Case Number: 1234567890

Health-Care Benefits Renewal

John Doe
APT 1234
1234 GENERIC DR
SAN ANTONIO TX 77777-7777

How to Renew

1. Review and Update the Form

- If any of the facts printed on this form are not correct, cross out the information and write in the correct information.
- **You must write any new facts in. This includes a new address or a change in immigration status.**
- If you update any information you must sign and return the renewal form to HHSC.

2. Submit Form

There are five ways to submit your renewal form to renew your benefits.

Pick only one:

- **YourTexasBenefits.com:** You can update the facts we have about you and upload your items online.
- **Mail**: Mail the renewal form with all the correct facts about you and the items we need from you to:

  TEXAS HEALTH AND HUMAN SERVICES COMMISSION
  P O BOX 149024
  AUSTIN, TEXAS 78714-9024
- **Fax**: Fax the renewal form with all the correct facts about you and the items we need from you packet to 1-877-447-2839, If your form is 2-sided, fax both sides.
- **Phone**: Call 2-1-1 (after you pick a language, press 2). If you have a hearing or speech disability, call 7-1-1 or any relay service.
- **In person:** At a benefits office. To find an office near you, go to YourTexasBenefits.com or call 2-1-1 (after you pick a language, press 1).

Items you may need to renew

- Employer and income information for everyone in your family (for example, from pay stubs, W-2, or wage and tax statements).
- Policy numbers for any current health insurance.
- Information about any job-related health insurance.

Questions about this form or Need help?	• **Online:** YourTexasBenefits.com • **Phone:** Call 2-1-1 or 877-541-7905 between 8 a.m. - 6 p.m. Central Standard Time Monday - Friday. If you have a hearing or speech disability, call 7-1-1 or any relay service. 1. Select your language (English is 1). 2. Select 2 (state benefit programs). 3. Select 1 (Help with SNAP. . . Medicaid). 4. Select 1 to enter your Social Security Number and Date of Birth (two-digit month, two-digit date, four-digit year) or select 2 to enter your case number. Enter 2 when it asks for you to enter the case number if you only know your Social Security number and date of birth. 5. Select Option 4 (Another Question not already listed). 6. Select Option 4 (Question Not Listed). • **In person:** At a benefits office. To find an office near you, go to YourTexasBenefits.com or call 2-1-1 (after you pick a language, press 1).

Case Name: John Doe

Case Number: 1234567890

Your Contact Information

Phone	Home	1234561234	Office		Other	1234561234
E-mail Address:	test123@hotmailll.com					

Facts About You (Head of Household)

Name	John Doe			
Home Address	Apt #	City	State	County
1234 GENERIC DR San Antonio TX 77777-7777	1234	San Antonio	Texas	Bexar
Mailing Address	Apt #	City	State	County
1234 GENERIC DR San Antonio TX 77777-7777	1234	San Antonio	Texas	Bexar

Your Renewal Facts

Name	Gender	Date of Birth	Relationship to Head of Household	This Person Lives	U.S. Citizen	Lives in Texas	Plans to Stay in Texas
Jane Doe	Male	09/04/2022	Son	At home	Yes	Yes	Yes

People in your household or on your Tax Return who DO NOT need to renew now

Name	Gender	Date of Birth	Relationship to Head of Household	Receiving Health Care Benefits	Lives in Texas	This person lives	Plans to Stay in Texas

Name	Gender	Date of Birth	Relationship to Head of Household	Receiving Health Care Benefits	Lives in Texas	This person lives	Plans to Stay in Texas
John Doe	Female	12/08/1989	Self	Yes	Yes	At home	Yes

Immigration Status		
Has immigration status changed?..	☐ Yes ☐ No	
If yes, complete the following:		
Name	Immigration Registration Number	Document Type

Facts about NEXT YEAR'S Federal Income Tax Return						
Name	Tax Dependent	Filing Separately	Filing Jointly	Filing Separately and as a Tax Dependent	Filing Jointly and as a Tax Dependent	Doesn't file taxes and isn't a Tax Dependent
Jane Doe						
John Doe						
Has tax status for any individual changed?			☐ Yes ☐ No			

Your Other Health Insurance Coverage		
Policy Holder's Name	Insurance Company	Effective Date

Does the health insurance cover family planning services? ☐ Yes ☐ No

If yes, if we file a claim on your health insurance, will it cause you physical, emotional, or other harm from your spouse, parents or other persons? ☐ Yes ☐ No

If yes, tell us why filing a claim with your health insurance company would cause you harm.

____

____

____

Income

Update Income (If the facts about your income have changed you must correct any wrong information).............................

Name	Name of Employer	Income Type	Amount	Total Pretax Contributions Per Pay

				Period
John Doe	Wells Fargo Bank	Wages	0.00	0.0

Add New Income ....

You must report all types of income including:
-Income from a job -Unemployment, Pensions -Social Security -Retirement accounts -Net Alimony received if your divorce decree or separation agreement was executed or last modified on or before 12/31/2018.
-Farming / fishing -Net rental / royalty -Other income

Name	Person, company, or agency paying the money. If you were working for yourself, write "self."	Employer Address	Employer Phone Number	Hours worked per week	Amount	Total Pretax Contributions Per Pay Period	How often is it contributed?	Date Contributed

If you need to list more income, add more pages with the same facts.

Expenses

Add New Expense ....

Name	Expenses Type	Amount / Value	How Often Paid

More Facts about the People included on this Form

Is anyone pregnant?.......... ☐ Yes ☐ No

a.) If yes who is pregnant? ________

b.) Is this your first pregnancy? ☐ Yes ☐ No

c.) How many babies are expected during this pregnancy? ________

d.) Due date (mm/dd/yyyy): ________

e.) Was anyone in your home pregnant during the last 12 months? ☐ Yes ☐ No

If yes, who was pregnant? ________

When did the pregnancy end? (mm/dd/yyyy): ________

Does a child applying for health care travel with a family member who is a migrant farm worker? ☐ Yes ☐ No

If yes, who? ________

Does anyone have unpaid medical bills from the last 3 months?.. ☐ Yes ☐ No

If yes, who? ____________

In the last 12 months, did you transfer, deed, sell or give away any houses, lots, land or money, or did you waive your right to any income? ☐ Yes ☐ No

Is anyone who is applying for health coverage in jail (incarcerated)? ☐ Yes ☐ No

If yes, who? ____________

If you want, you can give someone the right to act for you (an authorized representative).
That person can:

- give and get facts for this application.
- take any action needed for the application process. This includes appealing an HHSC decision.
- take any action needed to enroll in Medicaid or CHIP. This includes picking a health plan.
- take any action needed to get benefits. This includes reporting changes and renewing benefits.

By agreeing to act as your authorized representative, I agree to:

- fulfill all your responsibilities related to Medicaid;
- keep information about you private;
- obey state and federal laws about conflict of interest and keeping information private, including:
  - laws that protect information on people who apply for or receive Medicaid (42 CFR part 431, subpart F);
  - laws about the privacy and safety of personally identifiable information (45 CFR §155.260(f)); and
  - laws barring the state from paying anyone other than your provider or you for Medicaid services, except in a few circumstances (42 CFR §447.10).

Do you want to give someone the right to act for you - to be your authorized representative? ☐ Yes ☐ No

You can have only one authorized representative for all your benefits from HHSC. If you want to change your authorized representative: (1) log in to your account on YourTexasBenefits.com and report a change, or (2) call 2-1-1 (after you pick a language, press 2). If you're a legally appointed representative for someone on this application, send proof with the application.

Authorized Representative's Name: ____________

Organization ____________

Address ____________

Phone Number ____________

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.

Signature ______________________________ Date: ______________

Family violence exemption

- If you're afraid that giving us facts about someone could cause harm (physical or emotional) to you or your child, you might be able to get the "Family Violence Exemption." This means you might not have to give us facts about that person.

Healthy Texas Women provides free women's health and family planning services for women ages 15-44. To keep your participation in Healthy Texas Women private, you can get letters about the program at a different address than what is on your application. Fill out the section below to use a confidential address and phone number.

Mailing Address - Street:	
City:	
State:	
Zip:	
Phone number:	

Women 15-44 years old who do not qualify for Medicaid or CHIP are automatically tested for Healthy Texas Women (HTW) eligibility. Check the box below if you waive HTW testing.

Name:		I do not want to be tested for HTW.	☐ Yes	☐ No
Name:		I do not want to be tested for HTW.	☐ Yes	☐ No
Name:		I do not want to be tested for HTW.	☐ Yes	☐ No

Preferred Method of Contact by Health Plan Providers or Managed Care Organizations

If you get health benefits from us, your health plan provider or managed care organization (MCO) may contact you for the following.

- Appointment reminders
- Information about your health care matters
- Other important notices

You can choose to receive this contact by phone, text message or email.

Text message and e-mail are not encrypted and may not be secure. The risks include an unauthorized third party intercepting confidential or private information. If one of these is your preferred method of communication for your health care, be aware of these risks when sending your personal information by text or email.

Your MCO or health plan provider must take reasonable steps to make sure that your health care information stays private.

By completing the information below, you acknowledge that you understand the risks associated with receiving electronic communications and consent to HHSC sharing your preferred method of contact with your MCO or health plan provider.

Select your preferred contact method from the list below.

Name: John Doe

Language you prefer to be contacted in: Spanish

Method	Details
2 By Telephone	**Telephone Number:** (123) 456-1234 (if contacted by cell phone, the call may be auto-dialed or pre-recorded, and your carrier's usage rates may apply)
1 By Text message	**Cell phone number:** (123) 456-1234 (Carrier message and data rates may apply)
3 By e-mail	**E-mail address:** test123@hotmailll.com

Signing up to vote

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you are not registered to vote where you live now, would you like to apply to register to vote here today?

☐ Yes ☐ No

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private. If you believe that someone has interfered with your right to register or to decline to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the

Elections Division,
Secretary of State,
PO Box 12060,
Austin, TX 78711.
Phone: 1-800-252-8683

Agency Use Only: Voter Registration Status

Agency Use Only: Voter Registration Status

☐ Agency registered ☐ Client declined ☐ Agency transmitted ☐ Client to mail ☐ Mailed to client ☐ Other

Agency staff signature ____________________

Important Information for Former Military Service Members

Women and men who served in any branch of the United States Armed Forces, including Army, Navy, Marines, Air Force, Coast Guard, Reserves or National Guard, may be eligible for additional benefits and services. For more information, please visit the Texas Veterans Portal at https://veterans.portal.texas.gov.

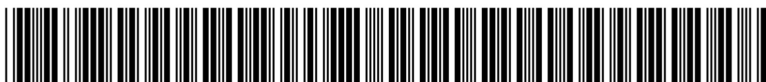
Read & sign this application

I'm signing this application under penalty of perjury which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false or untrue information.

- I know that I must tell the Texas Health and Human Services Commission (HHSC) if anything changes (and is different than) what I wrote on this application. To report changes, I can go to YourTexasBenefits.com or call 2-1-1 or 1-877-541-7905. I understand that a change in my information could affect the eligibility for member(s) of my household.

- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file

I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed).
If not , ____________________ is incarcerated.
(name of person)



We need this information to check your eligibility for help paying for health coverage if you choose to apply. We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof.

Renewal of coverage in future years

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the agency to use income data, including information from tax returns. The agency will send me a notice, let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next

☐ 5 years (the maximum number of years allowed), or for a shorter number of years:

☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year ☐ Don’t use information from tax returns to renew my coverage.

If anyone on this application is eligible for Medicaid

I am giving to HHSC the rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving to HHSC rights to pursue and get medical support.

Does any child on this application have a parent living outside of the home? ☐ Yes ☐ No

If yes, I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell HHSC and I may not have to cooperate.

My right to appeal

If I think HHSC has made a mistake, I can appeal its decision. To appeal means to tell someone at HHSC that I think the action is wrong and ask for a fair review of the action. I know that I can find out how to appeal by contacting HHSC at 2-1-1 or 1-877-541-7905 Press 2 after you pick a language and ask to speak with someone about your Medicaid. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

If you think you have been discriminated against because of race, color, national origin, age, sex, disability, or religion, you can file a complaint by calling (888) 388-6332.

Sign this application

Signature	Date (mm/dd/yyyy)

The person who filled out the form or their authorized representative should sign.