EPILEPSY FOUNDATION
END EPILEPSY TOGETHER

CENTRAL & SOUTH TEXAS

Dear Patient:

Welcome, and thank you for applying for the **DSHS Epilepsy Program** with the Epilepsy Foundation of Central and South Texas. Please send the following documentation to our office to complete the application:

Proof of residency:
Send a copy of a document that shows where do you live and plan to continue living.
(See page #2 of the application for examples you can use)

Proof of Income:

- Send a copy of your income (See page #2 of the application for examples you can use)

Copy of ID:

- Send a copy of any picture ID.

In order to process your application, you must turn in all documents requested. Please email, mail, or fax the application to:

Epilepsy Foundation Central & South Texas
8601 Village Dr. Ste 220 San Antonio, TX 78217
Fax #: 210-653-5355
Email: christine@efcst.org

If you have any questions or comments, do not hesitate to contact us.

Sincerely,
Christine Calderon
Clinical Services Manager

APPLICATION FOR HEALTH CARE ASSISTANCE

1. Complete your name and address;
2. Sign and date the application; and
3. Answer as many questions as you can on this application

Turn in or mail back your application today even if you cannot answer all the questions.

YOUR RESPONSIBILITIES

Applicants are responsible for completing page one of the application form for medical services assistance.

Applicants are responsible for providing documents requested by the contractor. Examples of some of the items you may be asked to prove and documents you can use for proof are:

Where You Live and Plan to Continue Living

- Possible Proof: Valid Texas Drivers License
- Current voter registration
- Rent or utility receipts for one month prior to the month of application
- Motor vehicle registration
- School records
- Medical cards or other similar benefit cards
- Property tax receipt
- Mail addressed to the applicant, his/her spouse, or children if they live together
- Other documents considered valid by the contractor

Your Income

- Possible Proof: Pay check stubs
- Pay checks
- W-2 tax forms or income tax returns
- Sales records
- Statements from employers
- Award letters
- Legal documents
- Statements from persons giving you money

Other Health Care Coverage

- Possible Proof: Award or claim letters
- Insurance policies
- Court documents
- Other legal papers

Information on social security numbers should be given if this information is available. Information on sex (Male/Female) is voluntary. These types of information will not affect your eligibility.

You must give information about health care insurance and any other third party financially liable for health care services.

SOLICITUD DE ASISTENCIA MÉDICA

1. Ponga su nombre y domicilio.
2. Firme y feche la solicitud.
3. Responda el mayor número de preguntas que pueda en esta solicitud.

Entregue su solicitud o mándela por correo postal hoy mismo aunque no pueda responder todas las preguntas.

SUS RESPONSABILIDADES

El solicitante es responsable de la primera página del formulario de solicitud de asistencia de servicios médicos.

El solicitante es responsable de proveer los documentos que el contratista solicite. Los siguientes son algunos ejemplos de las cosas que podrían pedirle que compruebe y los documentos que puede usar como comprobantes:

Dónde vive y dónde piensa seguir viviendo

- Posible comprobante: licencia de conducir de Texas válida
- Registro actual de votante
- Recibos de renta o servicios públicos del mes anterior al mes de solicitud
- Registro de automóvil
- Registros escolares
- Tarjetas médicas o cualquier otro tipo de tarjeta de prestaciones similar
- Recibos de impuestos sobre la propiedad inmobiliaria
- Correspondencia dirigida al solicitante, a su cónyuge o a sus hijos, si ellos viven con el solicitante
- Otros documentos que el contratista considere que son válidos

Sus ingresos

- Posible comprobante: talones de cheque de paga
- Cheques de paga
- Formularios de impuestos W-2 o declaraciones de impuestos sobre la renta
- Registros de ventas
- Declaraciones de los empleadores
- Cartas de adjudicación
- Documentos jurídicos
- Declaraciones de las personas que le dan dinero a usted

Otro tipo de cobertura médica

- Posible comprobante: cartas de adjudicación o reclamación
- Pólizas de seguro
- Documentos judiciales
- Otro tipo de documentación jurídica

Debe dar la información respecto a los números del Seguro Social si tiene dicha información disponible. La información respecto al sexo (si es hombre o mujer) es voluntaria. Estos tipos de información no afectan su derecho a participar.

Usted debe dar la información sobre el seguro médico y cualquier tercera persona que sea financieramente responsable de los servicios de atención de salud.

TEXAS Health and Human Services

Application for Program Benefits

Form 3094
July 2023

This form can be used to apply for health care assistance through the Epilepsy Program. Please complete every field unless instructed to check all that apply.

Section I. Primary Responsible Adult or Adult Applicant Information

*If applicant is applying on behalf of a child, they will be named in Section II.

Name (Last, First, Middle)	Sex ◯ Male ◯ Female	Date of Birth	Race or Ethnicity	
Home Address (Street, Apt. or P.O. Box)	City	County	State	ZIP Code
Home Area Code and Phone No.		Mobile Area Code and Phone No.		
Email Address				

Communication Preferences

The following form fields are optional and do not affect eligibility.

Preferred method of contact (check all that apply): ..... ☐ Email ☐ Phone ☐ Mail

Preferred Spoken Language: ..... ☐ English ☐ Spanish ☐ Other _____

Preferred Written Correspondence: ..... ☐ English ☐ Spanish ☐ Other _____

☐ By checking this box, I authorize my health care provider to contact me via voice mail or text messaging to the mobile phone number listed above.

Do you or another applicant have an immediate medical need? ◯ Yes ◯ No

Important Information for Former Military Services 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, visit the Texas Veterans Portal at **https://veterans.portal.texas.gov**.

Are you a veteran? ◯ Yes ◯ No

Section II. Household Information

Number of People in the Household: _____

This number will include you and anyone who lives with you for whom you are legally responsible. Minors should include parent(s) or legal guardian(s):

Household Members (including Primary Responsible Adult or Adult Applicant)

Name (Last, First, Middle)	Date of Birth	Sex	Race or Ethnicity	Relationship	Has Comprehensive Health Care Coverage? *
					◯ Yes ◯ No
					◯ Yes ◯ No
					◯ Yes ◯ No
					◯ Yes ◯ No
					◯ Yes ◯ No
					◯ Yes ◯ No
					◯ Yes ◯ No

* Comprehensive health care coverage includes Medicare, Medicaid, Children's Health Insurance Program (CHIP), veteran's benefits, TRICARE, private insurance, etc. An authorized program representative will submit a claim for reimbursement from insurer for any benefit, service or assistance received by member with comprehensive coverage. Nutrition services (WIC, SNAP) are not comprehensive health care.

Do you, or does anyone in your household, have any special circumstances? ..... ◯ Yes ◯ No

If Yes, provide a detailed explanation of special circumstances below (Special circumstances would be an unusual situation that you rarely encounter.):

Section III. Other Benefits

Check all benefits that you receive.

- ☐ Children's Health Insurance Program (CHIP) Perinatal
- ☐ Supplemental Nutrition Assistance Program (SNAP)
- ☐ Women, Infants and Children (WIC) Program
- ☐ Medicaid for Pregnant Women
- ☐ Healthy Texas Women (HTW)
- ☐ None of these

Section IV. Acknowledgment

The statement I have made, including my answers to all questions, are true and correct to the best of my knowledge and belief. I agree to give eligibility staff any information necessary to prove statements about my eligibility. I agree to report all changes in income, family composition, residence, current address, employment and all types of health care coverage or benefits no later than 30 days after I become aware of the change. I understand that giving false information could result in disqualification and repayment.

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.)

Acknowledgment

I understand that this application is a legal document and that by signing this form, I am stating that from my personal knowledge, all facts included are true and correct. I understand that giving false information could result in disqualification or reimbursement for the cost of services and that if I am approved to receive program services, I will be held accountable for complying with program policies, including maintaining eligibility and fulfilling all other beneficiary responsibilities.

Statement of Release of Information

I authorize the release of income and medical information to and by the Texas Health and Human Services Commission and the provider, as necessary, to determine eligibility and to coordinate, render and bill for services.

Coverage Attestation

I attest that I, the primary applicant, have no other health insurance coverage than what is listed in Section III, Health Care Information, of this application. I authorize the program to bill the coverage sources listed for any services provided.

Applicant Signature _____ **Date** _____

Relationship to Applicant _____ **Signature of Person Assisting Applicant** _____ **Date** _____

For Facility Office Use Only

Name of Applicant	Type of Determination ◯ New ◯ Re-Certification	Client or Case No.
Case Record Action ◯ Approved ◯ Presumptive ◯ Supplemental ◯ Denied		Eligibility Effective Date

Section V. Household Income Information

List the applicant's household income below. Be sure to include the following types of income: Gross earned income; cash gifts or contributions; investment dividends, interest or royalties; non-educational loans; lawsuit or lump sum payments; mineral rights; pensions or annuities; reimbursements; Social Security benefit payments; unemployment payments; Veterans Affairs (VA); and workers' compensation. Refer to Definition of Income for additional information about different types of income.

Name of Household Member Receiving Money	Name of Agency, Person or Employer Who Provides Money	Type of Income	Amount Received	How Often Received (daily, weekly, every two weeks, twice a month, monthly)	Monthly Income Total
				Total Countable Monthly Income	
				Deductions	-
				Net Countable Monthly Income	

Verification of Income:

Section VI. Program Eligibility

	Household Member	Meets Program Eligibility
1.		☐
2.		☐
3.		☐
4.		☐
5.		☐

Section VII. Contractor Eligibility Certification

Eligibility Effective Date: _____

1. Are all household members eligible as Texas residents? ..... ◯ Yes ◯ No

2. Net Countable Monthly Household Income: ..... _____

3. Household Federal Poverty Level: ..... _____

4a. Proof of Income: ..... ◯ Yes ◯ Waived

4b. Reason for Waiver of Proof of Income: _____

5. Check each program below if you assessed the applicant's potential eligibility:

☐ Medicare ☐ Medicaid ☐ CHIP ☐ CHIP Perinatal

☐ Private insurance ☐ VA benefits ☐ TRICARE ☐ Workers' Compensation

6. If the applicant is potentially eligible for another program, did you assist the applicant with that application? ..... ◯ Yes ◯ No

7. Presumptive Eligibility: ..... ◯ Yes ◯ No ◯ N/A

8. Presumptive Eligibility End Date: ..... _____

Copayment Amount (if applicable): _____

Notes:

Name of Facility	**Facility Staff Member Signature**	**Date**

Form should be kept with client's record. Form should not be submitted to state office.

TEXAS
Health and Human Services

Form 3046
March 2023

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 of Texas 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 the release of all information, including but not limited to, income and medical information by and to the Texas Health and Human Services Commission (HHSC) 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 the 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, Department of Veterans Affairs benefits, TRICARE, and Workers' Compensation benefits, must be reported to the Provider. Benefits from health insurance may be considered the primary source of payment for health care received. I hereby assign to the Provider any such benefits. I also assign payment for benefits and services received from and through the Provider directly to the service providers.

I understand that to maintain program eligibility, I will be required to reapply for assistance at least every 12 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 am eligible or potentially eligible.

With few exceptions, I have the right to request and be informed about information that the state of Texas collects about me. I am entitled to receive and review the information upon request. I also have the right to ask the state agency to correct any information that is determined to be incorrect. (Reference: Government Code, Section 552.021, 522.023 and 559.004)

Applicant's Signature	Date	Provider Staff Signature	Date