How To Get Your Harris Health Plan

There is no cost to make a Harris Health Financial Assistance Application. If you are asked to pay, please call 713-566-6277.

Fill out the form called "Application for Financial Assistance." Be sure you, your husband or wife, and ALL children who live with you, between 18 and 26 years old, sign and date the form.

Mail to:	**For Renewal Applicant (except Medicare applicant)**: If your name, address, marital status, legal status, household member , and health care coverage have not changed since the last expiration, please complete and submit the application along with the family gross income in the past 30 days only. Please visit the website below for more information: https://www.harrishealth.org/access-care-hh/eligibility.
Harris Health Financial Assistance Program P.O. Box 300488, Houston, TX 77230 **OR** **Drop off at the nearest Eligibility Center**	

Harris Health System staff can sign you up for patient assistance programs available with drug manufactures via the Medication Assistance Program (MAP) Consent and Authorization (Form #283233). This form allows Harris Health to share your pertinent health information as it relates to the respective criteria requested by the manufactures and it allows Harris Health to sign applicable forms that are necessary to complete the application process should you qualify for patient assistance.

Please make and give Harris Health copies of:

This information, papers and signatures are needed for Harris Health Financial Assistance and Drug Replacement Programs.

1. Identification for you and your husband or wife:

- Marriage license / IRS 1040 if married
- Declaration and Registration of Informal Marriage if common law
- Other proof of marriage

And you need **one** proof with a picture on it:

- State issued driver license
- Current student ID
- Current employee job badge
- U.S. Immigration documents
- State issued ID card
- Passport with picture
- Foreign consulate ID card
- Agency letter

If you do not have a picture ID, you need **two** proofs:

- Birth certificate (not for married women)
- Marriage license or Declaration and Registration of Informal Marriage
- Hospital or birth records
- Adoption papers or records
- Current Harris County voter card
- Current check stub
- Other federal document showing your name and address in Harris County
- Social Security card
- Medicaid card
- Medicare card

2. Address with your name or your husband or wife's name

You need one proof dated within the last 60 days:

- Utility bill
- Mortgage coupon
- Business mail
- Check stub
- Credit card statement
- Medicaid or Medicare letter
- School record for children under age 18
- Certification documents or benefit checks from Social Security Administration or Texas Workforce Commission
- Certification paper from Supplemental Nutrition Assistance Program (SNAP), or SNAP Form TF0001
- Agency letter
- Statement from a licensed child care provider
- Harris Health System-Residence Verification Form filled out by a non-related person not living in your house

Or

You need one proof dated within the last year:

- Lease agreement
- Department of motor vehicle record
- Harris County voter card
- Automobile registration
- Property tax document
- Automobile insurance document
- Printout from IRS of most current year's tax filing

3. Gross income for the past 30days for you, your husband or wife and children over the age of 18 who are living with you.

As a new requirement for completion of your Harris Health Eligibility, every household member over the age 18 must sign and date on the application to allow Harris Health to check TWC information.

- Cash income
- Rental property
- Workmen's compensation
- Dividends and royalties
- Alimony
- Military pay and allowances
- Current check stubs
- Social Security award letter
- Child support documents
- Retirement award letter
- Current IRS 1040/1040A tax return (all pages) if self-employed
- Veteran Affairs letter or check
- Unemployment benefits record
- Agency letter
- Income on SNAP form TF0001
- Harris Health System- Statement of Self Employment Income Form if no tax return is filed
- Harris Health System- Statement of Wage Verification Form (for cash and personal check wages only)
- Harris Health System- Statement of Support Form if no income

4. Proof of how you are related to the children living with you who depend on you for support

- Birth certificate
- Proof of full time school enrollment for students aged 18 to 26
- Baptismal record
- Social Security award letter with dependent's names
- Baby's Popras forms
- U.S. Immigration applications with dependents'names
- Divorce decree or child support document
- Death certificate for previous household members
- School documents or insurance documents showing names of both parent and child
- Birth fact record or hospital armband for infants less than 90 days old
- U.S. Department of Health and Human Services- Office of Refugee Resettlement-Verification of Release Form (ORR UAC/R-1) for Unaccompanied alien child.

5. Immigration Status for you, your husband or wife and all your children who depend on you for support

You must show current or expired documents from the U.S. Citizenship and Immigration Services.

6. Health Care Coverage for you, your husband or wife and all your children who depend on you for support

Please show current proof of Medicaid, CHIP, CHIP Perinatal, Medicare, or health insurance.

7. If you have Medicare and are eligible for Harris Health System Financial Assistance Program

You must fill out a Medicare Asset Form and show proof of your current resources and liabilities (all pages of bank statements, credit card bills, loans, etc.).

8. You must fill out papers for programs such as but not limited to CHIP, CHIP Perinatal, Medicaid, TANF (Temporary Assistance for Needy Families), SSI (Supplemental Security Income), Title V or Healthy Texas Women Program (HTWP) if you can have these programs. To download and print the TX Medicaid /CHIP application, please go to: http://yourtexasbenefits.hhsc.texas.gov/sites/default/files/docs/1205-eng.pdf

Harris Health's Financial Assistance Program is not an insurance plan. Harris Health does not provide health insurance coverage under the Federal Health Insurance Marketplace Exchange.

HARRISHEALTH SYSTEM

Notice of Non-Discrimination

Harris Health System complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Harris Health System does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Harris Health System:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters; and
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters; and
  - Information written in other languages.

If you need these services, please call Harris Health's Language Access Services at 877-612-3004.

If you believe that Harris Health System has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Administrative Director – Patient Experience
Patient/Customer Relations Department
1504 Taub Loop, Houston, TX 77030
Telephone: 713-873-3939/Fax: 713-873-3166
Email: PCR@HarrisHealth.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Administrative Director – Patient Experience is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at:
http://www.hhs.gov/ocr/office/file/index.html.

Español (Spanish)
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-612-3004.

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-612-3004.

繁體中文 (Chinese)
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-612-3004。

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-612-3004 번으로 전화해 주십시오.

العربية (Arabic)
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية متوفر لك بالمجان. اتصل برقم 1-877-612-3004 (رقم)

اُردُو (Urdu)
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-877-612-3004

Tagalog (Tagalog – Filipino)
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-612-3004.

Français (French)
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposes gratuitement. Appelez le 1-877-612-3004.

हिंदी (Hindi)
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-877-612-3004** पर कॉल करें।

فارسی (Farsi)
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-877-612-3004 تماس بگیرید.

Deutsch (German)
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-612-3004.

ગુજરાતી (Gujarati)
સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-877-612-3004.

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-612-3004.

日本語 (Japanese)
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-877-612-3004 まで、お電話にてご連絡ください。

ພາສາລາວ (Lao)
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-877-612-3004.

HARRISHEALTH SYSTEM

APPLICATION FOR FINANCIAL ASSISTANCE

This is an Official Government Record. False or incomplete information given on this form may result in criminal action being taken under Sections 31.04 and 37.10, or other sections of the Texas Penal Code.

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Name:______________________________ Maiden Name: ______________________
Home Address:______________________________ Apt #:__________ County: ____________
City:______________ State: _______ Zip Code:__________ Email Address: ______________________
Home Telephone #:______________ Work Telephone #:______________ Mobile Telephone #: ______________

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Common Law/Informal married

Household members:

Last Name	**First Name**	Relationship	Date of Birth	Social Security #	Race	Ethnicity	Sex	Employed	Legal Status
		SELF			☐ White ☐ Black ☐ Asian ☐ Other ☐Unknown/No answer ☐ American Indian ☐ Alaska Native ☐ Pacific Islander	☐ Hispanic/ Latino ☐ Not Hispanic/ Latino	☐ M ☐ F	☐ Yes ☐ No	☐ US citizen ☐ Legal Resident ☐ Undocumented ☐ Work Permit ☐ Sponsored ☐ Visa
					☐ White ☐ Black ☐ Asian ☐ Other ☐Unknown/No answer ☐ American Indian ☐ Alaska Native ☐ Pacific Islander	☐ Hispanic/ Latino ☐ Not Hispanic/ Latino	☐ M ☐ F	☐ Yes ☐ No	☐ US citizen ☐ Legal Resident ☐ Undocumented ☐ Work Permit ☐ Sponsored ☐ Visa
					☐ White ☐ Black ☐ Asian ☐ Other ☐Unknown/No answer ☐ American Indian ☐ Alaska Native ☐ Pacific Islander	☐ Hispanic/ Latino ☐ Not Hispanic/ Latino	☐ M ☐ F	☐ Yes ☐ No	☐ US citizen ☐ Legal Resident ☐ Undocumented ☐ Work Permit ☐ Sponsored ☐ Visa
					☐ White ☐ Black ☐ Asian ☐ Other ☐Unknown/No answer ☐ American Indian ☐ Alaska Native ☐ Pacific Islander	☐ Hispanic/ Latino ☐ Not Hispanic/ Latino	☐ M ☐ F	☐ Yes ☐ No	☐ US citizen ☐ Legal Resident ☐ Undocumented ☐ Work Permit ☐ Sponsored ☐ Visa
					☐ White ☐ Black ☐ Asian ☐ Other ☐Unknown/No answer ☐ American Indian ☐ Alaska Native ☐ Pacific Islander	☐ Hispanic/ Latino ☐ Not Hispanic/ Latino	☐ M ☐ F	☐ Yes ☐ No	☐ US citizen ☐ Legal Resident ☐ Undocumented ☐ Work Permit ☐ Sponsored ☐ Visa

Please complete the Household Income and Household Expenses sections on Page 2- Back

Is anyone pregnant? ☐ No ☐ Yes, who? ______________________ Expected Due Date:______________

Does anyone have health insurance? ☐ No ☐ Yes, who? ______________________

Name of Insurance Company: ______________________ Member#: ______________

Have you or a member of your household applied for any Social Security benefits? ☐ No ☐ Yes, who? ____________ When? ____________

Is there a medical need? ☐ No ☐ Yes

You must report any changes of name, address, marital status, legal status, income, household members, and health care coverage right away. Failure to report these changes may mean you lose your assistance from Harris Health System and may be responsible to pay the costs of care from Harris Health System. Harris Health System has the right to ask for more information.

I certify under penalty of law that the information I have given to Harris Health System is true and complete to the best of my knowledge. My signature authorizes the release of information to Harris Health System vendors, contractors, state and federal agencies, or patient assistance programs to review records for auditing purposes.

I have read the "Statement of Applicant's Rights and Responsibilities" on Page 2 - Back ☐ **Yes** ☐ **No**

You, your husband or wife and all children 18 to 26 years old who live in your house must sign and date to get a Harris Health Plan with prescriptions

Your signature:	**Date:**
Signature of your husband or wife if married or common law:	**Date:**
Signature of your child 18 to 26 years old who lives in your house:	**Date:**
Signature of your child 18 to 26 years old who lives in your house:	**Date:**
Witness signature (if any line is signed with an "X"):	**Date:**

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HOUSEHOLD INCOME (Includes all gross income in the family)			HOUSEHOLD EXPENSES (Household total monthly expenses)	
Name of person working or getting money.	**Source of Income/ Company name**	**How often?** (weekly, bi-weekly, twice a month, monthly) and Amount	**Expenses**	**Monthly Amount**
			Rent/Mortgage/Housing	$
		$	Utilities (gas, water, electricity, telephone, cable)	$
			Food	$
			Insurance (car, home, other)	$
		$	Car Payment	$
			Medical Expenses	$
			Loans/Credit Cards	$
		$	Other –Explain	$
			Total Monthly Expenses	$
			Who paid for the household expenses? ☐ Myself ☐ Supporter	

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

I understand that, to maintain program eligibility, I will be required to reapply for assistance at least every twelve months and potentially sooner if I am identified eligible for any type of third party assistance.

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 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 is eligible or potentially eligible.

With few exceptions, you have the right to request and be informed about 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. See http://www.dshs.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 522.023 and 559.004)

If you provide us with your e-mail address, you agree to receive communications from Harris Health System about you and your family's financial assistance plan and eligibility. IF YOU PROVIDE US YOUR EMAIL ADDRESS, YOU MUST KEEP YOUR E-MAIL ADDRESS CURRENT.

You are responsible for maintaining your current and accurate e-mail address to receive communications from Harris Health System about you and your family's financial assistance plan and eligibility. You agree that e-mail may not be a private communication between you and Harris Health System – anyone with access to your e-mail account, such as a family member or employer, may be able to access these email communications.

I **authorize** the Texas Workforce Commission (TWC) to release the Unemployment Insurance claims records, Wage Record, or other record to **Harris Health System.** I understand that these are the records of a state agency, and I expressly **authorize** that agency to release these records to the Harris Health System for the following purpose: to process my application for Harris Health Financial Assistance Program. This Authorization shall be valid for a period of twelve months from the date of execution set forth below, or until my written revocation is received by TWC, This release shall apply to all time periods of records held or maintained by TWC unless specifically limited herein.