CENTRAL HEALTH

Medical Access Program
APPLICATION FOR HEALTH CARE ASSISTANCE

On the chart below, fill in the first line with information about yourself. Fill in the remaining lines for all members of your household (spouse and children under 18 years of age).

NAME (Last, First, Middle)	**DOB**	**U. S. Residency Status** Choose one: •Not a US Citizen or LPR •US Citizen •Legal Permanent Resident	**SSN** (Social Security Number) ***Required for U.S Citizens and Legal Permanent Residents**	**ITIN** (Individual Taxpayer Identification Number) ***Required only if you have been issued an ITIN by IRS**	**RELATION SHIP** Choose one: •Child •Grandchild •Other •Self •Spouse	**SEX** Choose one: •Female •Male	**RACE** Choose one: •African-American •Anglo •Asian •Hispanic •Native-American •Other

Mailing Address (Street or P.O. Box)	**Apt. #**	**City**	**County**
Home Address, if different from above.			
Home Telephone Number	**Other Telephone Number**		

1. What is your primary language?

Choose one:
Arabic, Burmese, Cantonese, English, Karen, Mandarin, Nepali, Other, Sign Language, Spanish, Vietnamese

2. What is your marital status?

Choose one:
Single, Married, Divorced, Separated, Widowed, Other

3. Do you plan to file a federal income tax return for the current year?

□ YES □ NO If YES, list your dependents? _____

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The word "household" in Questions #4-#11 refers to: **you, your spouse, and children under 18 years of age.** You do not need to include information on people who live with you but are not part of your "household."

4. Living Arrangements Check all boxes that apply to your household:

□ Own/Rents/Lives with someone □ Homeless □ Transitional

5. Are you or is anyone in your household pregnant?

□ YES □ NO If YES, who? _____

Do you need assistance applying for Medicaid or CHIP Perinatal? □ YES □ NO

6. Do you or anyone in your household have health care coverage?

Medicaid	□ YES	□ NO	If YES, Who?
Medicare	□ YES	□ NO	If YES, Who?
CHIP	□ YES	□ NO	If YES, Who?
CHIP Perinatal	□ YES	□ NO	If YES, Who?
Private Health Insurance	□ YES	□ NO	If YES, Who?

7. Have you or anyone in your household been declared disabled through SSA?

□ YES □ NO If YES, who? _____

8. Do all family members plan to remain in Travis County?

□ YES □ NO If NO, who and explain: _____

9. Did you or your family members move to Travis County solely for the purpose of obtaining health care assistance?

□ YES □ NO

10. Are you or anyone in your household a Legal Permanent Resident being sponsored? A Sponsor's income will be counted as part of the household income for the first three years.

□ YES □ NO

If YES, give the name of who is being sponsored and the name of the sponsor: _____

11. List all of your household's income below. Be sure to include the following: Government checks; money from training or work; money you collect from charging room and board; cash gifts or contributions from parents, relatives, friends, and others; sponsor's income; child support; and unemployment.

Name of person receiving money	Name of agency, person, or employer who provides the money	**Gross** amount received (before tax deductions)	How often received? (daily, weekly, twice a month, monthly?)	In School? Yes/No

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APPLICANT RESPONSIBILITIES

Central Health's Medical Access Program (MAP) and MAP BASIC (collectively, Program(s)) help people access health care by paying for certain health care services. Whether you qualify for MAP or MAP BASIC depends on your income, where you live, the availability of other health care coverage, and the existence of alternate sources of payment for health care. Your ethnicity, color, religion, creed, national origin, gender, disabling condition, sexual orientation, or political belief(s) will not be considered and will not affect your eligibility for these Programs.

By my signature below, I swear that all the statements I have made in connection with my application for these Program benefits, including my answers to all questions about income, county of residence, and other payment sources are true and correct to the best of my knowledge and belief. I understand that, because my eligibility for these Programs is based on my answers to these questions, any omission, failure or refusal to provide Central Health with requested information, or giving false or misleading information in response to eligibility questions, may cause Central Health to terminate my Program benefits and to seek recovery of any payment Central Health made, on my behalf for health care services.

I agree to report any of the following life changes to Central Health within 14 days of the date of the change:

a. mailing address and telephone number
b. address where I live
c. any change in income that may affect my eligibility
d. number of people who live with me/ or a household member becomes pregnant
e. enrollment in Medicaid, CHIP, Medicare, or other private health insurance or notification that I am eligible for any coverage program that may pay for my care

If Central Health identifies an unreported change to any of these five material areas of my application, I understand that my Program benefits may be terminated and that Central Health can take any other action within its authority, including filing civil or criminal charges against me.

I understand that my enrollment in MAP and MAP Basic is conditioned on my agreement to allow Central Health to verify the statements I have made in connection with my application for Program benefits and that enrollment status may remain pending until such agreement is given and verification is obtained from a credible source (e.g., Social Security Administration or the Texas Workforce Commission). I further understand and agree that Central Health may request that I pay for a portion of the cost of my health care and that Central Health may recover any costs it paid for my health care from a third party in the event that I file a claim for personal injury damages.

Finally, I acknowledge and agree that my initials signify:

_____ My authorization for my employer, the Social Security Administration, the Texas Health & Human Services Commission, the Texas Department of State Health Services, and the Texas Workforce Commission to release benefits, enrollment, claims, wage, and other records to Central Health; and

_____ My authorization will be valid for a period of twelve months from the date I sign this Applicant Responsibilities form or until I revoke my authorization in a signed writing delivered to Central Health;

_____ My acknowledgement that I am responsible for ensuring that my mailing address, telephone number, and any cell phone number or email address I list beneath the next paragraph are accurate and are up to date (i.e. current) at all times during my Program enrollment; and

_____ (Optional) I understand there are risks associated with sending unencrypted text messages and emails, and I am providing my *consent* to receive information from Central Health regarding scheduled appointments, my application status, renewals and changes to Program coverage and benefits via—

- ☐ Cell phone. My current cell phone number is _____
- ☐ Email address. My current email address is _____.

Name of Applicant

Signature of Applicant

Program Identification Number

Date

Name of Personal Representative ("PR")

Signature of Personal Representative

PR's Relationship to Applicant

Date

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Required Documents

A. Once you have completed the application, please make sure you have included:

- ☐ **Copy of Identification**, such as**:** Driver's License, Identification Card, Passport or Passport card, Student ID, Employment Authorization card, I-551 U.S. Legal Permanent Resident card, I-94 with photo, etc.

- ☐ **Copy of U. S. Residency/Citizenship Status**, such as: Birth Certificate, Naturalization Certificate, Visa/Passport, I-551 U.S Legal Permanent Resident card, I-94, etc.

- ☐ **Proof of address**, such as: electric bill, telephone bill, gas bill, lease agreement, rent receipt, property tax receipt, landlord's statement, or postmarked mail.

- ☐ **Proof of income**, such as: Check stubs, child support receipts or printout from Domestic Relations, proof of TANF grant amount, Workers' Compensation check stubs or benefit letter, current year's Social Security benefit letter, current year's Veterans' Administration benefit letter, unemployment benefits letter, letter indicating cash contributions, current year's retirement benefits letter.

- ☐ **Proof of other current health coverage**, such as: Medicare card, private health insurance card, Medicaid/CHIP card or HHSC Medicaid/CHIP letter for the current month.

B. All documents must be current and/or dated within the last 30 days.

C. Please photocopy required documents. Keep your originals for your records.

Submitting Your Application

Please make sure you complete this application and submit it along with copies of the requested documents:

- **Online at:** documents.apply4map.com

- **By mail to:** Medical Access Program
  P.O. Box 300489
  Austin, TX 78703

- **Or fax them to:** 512-776-0457

Questions

If you have questions, please contact our Eligibility Services Customer Service Call Center at 512-978-8130.