TEXAS
Health and Human Services

Form 3045
November 2019-E

Office of Primary and Specialty Health

Presumptive Eligibility Notice

This form can be used to apply for health care assistance through the Primary Health Care Services Program and/or the Title V Fee-for-Service Program.

Date	Case No.	Expiration Date

Office Address (Street, City, State, ZIP Code)	Area Code and Office Phone No.

Provider Staff Name

Applicant Name or Legally Responsible Adult or Caretaker	Applicant or Legally Responsible Adult or Caretaker Phone No.

Applicant Mailing Address (Street, City, State, ZIP Code)

Home Address (Street, City, State, ZIP Code), if different from above

1. Your individual or household application for the following program has been **approved**.
   ◯ Primary Health Care Services ◯ Title V Fee-for Service

2. The following services will be provided between _____ and _____.
   (MM/DD/YYYY) (MM/DD/YYYY)

Family Member Name	Date of Birth	Services

Due to my need of immediate medical care, I was not able to complete the eligibility determination process for the program. I understand that I must return the requested documentation/verification within 90 days of today's date.

My appointment to complete the program's eligibility process is scheduled for: _____.
(MM/DD/YYYY)

_____ _____
Applicant Signature Date