MAP ID: _____

HOUSEHOLD ID: _____

DATE PRINTED: _____

Program Enrollment Application

Complete all the information requested. If your information is pre-printed below, review and make corrections where necessary. Draw a line through any incorrect information and add the corrected or missing information.

Household information

The word "household" refers to: you, your spouse, your children and anyone else that lives with you and with whom you have a legal relationship. You do not need to include information on people who live with you but are not part of your "household."

NAME (Last, First, Middle)	**DATE OF BIRTH** (MM/DD/YYYY)	**RELATIONSHIP**	**U.S. RESIDENCY STATUS**	**SOCIAL SECURITY # OR ITIN** (Individual Taxpayer Identification #)	**PREFERRED LANGUAGE**

You must complete the form on the following pages. →

NAME (Last, First, Middle) Include all the individuals listed on the first page.	**RACE**	**ETHNICITY**	**SEX** (on your birth certificate)	**GENDER IDENTITY**

Residency: If you, the applicant, are currently experiencing homelessness enter the location where you sleep at night. In the box requesting physical address you can use cross streets or the address of the shelter. You also need to add the city, county, and zip code where you sleep. If you do not know the zip code enter 78701.

Are you currently homeless? ☐ No ☐ Yes

Physical address (street address only, no P.O. Box) Apt.#, city, zip code, county:

_____

Mailing Address, if different from above (street or P.O. Box):

_____

Home telephone number: _____

Cell telephone number: _____

Email address: _____

I agree to receive text messages* ☐ No ☐ Yes

I agree to receive email messages* ☐ No ☐ Yes

* I understand that in providing consent to receive text messages and/or emails above that there are risks associated with sending unencrypted text messages and emails, and I am providing my consent to receive information from Central Health (e.g. scheduled appointments, my application status, renewals and changes to program coverage and services).

You must complete the form on the following pages. →

Answer all the questions on this application.

1. What is your marital status?

   ☐ Single ☐ Married/Common Law Married ☐ Divorced ☐ Separated ☐ Widowed

2. Are you or is anyone in your household pregnant? ☐ No ☐ Yes

   If Yes, who? ______________________________

3. Has anyone in your household received any income in the last 30 days? ☐ No ☐ Yes

   If Yes, list all of your household's income below. Be sure to include the following: Government checks; money from training or work; sponsor's income; child support; and unemployment.

NAME OF PERSON RECEIVING MONEY	TYPE OF INCOME RECEIVED	GROSS AMOUNT RECEIVED (before tax deductions)	HOW OFTEN RECEIVED?	EMPLOYER PHONE NUMBER
	☐ Wages ☐ Self-Employment ☐ Social Security benefits ☐ Unemployment benefits ☐ No income ☐ Other income		☐ Daily ☐ Weekly ☐ Biweekly ☐ Twice a month ☐ Monthly ☐ No income in the last 30 days	
	☐ Wages ☐ Self-Employment ☐ Social Security benefits ☐ Unemployment benefits ☐ No income ☐ Other income		☐ Daily ☐ Weekly ☐ Biweekly ☐ Twice a month ☐ Monthly ☐ No income in the last 30 days	
	☐ Wages ☐ Self-Employment ☐ Social Security benefits ☐ Unemployment benefits ☐ No income ☐ Other income		☐ Daily ☐ Weekly ☐ Biweekly ☐ Twice a month ☐ Monthly ☐ No income in the last 30 days	

You must complete the form on the following pages. →

4. Do you or anyone in your household have health care coverage? ☐ No ☐ Yes

   If Yes- Check which health care coverage and write the name(s) of all household members with coverage.

   ☐ MAP or MAP Basic. Who? _____

   ☐ Medicare. Who? _____

   ☐ Medicaid. Who? _____

   ☐ CHIP. Who? _____

   ☐ CHIP Perinatal. Who? _____

   ☐ ACA/Health insurance. Who? _____

   ☐ Sendero. Who? _____

   ☐ Private/Employer sponsored insurance. Who? _____

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

   ☐ No ☐ Yes ☐ I reside outside Travis County

6. Have you or anyone in your household been declared disabled through Social Security Administration?

   ☐ No ☐ Yes

   If, Yes, who? _____

7. If you are enrolled in MAP or MAP Basic, which primary care clinic system do you currently use or would you like to use?

   ☐ CommUnityCare ☐ Lone Star Circle of Care ☐ People's Community Clinic

   ☐ UT School of Nursing ☐ No Preference

8. Do you have an upcoming medical appointment or procedure?

   ☐ No ☐ Yes Date: _____

9. Have you or anyone in your household had a medical appointment in the last 30 days?

   ☐ No ☐ Yes Date: _____

You must complete the form on the following pages. →

Applicant responsibilities

Central Health's programs help people access health care by paying for or providing certain health care services. Whether you qualify for MAP or MAP Basic as a member or Central Health Financial Assistance or Justice Involved Health as one of its patients ("Central Health Programs", and each a "Program") depends on factors such as your income, where you live, the availability of other health care coverage, and the existence of alternate sources of payment for health care. However, 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 Central Health Programs, 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 participation in Central Health's Programs 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. Any change to my mailing address or telephone number
b. Any change to the address where I live
c. Any change in income that may affect my eligibility
d. Any change in the number of people in my household, including 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 health care

If Central Health identifies any unreported life changes applicable to my Program eligibility, I understand that my participation in the Program 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 a Central Health Program 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

You must complete the form on the following pages. →

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.

Use of Eligibility Documents

If I am ineligible to enroll in MAP or MAP Basic and I am currently enrolled in CommUnityCare's sliding fee scale program, I consent to CommUnityCare sharing my household information and documents with Central Health ("Enrollment Information"). I further consent for Central Health to use and rely upon my Enrollment Information to determine my eligibility for its Central Health Financial Assistance Program.

Consent to Text Messaging and Email Communication

I understand if I agreed to receive text messages or emails in my application for these Program benefits, I have provided my consent to receive information from Central Health regarding scheduled appointments, my application status, renewals and changes to Program coverage and benefits, and other important information via text message or email. I understand there are risks associated with sending unencrypted text messages and emails and that anyone with access to my email account or cell phone (such as a family member or employer) may be able to access these communications. I understand I may revoke my authorization for text messages or emails from Central Health at any time in a signed writing delivered to Central Health.

Authorization for Third Party Verification

By my signature below, I am authorizing 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. I understand that 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.

Printed name of applicant	Applicant signature	Date
Printed name of spouse/common law spouse	Spouse/common law spouse signature	Date
Printed name of application/personal representative	Application/personal representative signature	Date
Relationship to the applicant		

You must complete the form on the following page. →

How to complete the application process instructions:

1. If you are filling out a blank application, answer all the questions on the application.

2. If you were mailed an application with your responses pre-filled in, read all the responses printed:
   - If something is not correct mark a line through it and write the correct information above it.
   - If the question is blank provide an answer.
   - If the question does not apply to you enter N/A. Do not leave the question blank.

3. Provide a copy (do not send originals) of the following:
   - A **photo ID** for all adults in the household such as:

     A 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.

     If applying for CH Financial Assistance, provide an ID for the applicant only.

   - One of the following for all members of the household:

     A Birth Certificate, Naturalization Certificate, Visa/Passport, I-551 U.S Legal Permanent Resident card, I-94, Baptismal record, Voter Registration card, Border Crossing card.

     If applying for CH Financial Assistance, provide the information for the applicant only.

   - **Proof of address** dated from the last 30 days such as:

     Postmarked mail, most current billing cycle electric, telephone, or gas bill, lease agreement, rent receipt, property tax receipt, landlord's statement.

   - **Proof of income** received in the last 30 days for all adults in the household such as:

     Check stubs, Unemployment benefits letter, current year's- Social Security benefit letter, Veterans' Administration benefit letter, Retirement benefits letter, Letter indicating cash contributions, Child Support receipts or printout from Domestic Relations payments, proof of TANF grant amount, Workers' Compensation check stubs or benefit letter

   - **Health insurance ID cards**/letter for all household members with health insurance such as:

     Medicare card, private health insurance card, Medicaid/CHIP card or HHSC Medicaid/CHIP letter for the current month.

Instructions continue on the following page. →

4. Each adult household member must sign and date the Applicant Responsibilities form.

5. To submit your application and documents
   - Mail in the envelope provided
   - Fax to: 512.776.0457. If sent by fax, be sure to send both sides of the application.
   - Drop off in the Mailbox located at Southeast Health & Wellness Center or the Central Health Northeast Health Resource Center.

If you have any questions, contact our Central Health Navigation Center at 512.978.8130, option 1, Monday–Friday, 8 a.m.–5 p.m.