TEXAS Health and Human Services

Form 3031
March 2023

Children with Special Health Care Needs (CSHCN)

Program Application

Applicant Information

Tell us about the person who needs our help. Use the name as it appears on the proof of birth document.

First Name:	Middle Name:	Last Name:
Date of Birth:	Social Security No.(if available):	Sex: ◉ Male ◯ Female
CSHCN Client ID No.:	Citizenship Status: ◯ U.S. citizen ◯ Non-citizen ◯ Eligible Immigrant	

Date of Texas Residency (if you were born in Texas, use your date of birth).
Otherwise, use the first day of the month you located to Texas:

Proof of birth date. First-time applicants, send us one of the following: Birth certificate, passport, Bureau of Vital Statistics record, adoption records, Medicaid ID, CHIP card, hospital or public health birth record, Native American census record, immigration documents, paternity records from the Attorney General, Social Security Administration records, court or child support orders, or school or day care records (call your Regional Office for form).

Contact Information

Home Address:	City:	State:	ZIP Code:
Mailing Address (if different):	City:	State:	ZIP Code:

Area Code and Home Phone:	Area Code and Work Phone:	Area Code and Cell Phone:

Email Address:

Proof of Residency. Proof must show the parent or guardian name and the home address you listed above. Proof must also be unexpired and dated within the time frame listed below. Examples of common proofs include:

- utility bill from the last 60 days;
- valid Texas Driver License or ID card;
- valid Texas Voter Registration;
- rent receipt or mortgage payment in the last 60 days;
- current lease;
- any current Medicaid ID; or
- school records for current year (Call your local office for a form).

If you have questions about a proof of residency, call 800-252-8023.

Language Preferences

Preferred spoken language: ◯ English ◯ Spanish

Which language would you like written correspondence in? ◯ English ◯ Spanish

Income Information

What sources of income do you have?

☐ Self-employment ☐ Employment ☐ No household income ☐ VA, retirement, or railroad pension

☐ Rental property ☐ Child support ☐ Dividends or royalties ☐ SSI (Do not include the applicant's SSI income)

☐ Unemployment benefits ☐ Other: _____

What is the pay cycle for this source of income? ◯ Weekly ◯ Every two weeks ◯ Twice per month ◯ Monthly ◯ Yearly

Proofs of income. You must send proof of every source of income for every member of your household that is **legally obligated** to support the applicant.

Proofs must be dated from the last 60 days and be one of the following:

- Paycheck stubs;
- Signed letter from employers;
- Bank statement that shows direct deposit of benefits;
- SSI check or award letter;
- Medicaid Form 1028;
- Unemployment benefit award letter;
- Divorce decree, Attorney General document, or canceled check showing the amount of child support; or
- CSHCN Services Program Employment Verification form (call Regional office for form).

If you have questions about income verification, call 800-252-8023.

Household Information

Provide information for each additional person who lives in your house.

First Name:	Middle Name:	Last Name:	Date of Birth:

Area Code and Home Phone:	Area Code and Work Phone:	Area Code and Cell Phone:

Email Address:

Citizenship Status: ◯ U.S. citizen ◯ Non-citizen ◯ Eligible Immigrant

Is this person legally responsible for the applicant? ◯ Yes ◯ No

Can this person speak for the applicant? ◯ Yes ◯ No

Relationship to Applicant:

◯ Parent/Guardian ◯ Spouse ◯ Sibling ◯ Child ◯ Caregiver ◯ Other: _____

What sources of income do you have?

☐ Self-employment ☐ Employment ☐ No household income ☐ VA, retirement, or railroad pension

☐ Rental property ☐ Child support ☐ Dividends or royalties ☐ SSI (Do not include the applicant's SSI income)

☐ Unemployment benefits ☐ Other: _____

What is the pay cycle for this source of income? ◯ Weekly ◯ Every two weeks ◯ Twice per month ◯ Monthly ◯ Yearly

Additional Household Member

Provide information for each additional person who lives in your house.

First Name:	Middle Name:	Last Name:	Date of Birth:

Area Code and Home Phone:	Area Code and Work Phone:	Area Code and Cell Phone:

Email Address:

Citizenship Status: ◯ U.S. citizen ◯ Non-citizen ◯ Eligible Immigrant

Is this person legally responsible for the applicant? ◯ Yes ◯ No

Can this person speak for the applicant? ◯ Yes ◯ No

Relationship to Applicant:

◯ Parent/Guardian ◯ Spouse ◯ Sibling ◯ Child ◯ Caregiver ◯ Other: _____

What sources of income do you have?

☐ Self-employment ☐ Employment ☐ No household income ☐ VA, retirement, or railroad pension

☐ Rental property ☐ Child support ☐ Dividends or royalties ☐ SSI (Do not include the applicant's SSI income)

☐ Unemployment benefits ☐ Other: _____

What is the pay cycle for this source of income? ◯ Weekly ◯ Every two weeks ◯ Twice per month ◯ Monthly ◯ Yearly

Add Member **Remove Member**

Insurance Information

☐ The applicant is not covered under any medical insurance.

☐ The applicant has coverage, which is described below.

Medicaid includes Supplemental Nutrition Assistance Program food benefits(SNAP), Temporary Assistance for Needy Families (TANF), and other programs.

Does the applicant have any kind of Medicaid? ◯ Yes ◯ No Medicaid No.:

Does the applicant have Children's Health Insurance Program? ◯ Yes ◯ No

Medical Provider Name:	Dental Provider Name:	CHIP No.:	Coverage Start Date:

Does the applicant have Medicare Part A? ◯ Yes ◯ No Medicare (HICN) No.: Start Date of Part A:

Does the applicant have Medicare Part B? ◯ Yes ◯ No Start Date of Part B:

Does the applicant have Medicare Part C? ◯ Yes ◯ No Start Date of Part C:

Does the applicant have Medicare Part D? ◯ Yes ◯ No Start Date of Part D:

Does the applicant have any kind of Medigap or Medicare supplemental coverage? ◯ Yes ◯ No

Member ID No:	Plan Name:	Coverage Start Date:	Phone No.:

Does the applicant have any kind of private insurance? ◯ Yes ◯ No

Does the policy cover medical costs? ◯ Yes ◯ No

Does the policy cover prescriptions? ◯ Yes ◯ No

Insurance Provider Name:	Provider Phone No.:	Employer Name:	Employer Phone No:

Member/Policy Holder Name:	Member/Policy No.:	Member Social Security No.:	Coverage Start Date:

Monthly Premium:

Do you need help paying this premium? ◯ Yes ◯ No

If approved as a client, the program can help pay this premium ..... ☐ Check here to opt out.

Proof of insurance. You **must** send a copy of an ID card *(front and back)* or official letter for each and every type of coverage.

The application is **incomplete** without:

- ☐ Proof of birthdate (first-time applicants)
- ☐ Proof of residency
- ☐ Proofs of income for all household adults
- ☐ Proofs of all of the applicant's medical and dental coverage
- ☐ Your signature and date on the next page
- ☐ Physician/Dentist Assessment Form signed and dated by your doctor or dentist

Privacy Notification

With few exceptions, you have the right to request 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. (Government Code, Section 552.021, 552.023, 559.003 and 559.004.)

Coverage Attestation

By signing below, I attest that the applicant has no other coverage than what is listed in the *Insurance Information* section of this application.

I authorize the program to bill the coverage sources listed for any services provided.

Statement of Release of Information

I authorize release of medical information to the Texas Health and Human Services Commission (HHSC) as necessary to determine and maintain eligibility of the client and coordinate services.

Acknowledgment

I understand that this application is a legal document and that by signing I am stating from my personal knowledge that the facts in the application are true and correct. I understand that the application will not be accepted if it is incomplete.

If you are approved, you are responsible for maintaining your program eligibility.

I understand that if I am unable to provide an original signature on this application, my name will be typed or printed in the space for Applicant Signature and an authorized representative will sign on my behalf.

Applicant Signature **Date**

Authorized Use Only

Authorized Representative Signature **Date**

Authorized Representative Name (Printed) **Title**

These pages show your rights and duties. You must read and understand them.

Your Rights

- You have the right to know all of the information that we collect about you.
- You have the right to be given this information if you ask for it.
- You have the right to review it.
- You have the right to ask us to correct any thing that is not correct.
- You understand that the website https://www.hhs.texas.gov/laws-regulations/legal-information/hipaa-privacy-laws will tell you how we will keep your information private.
- You have the right to be treated fairly, equally, and without regard to race, color, creed, religion, national origin, gender, age, political beliefs, or disability.
- You understand that this treatment will go along with state and federal law. If you think you have not been treated fairly and equally, you can call the Office of Civil Rights of the United States Department of Health and Human Services at 800-368-1019.
- You understand that what you write on the Program application will not be shared with the Internal Revenue Service (IRS) or the United States Citizenship and Immigration Services (formerly the Immigration and Naturalization Service [INS]).
- You have the right to use the appeals process when you disagree with a decision we make about you.
- You have the right to receive a timely response to your appeals.
- You have the right to two types of appeals: the administrative review and the fair hearing. (See below.)

Administrative Review

This type of appeal is a way for you to tell us the reasons why you think we should change one of our decisions about your case. You must request a review **within 30 days** of the date on the letter that tells you our decision. You must state in your request why you disagree with our decision. Be sure to include any items or proof that you think help to support what you state in the request.

You can ask for a review by sending a fax to 512-776-7238, or by sending a written request to:

CSHCN Services Program Administrative Review
Texas Health and Human Services
Office of Primary and Specialty Health, Mail Code 1938
P.O. Box 149030
Austin, Texas 78714-9947

We will send you a letter after we finish our review. The letter will tell you our decision. If you do not agree with that decision, you have a right to request a fair hearing.

Fair Hearing

You can request a fair hearing when you disagree with our decision from the administrative review. You must request a hearing **within 20 days** of the date on the letter that tells you our decision from the administrative review. If you do **not** request a hearing within the 20-day period, you will give up your right to the hearing, and our decision from the administrative review will be final.

If you request a hearing, you should state why you disagree with our decision. Be sure to include any items or proof that you think will help to support what you state in the request.

You may represent yourself or have legal counsel or another spokesperson at the hearing. You can ask for a fair hearing by sending a fax to 512-776-7238, or by sending a written request to:

CSHCN Services Program Fair Hearing
Texas Health and Human Services
Office of Primary and Specialty Health, Mail Code 1938
P.O. Box 149030
Austin, Texas 78714-9947

Your Duties

Your duties are the things you must do as a client in our program. We show you the types of duties you have in the lists below.

About this application:

- You must put only true, correct, and complete information on this application.
- You must answer every question on the application.
- You must not leave out any information that the application asks for.
- You must give us any proof we ask for. We can ask you to give proof of anything that you write on the application.
- You must reapply to our program on time every 12 months, even if you are on the waiting list. "On time" means on or before the date when your eligibility ends.
- You must tell us about any changes in the facts about yourself within 30 days of the change. These facts include your address, phone number income, health care coverage, and family situation. You must **not** wait until your next application to update these facts if they change.

About the Program rules:

- You understand that our program rules describe all of your rights and duties.
- You understand that we will give you a copy of the rules if you ask for one.
- You agree to abide by all of our rules.

About where you live:

- You must intend to continue living in Texas.
- You must not claim to be a resident of another state or country.
- You understand that we cannot pay for services for anyone who comes to Texas just to get health care.

About how to get services:

- You must get services from doctors and others who are part of our program.
- You can get services from others if you want to, but we cannot pay for those services.

About other insurance you may have:

- You understand that we will only pay for services you get **after** all your other insurance or health care programs have refused to pay for them.
- You understand that state law may allow your insurance benefits to be paid directly to us. In that case, the health insurance company can pay us back directly for any care we paid for.
- You understand that when you sign the Program's Application form, you are saying that:
  - we can collect the payments of any health insurance benefits intended for you; and
  - your insurance company can pay your healthcare providers directly for benefits and services you get through us.
- You agree to pay us back if you ever get money from a lawsuit that pays for services we already paid for.

About money you may owe us:

- You understand that if we overpay you or pay you in error, you **must** pay back any money that you owe us.
- You will pay us within a reasonable time after we tell you that you owe us money.
- You understand that we can take the amount you owe out of any money we pay in future.
- You must pay the money back even if you are no longer in our program or you leave our program.
- You or your estate will pay us any money that you owe in a single lump sum if you are no longer in our program.

CSHCN Services Program Regional and Local Offices

The CSHCN Services Program offers case management services to all applicants at no cost. Case managers help families who are having trouble getting medical services, school services, medical equipment and supplies, and other help they need. Contact the closest health service regional office near you to get case management.

Region 1

1A – Amarillo Regional Office

3407 Pony Express Way
Amarillo, TX 79118

Phone: 806-477-1109
or 806-655-7151
Fax: 806-373-4757

1L – Lubbock Regional Office

6302 Iola Ave.
Lubbock, TX 79424-2721

Phone: 806-744-3577
or 806-783-6452
Fax: 806-783-6455

Region 2

2A – Abilene Office

Phone: 325-795-5847

Region 3

3 – Regional Sub-Office (Arlington)

1301 South Bowen Road, Suite 200
Arlington, TX 76013-2262

Phone: 817-264-4634
or 817-264-4619
Fax: 817-264-4911

Region 4

4/5N – Regional Sub-Office (Tyler)

2521 West Front Street
Tyler, TX 75702-7822

Phone: 903-533-5269
Toll free: 877-340-8842
Fax: 903-535-7593

Athens Office

101 West Baker Street
Athens, TX 75751

Phone: 903-675-9107
Fax: 903-675-3622

Carthage Office

1430 South Adams
Carthage, TX 75633

Phone: 903-693-9322
Toll free: 800-306-0568
Fax: 903-694-2316

Gilmer Office

324 Yapaco
Gilmer, TX 75644

Phone: 903-843-3030
Fax: 903-843-4264

Henderson Office

700 Zeid Blvd
Henderson, TX 75652

Phone: 903-655-6256
Toll free: 800-306-0568
Fax: 903-655-0104

Linden Office

213 Hwy 8 N
Linden, TX 75563

Phone: 903-756-4807
Fax: 903-843-4264

Longview Office

1750 North Eastman Road
Longview, TX 75601-3347

Phone: 903-232-3221
or 903-232-3289
Toll free: 866-327-1364
Fax: 903-232-3278

Mineola Office

714 Greenville Hwy
Mineola, TX 75773

Phone: 903-569-8164
Toll free: 866-518-0601
Fax: 903-569-6243

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Region 4 – Continued

Marshall Office 4105 Victory Drive Marshall, TX 75670 **Phone**: 903-927-0218 **Toll free**: 866-327-1364 **Fax**: 903-927-0290	**Mount Pleasant Office** 1014 North Jefferson Mount Pleasant, TX 75455 **Phone**: 903-577-1929 or 903-575-1138 **Toll free**: 866-268-6465 **Fax**: 903-577-8957	**Palestine Office** 330 E. Spring Street, Suite D Palestine, TX 75801 **Phone**: 903-661-6089 **Fax**: 903-729-7034
Paris Office 1460 19th Street NW Paris, TX 75460 **Phone**: 903-737-0236 **Fax**: 903-737-0330	**Sulphur Springs Office** 1400 College, Suite 167 Sulphur Springs, TX 75482 **Phone:** 903-439-9331 **Toll Free:** 866-518-0601 **Fax:** 903-439-9335	**Texarkana Office** **3115 South Lake Drive, Suite 120** **Texarkana, TX 75501** **Telephone**: 903-791-3229 **Fax**: 903-791-3238

Region 5 North

Center Office 912 Nacogdoches Center, TX 75935 **Phone:** 936-598-1231 **Fax:** 936-591-0162	**Crockett Office** 1034 South Fourth Street Crockett, TX 75835 **Phone:** 936-544-4734 **Fax:** 936-544-0280	**Jasper Office** **Jasper-Newton County Public Health District** 139 West Lamar Jasper, TX 75951 **Phone:** 409-384-6829, Ext. 231 **Fax:** 409-384-7861
Kirbyville Office 314 North Herndon Kirbyville, TX 75956 **Phone:** 409-423-7544 **Fax:** 409-423-4027	**Livingston Office** 410 East Church Street, Suite B Livingston, TX 77351 **Phone:** 936-328-8240, Ext. 232 **Toll Free:** 888-851-4748 **Fax:** 936-328-8249	**Lufkin Office** 1210 South Chestnut Lufkin, TX 75901 **Phone:** 936-633-3657, 936-633-3769, or 936-633-3730 **Toll Free:** 877-340-8840 **Fax:** 903-791-3238

Region 6 & 5 South

6/5S – Regional Office (Houston)

5425 Polk Avenue, Suite J
Houston, TX 77023-1497

Phone: 713-767-3111
Fax: 713-767-3125

CSHCN Services Program Regional and Local Offices

The CSHCN Services Program offers case management services to all applicants at no cost. Case managers help families who are having trouble getting medical services, school services, medical equipment and supplies, and other help they need. Contact the closest health service regional office near you to get case management.

Region 7

7T – Temple Office	7A – Austin Office
2408 South 37th Street Temple, TX 76504-7168 **Phone:** 254-771-6774 or 254-771-6738 **Front Desk:** 254-778-6744 **Toll Free:** 800-789-2865 **Fax:** 254-778-5490	1601 Rutherford Lane, Suite C-3 Austin, TX 78754-5119 **Phone:** 512-873-6315 or 254-771-6738 **Toll Free:** 800-789-2865 **Fax:** 512-873-6345

Region 8

8 – San Antonio Office	Eagle Pass Office	Victoria Office
7430 Louis Pasteur Drive San Antonio, TX 78229-4507 **Phone:** 210-949-2142 or 210-949-2155 **Fax:** 210-949-2047	1593 Veterans Boulevard Eagle Pass, TX 78852 **Phone:** 830-758-4254 or 830-758-4252 **Fax:** 830-773-4688	2306 Leary Lane Victoria, TX 77901 **Phone**: 361-574-7421 **Fax**: 361-574-7396

Region 9 & 10

9/10 – El Paso Office	Midland Office	San Angelo Office
401 East Franklin, Suite 210 El Paso, TX 79901-1206 **Phone:** 915-834-7675 **Fax:** 915-834-7808	1101 N. Midland Dr. Midland, TX 79703 **Phone:** 432-683-9492 **Fax:** 432-571-4141	622 South Oakes, Suite H San Angelo, TX 76903 **Phone:** 325-659-7853 **Fax:** 325-655-6798

Region 11

11H – Harlingen Office	Alice Office	11C – Corpus Christi Office	11L – Laredo Office
601 West Sesame Drive Harlingen, TX 78550-4040 **Phone**: 956-423-0130 **Fax**: 956-444-3293	408 N. Flournoy, Suite C Alice, TX 78332 **Phone**: 361-660-2263 **Fax**: 361-668-4000	5155 Flynn Pkwy. Corpus Christi, TX 78411 **Phone**: 361-878-3450 **Fax**: 361-883-4414	1500 Arkansas Avenue, Suite 3 Laredo, TX 78043 -3049 **Phone**: 956-794-6385 **Fax**: 956-729-8600
11M - McAllen Office	**Mercedes Office**	**Brownsville Office**	**Rio Grande City Office**
4501 West Business Hwy 83 McAllen, TX 78501 -9907 **Phone**: 956-971-1373 **Fax**: 956-971-1275	202 West 2nd Street Mercedes, TX 78570 **Phone**: 956-825-5310 **Fax**: 956-825-5320	1000 W. Price Road Brownsville, TX 78520 **Phone**: 956-554-5500 **Fax**: 956-554-5581	608 N. Garza Rio Grande City, TX 78582 **Phone**: 956-487-5556 **Fax**: 956-487-8865