TEXAS Health and Human Services

Medical Facility Referral

Form H1038
July 2004

PART I – To be completed in triplicate by Medical Facility Staff on persons NOT currently receiving public assistance and who wish to make application to the Texas Health and Human Services Commission for assistance. This form is to be mailed to the local eligibility determination office.

1. Name of Applicant	Medicare Claim No.	Date of Birth	Sex	Race
Address (Street, City, State, ZIP)			County	
2. Name of Medical Facility				
Address (Street, City, State, ZIP)			County	

3. Complete this section ONLY if someone is acting on behalf of the applicant.

Name of Person Acting on Behalf of Applicant	Relationship
Address (Street or P.O. Box, City, State, ZIP)	

4. I wish to make application to the Texas Health and Human Services Commission for Temporary Assistance for Needy Families and/or Medical Assistance because I am in need, and/ Deseo solicitar Asistencia Temporal a Familias Necesitadas (TANF) o Asistencia Médica a la Comisión de Salud y Servicios Humanos de Texas porque tengo necesidad y porque

- ☐ **I am 65 years of age or older./** Tengo 65 años de edad o más.
- ☐ **I am blind./**Soy ciego(a).
- ☐ **I am permanently and totally disabled./** Estoy total y permanentemente discapacitado(a).
- ☐ **I have children under 19 years of age who are living at home and are deprived of parental support because of death, absence, or incapacity of a parent./** Tengo en la casa niños menores de 19 años de edad a quienes les falta manutención de uno de los padres debido a la muerte, ausencia o discapacidad de uno de los padres.

Signature – Person Acting on Behalf of Applicant Firma – Representante del Solicitante	**Date** Fecha	**Signature – Applicant** Firma – Solicitante	**Date** Fecha

5. Next of kin (or person able to supply information if applicant is unable to)	
Address (Street or P.O. Box, City, State, ZIP)	Telephone No. (inc. A/C)

PART II – To be completed by worker after completing an application.

	1. Date Referral Received	2. Category
3. Income Assistance ☐ **Eligible** ☐ **Ineligible** ⟵ Effective Date of Action	If ineligible, give reason:	
4. Medical Assistance ☐ **Eligible** ☐ **Ineligible** ⟵ Effective Date of Action	If ineligible, give reason:	

5. To be completed ONLY if the applicant is eligible, has income, and is residing in a Nursing Care Facility

a. Monthly Amount To Be Applied to Personal Needs..... **$** _____

b. Monthly Amount To Be Applied to Support, Maintenance and Treatment..... **$** _____

Signature –Worker	Date

With a few exceptions, you have the right to request and be informed about the information that the Texas Health and Human Services Commission (HHSC) obtains about you. You are entitled to receive and review the information upon request. You also have the right to ask HHSC to correct information that is determined to be incorrect (Government Code, Sections 552.021, 552.023, 559.004). To find out about your information and your right to request correction, please contact your local eligibility determination office.	Con algunas excepciones, usted tiene el derecho de saber qué información obtiene sobre usted la Comisión de Salud y Servicios Humanos de Texas (HHSC) y de pedir dicha información. Si desea recibir y estudiar la información, tiene el derecho de solicitarla. También tiene el derecho de pedir que la HHSC corrija cualquier información incorrecta (Código Gubernamental, Secciones 552.021, 552.023, 559.004). Para enterarse sobre la información y el derecho de pedir que la corrijan, favor de ponerse en contacto con la oficina local de determinación de elegibilidad.