TEXAS
Health and Human Services

Form 3046
March 2023

Statement of Applicant's Rights and Responsibilities

By signing this application for assistance, I affirm the following:

The information on the application and its attachments is true and correct. This application is a legal document. Deliberately omitting information or giving false information may cause the Provider to terminate services to a member of my household/ family or me.

If I omit information, fail or refuse to give information, or give false or misleading information about these matters, I may be required to reimburse the state of Texas for the services rendered if I am found to be ineligible for services. I will report changes in my household/family situation that affect eligibility during the certification period (changes in income, household/family members and residency).

I authorize the release of all information, including but not limited to, income and medical information by and to the Texas Health and Human Services Commission (HHSC) and Provider in order to determine eligibility, to bill or to render services to my household/family or me.

I understand I may be asked by the Provider to provide proof of any of the information provided in this application.

Health insurance coverage, including but not limited to, individual or group health insurance, health maintenance organization membership, Medicaid, Medicare, Department of Veterans Affairs benefits, TRICARE, and Workers' Compensation benefits, must be reported to the Provider. Benefits from health insurance may be considered the primary source of payment for health care received. I hereby assign to the Provider any such benefits. I also assign payment for benefits and services received from and through the Provider directly to the service providers.

I understand that to maintain program eligibility, I will be required to reapply for assistance at least every 12 months.

I am a bona fide resident of Texas or a dependent. I physically live in Texas, maintain living quarters in Texas, and do not claim to be a resident of another state or country, or am a dependent of a bona fide Texas resident.

Some programs provide care through program-approved providers. I understand that to receive benefits from such programs, treatment must be received through those program-approved providers.

I understand that criteria for participation in the program are the same for everyone regardless of sex, age, disability, race or national origin.

I understand I have the right to file a complaint regarding the handling of my application or any action taken by the program with the HHSC Civil Rights Office at 1-888-388-6332.

I understand that I will receive written documentation concerning the services for which my household/family or I am eligible or potentially eligible.

With few exceptions, I have the right to request and be informed about information that the state of Texas collects about me. I am entitled to receive and review the information upon request. I also have the right to ask the state agency to correct any information that is determined to be incorrect. (Reference: Government Code, Section 552.021, 522.023 and 559.004)

Applicant's Signature	Date	Provider Staff Signature	Date