HARRISHEALTH SYSTEM

How to Get Your Harris Health Financial Assistance Program

There is no cost to make a Harris Health Financial Assistance Application

To obtain Harris Health financial assistance you must complete Harris Health's "Application for Financial Assistance." Be sure you, your spouse, and ALL children between 18 and 26 years old who live with you sign and date the form.

Mail Application to:
Harris Health Financial Assistance Program
P.O. Box 300488, Houston, TX 77230

For Renewal Applicant (except Medicare applicant): If your name, address, marital status, legal status, number of household member(s), and/or health care coverage has not changed since the expiration of your prior application, please complete and submit this application along with your family gross income for the past 30 days only. Please visit the website below for more information: https://www.harrishealth.org/access-care-hh/eligibility.

Harris Health staff is able to enroll you in patient assistance programs available with drug manufactures if you complete the Medication Assistance Program (MAP) Consent and Authorization (Form #283233). This form allows Harris Health to share your health information requested by drug manufacturers and to sign other forms that are necessary to complete your application if you qualify for assistance.

Please Provide Harris Health copies of:

1. Identification of you and if applicable, your spouse:
Provide either: **(1)** Marriage license/IRS 1040, if married; **(2)** Declaration and Registration of Informal Marriage, if marriage is common law; or **(3)** Other proof of marriage and common law marriage **AND** provide one of the following forms of picture identification: **(1)** State-issued driver license; **(2)** State-issued ID card; **(3)** Current student ID; **(4)** Current employee job badge; **(5)** U.S. Immigration documents; **(6)** Passport with picture; **(7)** Foreign consulate ID card; or **(8)** Agency letter. **If you do not have one of the above-listed forms of picture identification provide two of the following documents: (1)** Birth certificate (not for married women); **(2)** Marriage license or Declaration and Registration of Informal Marriage; **(3)** Hospital or birth records; **(4)** Adoption papers or records; **(5)** Current Harris County voter card; **(6)** Current check stub; **(7)** Other federal document showing your name and address in Harris County; **(8)** Social Security card; and/or **(9)** Medicaid card; Medicare card.

2. Gross income for the past 30 days for you, your spouse, and adult children between 18 and 26 and who are full time students living with you:
All household members over 18 must sign and date the application so to allow Harris Health to check the Texas Workforce Commission employment records.
Provide all of the following, if applicable: **(1)** Proof of cash income; **(2)** Current check stubs; **(3)** Proof of income from rental property; **(4)** Workmen's compensation; **(5)** Proof of dividends and royalties; **(6)** Proof of alimony received; **(7)** Proof of military pay and allowances; **(8)** Child support documents; **(9)**Social Security award letter; **(10)**Retirement award letter; **(11)** Current IRS 1040 tax return(all pages) if self-employed; **(12)** Veteran Affairs letter or check; **(13)** Agency letter; **(14)** Unemployment benefits record; **(15)** Income on SNAP form TF0001; **(16)** Harris Health System-Statement of Self Employment Income Form if no tax return is filed; **(17)** Harris Health System-Wage Verification Form (for cash and personal check wages only); and **(18)** Harris Health System-Statement of Support Form, if no income.

3. Address with your name or your spouse's name:
Provide one of the following documents dated within the last 60 days: **(1)**Utility bill; **(2)** Check stub; **(3)** Mortgage coupon; **(4)** Credit card statement; **(5)** Business mail; **(6)** Medicaid or Medicare letter; **(7)** School record for children under 18; **(8)** Certification documents or benefit checks from Social Security Administration or Texas Workforce Commission; **(9)** Certification paper from Supplemental Nutrition Assistance Program (SNAP), or SNAP Form TF0001; **(10)** Agency letter; **(11)** Statement from a licensed child care provider; or **(12)** Harris Health System-Residence Verification Form filled out by a non-related person not living in your house. **If you do not have one of the above documents dated within the last 60 days, provide one of the following documents dated within the last year: (1)** Lease agreement; **(2)** Property tax document; **(3)** Department of motor vehicle record; **(4)** Automobile insurance document; **(5)** Harris County voter card; **(6)** Automobile registration; or **(7)** Printout from IRS of most current year's tax filling.

4. Documentation of Dependent Children Living With You:
Provide one of the following documents: (1) Birth certificate; **(2)** Baptismal record; **(3)**Proof of full time school enrollment for students 18 to 26; **(4)** Social Security award letter with dependent's names; **(5)** Baby's Popras forms; **(6)** U.S. Immigration applications with dependents' names; **(7)** Divorce decree or child support document; **(8)** Death certificate for previous household members; **(9)** School documents or insurances documents showing names of both parent and child; **(10)** Birth fact record or hospital armband for infants less than 90 days old; or **(11)** 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 spouse, and your dependent children: Provide current or expired documents from the U.S. Citizenship and Immigration Services.

6. Health Care Coverage for you, your spouse, and your dependent children**:** Provide 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:
https://yourtexasbenefits.com/GeneratePDF/StaticPdfs/en_US/H1205_Dec2018.pdf

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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 اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-612-3004.

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

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 proposés 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)
સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. કૉલ 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. ໂທ 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 Section 37.10 or other sections of the Texas Penal Code.

There is no cost to make a Harris Health Financial Assistance Application

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

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	$
Are you a current Harris Health System employee? ☐ Yes ☐ No If yes, please list the current income received from Harris Health System.		$	Medical Expenses	$
			Loans/Credit Cards	$
Are you a Harris Health System retiree? ☐ **Yes** ☐ **No** If yes, please list any income being received from Harris Health System.		$	Other –Explain	$
			Total Monthly Expenses	$
Are you a former Harris Health System employee? ☐ Yes ☐ No			**Who paid for the household expenses?** ☐ **Myself** ☐ **Supporter**	

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Is anyone pregnant? ☐ No ☐Yes, who?_____Expected Due Date:_____
Does anyone have health insurance? ☐ No ☐ Yes, who? _____
Name of Insurance Company:_____Member #: _____
Do you or a member of your household receive Medicare because of disability or ALS or ESRD? ☐ No ☐Yes, who?_____
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.

APPLICANT'S AFFIRMATION OF RIGHTS AND RESPONSIBILITIES

By signing this application for assistance, I affirm the following:

I affirm under penalty of perjury that the information on the application and its attachments is true and correct. This application is a legal document. Deliberately omitting information or giving false or misleading information may cause Harris Health to terminate services to me or a member of my household/family.
I understand that if I deliberately omit information or give false or misleading information, I may be required to reimburse Harris Health and the State for the services rendered if I am found to be ineligible for services.
I will report changes in my household/family situation, including changes in income, household/family members, and residency that affect eligibility during the certification period within 14 days of the change.
I authorize the release of all information, including but not limited to income and medical information, to the Texas Health and Human Services Commission (HHSC), the Texas Department of State Health Services (DSHS), or Harris Health in order to determine eligibility, to bill, or to render services to me or my household/family.
I understand that Harris Health may ask me to provide proof of any of the information provided in this application.
I must report to Harris Health any 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.
Because benefits from health insurance may be considered the primary source of payment for health care received, I hereby assign to Harris Health any such benefits as well as any payment for benefits and services received from and through Harris Health 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 as eligible for any type of third-party assistance.
I am a bona fide resident or am a dependent of a bona fide resident of Harris County for Harris Health Financial Assistance and a resident of Texas for grant programs. I physically live in Harris County, maintain living quarters in Harris County, Texas, and do not claim to be a resident of another county or state.
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 am eligible or potentially eligible.
With few exceptions, I have the right to request and to be informed about information that the State of Texas collects. 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. See http://www.dshs.state.tx.us; Texas Government Code §§ 552.021, 552.023 and 559.004.
If I provide Harris Health with my e-mail address, I agree to receive e-mail communications from Harris Health about me and my family/household's financial assistance plan and eligibility. **If I provide Harris Health my e-mail address, I will keep my e-mail address current**. I agree that e-mail may not be a private communication between me and Harris Health because anyone with access to my e-mail account, such as a family member or employer, may be able to access these e-mail communications.
I authorize the Texas Workforce Commission (TWC) to release the Unemployment Insurance claims records, Wage Record, or other record to Harris Health. 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 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.

I have read the "APPLICANT'S AFFIRMATION OF RIGHTS AND RESPONSIBILITIES" ☐ Yes ☐ No

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

Your signature:	**Date:**
Signature of your spouse 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:**