TEXAS Health and Human Services

Form 3029
September 2023

PHC and Title V MCH FFS

Application For Program Benefits

This application should be used to apply to the Primary Health Care (PHC) Program and the Title V Maternal & Child Health Fee-For-Service (Title V MCH FFS) Program.

Section I. Applicant Information

***If applying for a child, the parent or legal guardian must be listed as the applicant.**

Name of Individual	Sex	Date of Birth	Race or Ethnicity

Home Address	City	County	State	ZIP Code

Primary Area Code and Phone No.	Secondary Area Code and Phone No.

Email Address

Communication Preferences

The following fields do not affect eligibility. (Check all that apply)

How may we contact you? ☐ Email ☐ Phone ☐ Mail

Preferred Spoken Language ☐ English ☐ Spanish ☐ Other: _____

Preferred Written Language ☐ English ☐ Spanish ☐ Other: _____

Section II. Household Members

List all Household Members. Household members include the applicant and anyone who lives with them and for whom they are legally responsible for. Children under age 18 may be included as household members. Unborn children of pregnant women must be included as household members. See application instructions for more information on household members.

Number of Household Members: _____

Primary Health Care Program (PHC**); Title V Child Health & Dental (**TV CHD**); Title V Prenatal Medical & Dental (**TV PMD**)*

Name *(Last, First, Middle)*	**Date of Birth**	**Sex**	**Race or Ethnicity**	**Relationship to Applicant**	**Program Applying For?** *(*PHC, TV CHD, TV PMD or NA)*	**Enrolled in a Health Insurance Plan?**
				Applicant		◯ Yes ◯ No
						◯ Yes ◯ No
						◯ Yes ◯ No
						◯ Yes ◯ No
						◯ Yes ◯ No
						◯ Yes ◯ No
						◯ Yes ◯ No

Do you, or any other applicants, have an immediate medical or dental need? ◯ Yes ◯ No

Are you, or any other applicants, a veteran? ◯ Yes ◯ No

Important Information for Former Military Services Members – Women and men who served in any branch of the United States Armed Forces, including Army, Navy, Marines, Air Force, Coast Guard, Reserves or National Guard, may be eligible for additional benefits and services. For more information, visit the Texas Veterans Portal at **https://veterans.portal.texas.gov**.

Does any household member have any special circumstances that may affect their inclusion in the household member count? ◯ Yes ◯ No

If yes, please provide a detailed explanation:

Section III. Screening for PHC Adjunctive Eligibility

Are you applying to the PHC program? ◯ Yes ◯ No* *(If you checked no, continue with Section IV.)*

If you are applying to the PHC program, you may be eligible for PHC adjunctive eligibility*. Check all benefits you are currently receiving:

- ☐ Children's Health Insurance Program Perinatal (CHIP-P)
- ☐ Supplemental Nutrition Assistance Program (SNAP)
- ☐ Women, Infants, and Children (WIC) Program
- ☐ Medicaid for Pregnant Women
- ☐ Healthy Texas Women (HTW)
- ☐ None of these

*If a PHC applicant provides proof of active enrollment in one of these listed programs, verify current enrollment status by calling TMHP or accessing TexMedConnect. If confirmed, then adjunctive eligibility may be granted for the PHC program and Section IV will not need to be completed. Record the verification in Section VI notes.

Section IV. Household Income

List gross household income and include documentation. Household income includes adult household member incomes. Refer to Appendix I of the Program Policy Manual "Definition of Income" for additional information about different types of income.

Name of Household Member Receiving Money	Name of Employer or Person Who Provides Money	Type of Income	Gross Amount Received	How Often Received *(weekly, bi-weekly, bi-monthly or monthly)*	Monthly Income Total
				Total Countable Monthly Income:	
				Allowable Deductions:	
				Net Countable Monthly Income:	

Notes:

Section V. Acknowledgement

The statements I have made, including my answers to all questions, are true and correct to the best of my knowledge and belief. I agree to give eligibility staff any information necessary to prove statements about my eligibility. I agree to report all changes in income, family composition, residence, current address, employment and all types of health care coverage or benefits no later than 30 days after I become aware of the change. I understand that giving false information could result in disqualification and repayment.

Privacy Notification

With few exceptions, you have the right to request information that the state of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. (Government Code, Section 552.021, 552.023, 559.003 and 559.004.)

_____
Initials

Acknowledgment

I understand that this application is a legal document and that by signing this form, I am stating that from my personal knowledge, all facts included are true and correct. I understand that giving false information could result in disqualification or reimbursement for the cost of services and that if I am approved to receive program services, I will be held accountable for complying with program policies, including maintaining eligibility and fulfilling all other beneficiary responsibilities. _____ Initials

Statement of Release of Information

I authorize the release of income and medical information to and by the Texas Health and Human Services Commission and the provider, as necessary, to determine eligibility and to coordinate, render and bill for services. _____ Initials

Coverage Attestation

I attest that I, the primary applicant, have no other health insurance coverage than what is listed in Section III, Health Care Information, of this application. I authorize the program to bill the coverage sources listed for any services provided. _____ Initials

_____ _____
Applicant Signature **Date**

Section VI. Contractor Eligibility Determination

All questions must be answered by eligibility staff:

1. Texas resident ..... ◯ Yes ◯ No
2. Total calculated household income ..... _____
3. Household federal poverty level (FPL)% ..... _____
4. Documentation of income* ..... ◯ Yes ◯ No
5. Documentation of residency* ..... ◯ Yes ◯ No
6. Documentation of date of birth* (if applying for Title V CHD) ..... ◯ Yes ◯ No
7. If applicant is applying for **PHC Adjunctive Eligibility**, were benefits verified through Texas Medicaid & Healthcare Partnership (TMHP)? ..... ◯ N/A ◯ Yes ◯ No
8. Is applicant applying for **PHC Supplemental Benefits**?..... ◯ N/A ◯ Yes ◯ No

   If yes, list the PHC services applicant does not have primary coverage for and will be eligible for:

9. Is the applicant(s) potentially eligible for:
   - Medicaid? ..... ◯ Yes ◯ No
   - Medicaid for Pregnant Women? ..... ◯ Yes ◯ No
   - CHIP? ..... ◯ Yes ◯ No
   - CHIP Perinatal? ..... ◯ Yes ◯ No

***If an applicant qualifies for program benefits and has an immediate medical or dental need, but does not have the required documentation, then Presumptive Eligibility must be given.**

***Applicants currently enrolled in a healthcare plan but do not have any dental coverage, and would otherwise qualify for program benefits, will be eligible for Title V Dental benefits.**

Notes:

Section VII. Contractor Eligibility Certification

Eligibility Effective Date: _____

Name of Client	Program Eligibility *(PHC, TV CHD, TV PMD or NA)*	Type of Eligibility Granted *(Eligible or Presumptive Eligibility)*	Type of Determination *(New or Recertification)*	Copay Amount

By signing below, I attest that the above listed applicants have met program eligibility requirements. I have notified pregnant applicants they must apply for Medicaid for Pregnant Women or CHIP Perinatal. I have notified any applicants who appear eligible for other programs, including but not limited to, Medicaid or CHIP, must apply to those programs.

Name of Facility | **Staff Member Attestation Signature** | **Date**

This form must be kept with the client's record and should not be submitted to HHSC state office.

Eligible Clients must receive:

Form 3046, Statement of Applicant's Rights and Responsibilities

Form 3048, Notice of Eligibility

Presumptive Eligibility Clients must receive:

Form 3046, Statement of Applicant's Rights and Responsibilities

Form 3045, Presumptive Eligibility Notice

Applicants who did not qualify for program benefits must receive:

Form 3047, Notice of Ineligibility