

How To Get Your Harris Health Plan

There is no cost to make a Harris Health Financial Assistance Application. If you are asked to pay, please call 713-566-6277.

Fill out the form called "Application for Financial Assistance." Be sure you, your husband or wife, and ALL children who live with you, between 18 and 26 years old, sign and date the form.

<p>Mail to: Harris Health Financial Assistance Program P.O. Box 300488, Houston, TX 77230 OR Drop off at the nearest Eligibility Center</p>	<p>For Renewal Applicant (except Medicare applicant): If your name, address, marital status, legal status, household member, and health care coverage have not changed since the last expiration, please complete and submit the application along with the family gross income in the past 30 days only. Please visit the website below for more information: https://www.harrishealth.org/en/patients/access-care/eligibility-card/pages/default.aspx</p>
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Harris Health System has pharmacy staff who can sign you up for patient assistance programs to get free medicines from drug companies. You will be asked to sign the Medication Assistance Program (MAP) Consent and Authorization Form (Form #283233) that tells Harris Health to share your personal health information and sign any forms that are needed for you to get free medicine.

Please make and give Harris Health copies of:

This information, papers and signatures are needed for Harris Health Financial Assistance and Drug Replacement Programs, but may not be for other Department of State Health Services programs you may be eligible for like Expanded Primary Health Care Program (EPHC).

1. Identification for you and your husband or wife:

- Marriage license / IRS 1040 if married
- Declaration and Registration of Informal Marriage if common law
- Other proof of marriage

And you need a copy of **one** proof with a picture on it:

- | | |
|--|--|
| <input type="checkbox"/> State issued driver license | <input type="checkbox"/> State issued ID card |
| <input type="checkbox"/> Current student ID | <input type="checkbox"/> Passport with picture |
| <input type="checkbox"/> Current employee job badge | <input type="checkbox"/> Foreign consulate ID card |
| <input type="checkbox"/> U.S. Immigration documents | <input type="checkbox"/> Agency letter |

If you do not have a picture ID, you need a copy of **two** proofs:

- | | |
|--|--|
| <input type="checkbox"/> Birth certificate (not for married women) | <input type="checkbox"/> Other federal document showing your name and address in Harris County |
| <input type="checkbox"/> Marriage license or Declaration and Registration of Informal Marriage | <input type="checkbox"/> Social Security card |
| <input type="checkbox"/> Hospital or birth records | <input type="checkbox"/> Medicaid card |
| <input type="checkbox"/> Adoption papers or records | <input type="checkbox"/> Medicare card |
| <input type="checkbox"/> Current Harris County voter card | |
| <input type="checkbox"/> Current check stub | |

2. Address with your name or your husband or wife's name

You need a copy of one proof dated within the last 60 days:

- | | |
|---|--|
| <input type="checkbox"/> Utility bill | <input type="checkbox"/> Check stub |
| <input type="checkbox"/> Mortgage coupon | <input type="checkbox"/> Credit card statement |
| <input type="checkbox"/> Business mail | <input type="checkbox"/> Medicaid or Medicare letter |
| <input type="checkbox"/> School record for children under age 18 | |
| <input type="checkbox"/> Certification documents or benefit checks from Social Security Administration or Texas Workforce Commission | |
| <input type="checkbox"/> Certification paper from Supplemental Nutrition Assistance Program (SNAP), or SNAP Form TF0001 | |
| <input type="checkbox"/> Agency letter | |
| <input type="checkbox"/> Statement from a licensed child care provider | |
| <input type="checkbox"/> Harris Health System-Residence Verification Form filled out by a non-related person not living in your house | |

Or

You need a copy of one proof dated within the last year:

- | | |
|---|--|
| <input type="checkbox"/> Lease agreement | <input type="checkbox"/> Property tax document |
| <input type="checkbox"/> Department of motor vehicle record | <input type="checkbox"/> Automobile insurance document |
| <input type="checkbox"/> Harris County voter card | <input type="checkbox"/> Printout from IRS of most current year's tax filing |
| <input type="checkbox"/> Automobile registration | |

5. Immigration Status for you, your husband or wife and all your children who depend on you for support

You must show current or expired documents from the U.S. Citizenship and Immigration Services.

6. Health Care Coverage for you, your husband or wife and all your children who depend on you for support

Please show current proof of Medicaid, CHIP, CHIP Perinatal, Medicare, or health insurance.

7. If you have Medicare and are eligible for Harris Health System Financial Assistance Program

You must fill out a Medicare Asset Form and show proof of your current resources and liabilities (all pages of bank statements, credit card bills, loans, etc.).

You must fill out papers for CHIP, CHIP Perinatal, Medicaid, TANF (Temporary Assistance for Needy Families), SSI (Supplemental Security Income), Title V or Texas Women's Health Program (TWHP) if you can have these programs. To download and print the TX Medicaid /CHIP application, please go to:

<http://yourtexasbenefits.hsc.texas.gov/sites/default/files/docs/1205-eng.pdf>

3. Gross income for the past 30 days for you, your husband or wife and children over the age of 18 who are living with you.

- | | |
|---|--|
| <input type="checkbox"/> Cash income | <input type="checkbox"/> Dividends and royalties |
| <input type="checkbox"/> Rental property | <input type="checkbox"/> Alimony |
| <input type="checkbox"/> Workmen's compensation | <input type="checkbox"/> Military pay and allowances |
| <input type="checkbox"/> Current check stubs | <input type="checkbox"/> Child support documents |
| <input type="checkbox"/> Social Security award letter | <input type="checkbox"/> Retirement award letter |
| <input type="checkbox"/> Current IRS 1040/1040A tax return (all pages) if self-employed | |
| <input type="checkbox"/> Veteran Affairs letter or check | <input type="checkbox"/> Agency letter |
| <input type="checkbox"/> Unemployment benefit record | <input type="checkbox"/> Income on SNAP form TF0001 |
| <input type="checkbox"/> Harris Health System- Statement of Self Employment Income Form if no tax return is filed | |
| <input type="checkbox"/> Harris Health System- Statement of Wage Verification Form (for cash and personal check wages only) | |
| <input type="checkbox"/> Harris Health System- Statement of Support Form if no income | |
- 4. Proof of how you are related to the children living with you who depend on you for support**
- | | |
|---|--|
| <input type="checkbox"/> Birth certificate | <input type="checkbox"/> Baptismal record |
| <input type="checkbox"/> Proof of full time school enrollment for students aged 18 to 26 | <input type="checkbox"/> Social Security award letter with dependent's names |
| <input type="checkbox"/> U.S. Immigration applications with dependents' names | <input type="checkbox"/> Baby's Popras forms |
| <input type="checkbox"/> Divorce decree or child support document | |
| <input type="checkbox"/> Death certificate for previous household members | |
| <input type="checkbox"/> School documents or insurance documents showing names of both parent and child | |
| <input type="checkbox"/> Birth fact record or hospital armband for infants less than 90 days old | |
- U.S. Department of Health and Human Services- Office of Refugee Resettlement-Verification of Release Form (ORR UAC/R-1) for Unaccompanied alien child.

APPLICATION FOR FINANCIAL ASSISTANCE

This is an Official Government Record. False or incomplete information given on this form may result in criminal action being taken under Sections 31.04, 37.04, 37.10, or other portions of the Texas Penal Code.

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Name: _____ Maiden Name: _____
 Home Address: _____ Apt #: _____ County: _____
 City: _____ State: _____ Zip Code: _____ Email Address: _____
 Home Telephone #: _____ Work Telephone #: _____ Mobile Telephone #: _____

Marital Status: Single Married Separated Divorced Widowed Common Law/Informal married

Household members:

Last Name	First Name	Relationship	Date of Birth	Social Security #	Race	Ethnicity	Sex	Employed	Legal Status
		SELF			<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Other <input type="checkbox"/> Unknown/No answer <input type="checkbox"/> American Indian <input type="checkbox"/> Alaska Native <input type="checkbox"/> Pacific Islander	<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> US citizen <input type="checkbox"/> Legal Resident <input type="checkbox"/> Undocumented <input type="checkbox"/> Work Permit <input type="checkbox"/> Sponsored <input type="checkbox"/> Visa
					<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Other <input type="checkbox"/> Unknown/No answer <input type="checkbox"/> American Indian <input type="checkbox"/> Alaska Native <input type="checkbox"/> Pacific Islander	<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> US citizen <input type="checkbox"/> Legal Resident <input type="checkbox"/> Undocumented <input type="checkbox"/> Work Permit <input type="checkbox"/> Sponsored <input type="checkbox"/> Visa
					<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Other <input type="checkbox"/> Unknown/No answer <input type="checkbox"/> American Indian <input type="checkbox"/> Alaska Native <input type="checkbox"/> Pacific Islander	<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> US citizen <input type="checkbox"/> Legal Resident <input type="checkbox"/> Undocumented <input type="checkbox"/> Work Permit <input type="checkbox"/> Sponsored <input type="checkbox"/> Visa
					<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Other <input type="checkbox"/> Unknown/No answer <input type="checkbox"/> American Indian <input type="checkbox"/> Alaska Native <input type="checkbox"/> Pacific Islander	<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> US citizen <input type="checkbox"/> Legal Resident <input type="checkbox"/> Undocumented <input type="checkbox"/> Work Permit <input type="checkbox"/> Sponsored <input type="checkbox"/> Visa
					<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Other <input type="checkbox"/> Unknown/No answer <input type="checkbox"/> American Indian <input type="checkbox"/> Alaska Native <input type="checkbox"/> Pacific Islander	<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> US citizen <input type="checkbox"/> Legal Resident <input type="checkbox"/> Undocumented <input type="checkbox"/> Work Permit <input type="checkbox"/> Sponsored <input type="checkbox"/> Visa

Household Income: (includes all gross income in the family)

Name of person working or getting money	Source of Income/Company Name	How Often? (Weekly, Bi-weekly, twice a month, monthly)	Amount

Is anyone pregnant? No Yes, who? _____ Expected Due Date: _____
 Does anyone have health insurance? No Yes, who? _____
 Name of Insurance Company: _____ Member #: _____
 Have you or a member of your household applied for any Social Security benefits? No Yes, who? _____ When? _____
 Is there a medical need? No Yes

You must report any changes of name, address, marital status, legal status, income, household members, and health care coverage right away. Failure to report these changes may mean you lose your assistance from Harris Health System and may be responsible to pay the costs of care from Harris Health System. Harris Health System has the right to ask for more information.

I certify under penalty of law that the information I have given to Harris Health System is true and complete to the best of my knowledge. My signature authorizes the release of information to Harris Health System vendors, contractors, state and federal agencies, or patient assistance programs to review records for auditing purposes.

I have read the "Statement of Applicant's Rights and Responsibilities" on Page 2 - Back Yes No

You, your husband or wife and all children 18 to 26 years old who live in your house must sign and date to get a Harris Health Plan with prescriptions

Your signature:	Date:
Signature of your husband or wife if married or common law:	Date:
Signature of your child 18 to 26 years old who lives in your house:	Date:
Signature of your child 18 to 26 years old who lives in your house:	Date:
Witness signature (if any line is signed with an "X"):	Date:

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 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 release of all information, including but not limited to, income and medical information, by and to the Texas Department of State Health Services (DSHS) 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 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, Veterans Administration benefits, TRICARE, and Worker's Compensation benefits, must be reported to Provider. Benefits from health insurance may be considered the primary source of payment for health care received. I hereby assign to Provider any such benefits. I also assign payment for benefits and services received from and through Provider directly to the service providers.
I understand that, to maintain program eligibility, I will be required to reapply for assistance at least every twelve 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 is eligible or potentially eligible.
With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 522.023 and 559.004)
I understand and agree that the program does not provide payment for inpatient care. I understand that I must make my own arrangement for hospital care and that I am responsible for the cost of the care.
If you provide us with your e-mail address, you agree to receive communications from Harris Health System about you and your family’s financial assistance plan and eligibility. IF YOU PROVIDE US YOUR EMAIL ADDRESS, YOU MUST KEEP YOUR E-MAIL ADDRESS CURRENT.
You are responsible for maintaining your current and accurate e-mail address to receive communications from Harris Health System about you and your family’s financial assistance plan and eligibility. You agree that e-mail may not be a private communication between you and Harris Health System – anyone with access to your e-mail account, such as a family member or employer, may be able to access these email communications.