TEXAS
Health and Human Services

Form 3028
July 2018-E

Office of Primary and Specialty Health

Household Application

This form can be used to apply for the Primary Health Care (PHC) Services Program, the Title V Fee-For-Service Program or the Epilepsy Program.

Section I. Applicant Information

Name (Last, First, Middle)	Sex	Date of Birth	Race/Ethnicity
	◯ Male ◯ Female		

Social Security No. (Optional)	Area Code and Home Phone	Area Code and Mobile Phone

Home Address (Street, Apt. or P.O. Box)	City	County	State	ZIP Code

Communication Preferences

The following are optional questions and do not affect eligibility. The Office of Primary and Specialty Health keeps email addresses in strict confidentiality and does not share or sell with other third parties.

Email: _____

Sign up for free email updates from the program. This includes notifications regarding benefits, reminders and important dates. ..... ◯ Yes ◯ No

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

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

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

Have regular access to the Internet. ..... ◯ Yes ◯ No

Have a smart phone with Internet access. ..... ◯ Yes ◯ No

Section II. Applicant Health Care Information

I have comprehensive health care coverage. This includes Medicare, Children's Health Insurance Program (CHIP), Veterans Benefits, TRICARE, private insurance, etc. (If yes, an authorized program representative will submit a claim for reimbursement from your insurer for any benefit, service or assistance that you have received.) ..... ◯ Yes ◯ No

Check all benefits that you receive:

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

Section III. 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)/legal guardian(s).

Name (Last, First, Middle)	SSN (optional)	Date of Birth	Sex	Race/Ethnicity	Relationship

Name (Last, First, Middle)	SSN (optional)	Date of Birth	Sex	Race/Ethnicity	Relationship

Household Income Information

Name of person receiving money	Name of employer/person awarding money	Amount per month

Section IV. Applicant Acknowledgment

I have read the Rights and Responsibilities statements in the instructions for Form 3028.

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

_____
Please Initial

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 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.

Coverage Attestation

_____
Please Initial

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

_____
Please Initial

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.

_____ _____
Applicant Signature Date