MAP CENTRAL HEALTH MAP BASIC

Medical Access Program
APPLICATION FOR HEALTH CARE COVERAGE

First Name, Last Name
Mailing Address
City, State, Zip Code

MR#
Date Printed

Thank you for contacting Central Health and requesting an application for health care coverage.

Household Information

The word "household" refers to: you, your spouse, 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.

If you household information is pre-printed below, please review and make corrections where necessary. Draw a line through the name (s) of any person no longer in your household and/or add the names of any additional household members not listed below.

NAME (Last, First, Middle)	**RELATION SHIP** •Self •Spouse •Child •Grandchild •Other	**Date Of Birth** (month/day/year)	**U. S. Residency Status** • US Citizen •Legal Permanent Resident •Not a US Citizen or Legal Permanent Resident	**SSN** (Social Security Number) ***Required for U.S Citizens and Legal Permanent Residents**	**ITIN** (Personal identification number of the taxpayer) ***Required only if the IRS has issued you an ITIN.**
Zztest Test, Jane Doe	Self	09/23/1988	U.S. Citizen	123-45-6789	

NAME (Last, First, Middle)	RACE •African-American •Anglo •Asian •Hispanic •Native-American •Other	ETHNICITY •Hispanic/Latino •Non-Hispanic/Non-Latino	SEX (on your birth certificate) •Female •Male	Gender Identity Transgender Male, Transgender Female, Gender Queer, Gender Non-Conforming, Non-Binary, Other, Decline to answer
Zzztest Test, Jane Doe	African American	Non-Hispanic/Non-Latino	Female	

Home Address (Street Address only, no P.O. Box)	Apt. #	City	Zip	County
Mailing Address, if different from above (Street or P.O. Box)				
Home Telephone Number	**Cell Telephone Number**			

Please answer <u>all</u> the questions on this application.

1. **What is your primary language?** _____
2. **What is your marital status?** _____
3. **Do you plan to file a federal income tax return for the current year?**

   □ YES □ NO

   If **YES**, list your dependents: _____

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

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

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?** □ YES □ NO

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

☐ **Medicaid**	Who?
☐ **Medicare**	Who?
☐ **CHIP**	Who?
☐ **CHIP Perinatal**	Who?
☐ **Private Health Insurance**	Who?

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

□ 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?**

□ YES □ NO

If **YES**, give the name of who is being sponsored and the name of the sponsor: _____
A Sponsor's income will be counted as part of the household income for the first three years.

11. Has anyone in your household received any income in the last 4 weeks? □ YES □ NO

If YES, 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, loans 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, biweekly, twice a month, monthly)	In School? Yes/No

If NO, complete, sign and date the statement below:

I _____ certify that my household has received zero income in the last 30 days.

Signature: _____ Date: _____

12. List your average monthly household expenses.

Household Expense	**Amount**
Rent/Mortgage	$
Utilities (Gas, electricity, water)	$
Telephone	$
Transportation, such as gas, car payments, bus	$
Tax and Insurance on home per year	$
Other	$
Other	$
Total	

If you do not pay household expenses or your household income does not cover the cost of your expenses, please let us know how your household expenses are paid. If a family member, friend or agency is paying your expenses, you may be asked to provide a Financial Support Statement.

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-Printed

Signature of Applicant

Date

Program Identification Number

Name of Personal Representative ("PR")

Signature of Personal Representative

PR's Relationship to Applicant

Date

MAP CENTRAL HEALTH MAP BASIC

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- ☐ Email address. My current email address is _____.

Name of Applicant-Printed

Signature of Applicant

Date

Program Identification Number

Name of Personal Representative ("PR")

Signature of Personal Representative

PR's Relationship to Applicant

Date

Thank you for contacting Central Health and requesting an application for health care coverage.

Below are instructions on how to complete the application process.

1. **Answer All the Questions on the Application:**
   - 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. Please do not leave the question blank.

2. **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.

   ☐ **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

   ☐ **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 adult 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

3. **Each Adult household Member must Initial, Sign and Date <u>their own</u> Applicant Responsibilities form**

4. **Submit Your Application and Documents**
   - Online at: documents.apply4map.net
   - Mail in the envelope provided
   - Fax to: 512-776-0457
   - Drop off in the Mailbox located at Southeast Health and Wellness Center or the Central Health Northeast Eligibility Office

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