MAP ID: _____

HOUSEHOLD ID: _____

Applicant Responsibilities

Read both sides of the form. You must sign and date.

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.

You must complete the form on the back. →

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 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 a 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		