term care Medicaid services, related hospital and prescription drug services, and you are age 55 or older, the state can make a claim on your estate to recover the money that Medicaid has paid for your care. No claim will be made as long as you are survived by your spouse or your child who is under 21 or disabled.

Each question on the application form must be answered. Enter "no" or "N/A" to questions that do not apply. A question which is left blank will be considered unanswered. You may ask a friend or relative to help you.

Please include with the application proof of all income and things that are owned. The proof may be copies of award letters (VA, Social Security, Railroad Retirement); your last three bank statements; savings passbook; certificates of deposit; certificates of notes, stock or bonds; insurance policies (life, burial, hospitalization); transfer papers or deeds (for anything that was sold or given away within the past 36 months); and prepaid burial contracts.

The application should be signed by the applicant and the applicant's spouse, the guardian, power-of-attorney or responsible party for the applicant. After the application is received, it will be reviewed to determine eligibility. A face-to-face interview is not required. You will be notified of the decision.

If you have questions, please contact this office at the address shown above.

**Discrimination Complaints**

If you believe you have been discriminated against because of race, color, national origin, age, sex, disability or religion, you may file a complaint by contacting:  
 HHSC Civil Rights Office, 701 W. 51<sup>st</sup> St., Suite 104, MC W-206, Austin, TX 78751  
 Voice: 1-888-388-6332, TTY: 1-877-432-7232, Fax: 1-512-438-5885  
 You can also file a complaint by contacting: U.S. Department of Health and Human Services: 1-800-368-1019  
 TTY: 1-214-767-8940 Fax: 1-214-767-0432  
 Office for Civil Rights - Region VI, 1301 Young St., Room 1169, Dallas, TX 75202