Texas Department of State Health Services

NEWBORN SCREENING BENEFITS OVERVIEW AND APPLICATION PACKET

This packet contains an overview of the Newborn Screening Program (NBS) and the application eligibility process for NBS Benefits.

NBS PROGRAM OVERVIEW

The Department of State Health Services (DSHS) Newborn Screening Program tests dried blood spots for more than 50 genetic disorders. Your doctor has decided that you or your family member may have a disorder tested by the Program. The doctor has referred you to a specialist contracted through NBS Benefits. You have received this packet because the specialist thinks that you may be eligible for benefits.

In cooperation with contracted providers and within the limits of funds budgeted by DSHS, NBS Benefits will provide the following benefits to eligible clients:

- Clinical evaluations and follow-up care
- Confirmatory, follow-up and monitoring; laboratory testing
- Medications
- Vitamins
- Dietary supplements
- Medical foods (formula and low protein foods)

NBS Benefits does not cover durable medical equipment (DME).

Dependent on funding availability, benefits will be provided to a priority population in the following order:

1. children 0-2 years of age
2. children 3-5 years of age
3. children 6-21 years of age
4. pregnant women
5. women of child bearing age
6. adults (female or male)

To be eligible for NBS Benefits an individual must:

- Have an **abnormal screening result** or a confirmed diagnosis of a disorder screened by the Newborn Screening Program;
- Live within the boundaries of Texas;
- Have a **family income** that is at or below 350% of the federal poverty guidelines (FPL);
- If required, make financial participation payments in a timely manner;
- If requested by the program, provide current medical, financial, and residency information and/or documentation in a **timely manner**;
- Have a **parent, managing conservator, or legal guardian** agree to abide by the requirements in the rules if the individual is a minor; and
- Not be eligible for some **other program benefit,** such as Medicaid, Children's Health Insurance Program (CHIP), Children with Special Health Care Needs (CSHCN) or private health insurance that would pay for all or part of the benefits in question.

APPROVAL

When an NBS Benefits application and supporting documents have been reviewed and a determination is made, NBS Benefits will mail letters to you and the contract providers. If you are eligible, the letter will show:

- The starting and ending dates of eligibility; and
- The benefits and/or services the applicant is eligible to receive.

APPEAL OF ELIGIBILITY DETERMINATION/DENIAL

If you are not approved for NBS Benefits, you may appeal to the Newborn Screening Unit. You must send a written request for a hearing within 20 days after you receive the denial notice. We expect that the denial notice is received five days after the date of the notice. Appeals and requests for hearings can **be faxed to (512) 776-7593**,

or mailed to:

Newborn Screening Unit
Department of State Health Services
Mail Code 1918
P.O Box 149347
Austin, Texas 78714-9347

or hand delivered to:

1100 West 49th Street
Mail Code 1918
Austin, TX 78756

If the Newborn Screening Unit does not receive your request for a hearing within 20 days from your receipt of the denial notice, the decision is final.

CLIENT'S RESPONSIBILITY FOR REPORTING CHANGES

If you are approved for benefits, you are responsible for reporting changes. You must report changes in the following areas:

- Income
- Household size
- Residence address
- Employment
- Receipt of other program benefits such as Medicaid, CHIP and/or CSHCN
- Receipt of other third-party coverage benefits such as private insurance

Changes can be reported by mail, telephone, in-person, or through someone authorized to act on your behalf. Changes must be reported within 30 days when you become aware of the change. You must send papers that show proof of the change.

ANNUAL RENEWAL

NBS Benefits will mail you a letter 60 days before your eligibility period ends. The letter will include:

- The NBS Benefits Overview;
- NBS Benefit Application for Services;
- Statement of Rights and Responsibilities; and
- Informational material on other program benefits Medicaid, CHIP and Children with Special Health Care Needs.

Before the eligibility period ends you must:

- Apply or re-apply for other program benefits;
- Receive a letter showing that you are denied or are eligible for other program benefits;
- Complete the NBS Benefits Application for Services and Statement of Rights and Responsibilities;
- Gather papers (supporting documents) that prove your information; and
- **Send the complete application packet to your Physician Specialist's office.**

All supporting documents must be dated within 60 days from receipt in the Newborn Screening Unit.

TEXAS Health and Human Services

Texas Department of State Health Services

NEWBORN SCREENING BENEFITS
APPLICATION FOR SERVICES
SOLICITUD DE SERVICIOS A PRESTACIONES DE
PRUEBAS DE DETECCIÓN TEMPRANA A RECIÉN NACIDOS

APPLICANT INFORMATION / DATOS DEL SOLICITANTE		
Tell us about the applicant who needs our help. If applicant is under age 18; the parent, guardian, or representative must complete the application in full. / Llene los datos de la persona que necesita nuestra ayuda. Si el solicitante es menor de 18 años; el padre, tutor, o representante debe completar la solicitud en su totalidad.		
First Name / Primer Nombre:	Middle Name / Segundo Nombre:	Last Name / Apellido:
Date of Birth / Fecha de Nacimiento:	Female / Mujer ☐ Male / Hombre ☐	NBS Benefits Account #/ # dé Cuenta de NBS:
Diagnosis/ Diagnóstico:		
Physician Specialist's Name: Nombre del Médico Especialista:	What type of benefits are you requesting? ¿Qué tipo de beneficios está solicitando?	

RESIDENCE INFORMATION / DATOS DE RESIDENCIA		
Home Address / Domicilio:		Telephone / Teléfono:
City / Ciudad	State / Estado:	Zip Code / Código Postal:
Mailing Address (if different) / Dirección Postal (si es diferente):		
City / Cuidad:	State / Estado:	Zip Code / Código Postal:

- **Proof of residency:** Proof must show that the applicant, parent, or guardian lives at the address listed above and is within the boundaries of Texas.
  Comprobante de residencia: La prueba debe mostrar que el solicitante, padre, o tutor vive en la dirección mencionada anteriormente y se encuentra dentro de los límites de Texas.

- Proof must be dated within 60 days from receipt in the Newborn Screening Unit. Examples of common proofs include: (See table below.)
  La prueba debe ser fechada dentro los últimos 60 días a partir de ser recibida en la oficina del Programa de Detección de Recién Nacidos. Ejemplos de pruebas comunes incluyen: (Vea la tabla a continuación.)

Current Texas Driver License	Licencia de Conducir de Texas Corriente
Current Texas Voter Registration	Registro de Votante de Texas Corriente
Current Lease	Contrato de Alquilación Corriente
Rent Receipt	Recibo de Renta
Utility Bill	Factura de Servicios Púlicos
Telephone Bill	Factura de Teléfono

HOUSEHOLD INFORMATION / INFORMACIÓN DE MIEMBROS DEL HOGAR List all household members living in the home. / Anote todos los miembros que viven en el hogar.				
First and Last Name Primer Nombre y Apellido	Date of Birth Fecha de Nacimiento	Male Female Hombre Mujer	Live in Texas? ¿Vive en Texas? Yes/Si/No	Relationship to Applicant Parentesco con el Solicitante
1.				Applicant/Solicitante
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14				
15.				

- Add an additional page for more household members.
- Agregar una página adicional para más miembros del hogar.

PREGNANCY INFORMATION / INFORMACIÓN DE EMBARAZO	
Is the applicant or is anyone in the household pregnant? ¿Está el solicitante o alguien en el hogar embarazada?	☐Yes/Sí ☐No
If "Yes," who? / Si contesta "Sí," ¿Quién?	
Expected Due Date: / Fecha Esperada:	

- An unborn child is also counted in the household size.
- Un niño por nacer también se cuenta en el tamaño del hogar.

INCOME INFORMATION / DATOS DE INGRESOS			
Name of person receiving money. Nombre de la persona que recibe dinero.	Name of agency, person, or employer who provides the money. Nombre del patrón, la persona, o la agencia que paga el dinero.	Amount received. Cantidad recibida.	How often received? (daily, weekly, every two weeks, monthly) ¿Con qué frecuencia lo recibe? (diariamente, por semana, cada quincena, mensual)

- **Proof of Income:** You must send proof of income of every member legally obligated to support the applicant. Examples of common proofs include: (See chart below.)
  Comprobantes de Ingresos: Es necesario enviar un comprobante de cada miembro del hogar legalmente responsable de la manutención del solicitante. Ejemplos de pruebas comunes incluyen: (Vea tabla abajo.)
- **Proof** must be dated within 60 days from receipt in the Newborn Screening Program.
  La prueba debe ser fechada dentro los últimos 60 días a partir de ser recibida en la oficina del Programa de Detección de Recién Nacidos.

Paycheck Stubs	Talones de Cheques
Federal Income Tax Return	Declaración Federal de Impuestos
Social Security Benefits	Beneficios de Seguro Social
Social Security Disability	Seguro Social de Discapacidad
Supplemental Security Income	Seguro Suplementario
Unemployment Compensation	Compensación por Desempleo
Child Support Income	Ingresos de Manutención Infantil
Veterans Administration Payments	Pagos de Administración de Veteranos
Statement of Self-Employment Form and Receipts	Declaración de Ingresos de Negocio Propio y Recibos

OTHER PROGRAM BENEFITS / OTROS BENEFICIOS DE PRESTACIONES DE SALUD

NBS Benefits is a payer of last resort. Applicants are required to apply to other programs or benefits **before** applying to NBS Benefits. The other programs or benefits are:

- Medicaid;
- Children's Health Insurance (CHIP); and
- Children with Special Health Care Needs (CSHCN);

NBS Benefits es un pagador de último recurso. Solicitantes deben aplicar para otros programas o beneficios **antes** de solicitar para los beneficios de NBS Benefits. Los otros programas o beneficios son:

- Medicaid;
- Seguro de Salud para Niños (CHIP); y
- Programa de Servicios para Niños con Necesidades de Salud Especiales (CSHCN)

OTHER PROGRAM BENEFITS / OTROS BENEFICIOS DE PRESTACIONES DE SALUD	
Does the applicant have **Medicaid?** / ¿El solicitante cuenta con **Medicaid**?	☐ Yes/Sí ☐ No
Medicaid Number: / Número de Medicaid:	
Does the applicant have **CHIP**? / ¿El solicitante cuenta con **CHIP?**	☐ Yes/Sí ☐ No
CHIP Client Number:/ Número de CHIP:	
Does the applicant have Children with Special Health Care Needs (**CSHCN**) benefits? ¿El solicitante cuenta con prestaciones del Programa de Servicios para Niños con Necesidades de Salud Especiales (**CSHCN**)?	☐ Yes/Sí ☐ No
CSHCN Client Number: / Número de CSHCN:	
Does the applicant have Medicare Part B? ¿El solicitante cuenta con Medicare Parte B?	☐ Yes/Sí ☐ No

- If you receive benefits from any of the above programs, you must send a copy of the identification card or letter of eligibility.
- Si recibe beneficios de alguno de los programas anteriores, debe enviar una copia de la tarjeta de identificación o carta de elegibilidad.

PRIVATE HEALTH INSURANCE INFORMATION / DATOS DE SEGURO PRIVADO	
Does the applicant have any kind of private health insurance? ¿El solicitante cuenta con seguro privado?	☐ Yes/Sí ☐ No
Does the policy cover medical costs? ¿La póliza de seguro cubre gastos médicos?	☐ Yes/Sí ☐ No
Does the policy cover prescribed medications? ¿La póliza de seguro cubre medicamentos con receta?	☐ Yes/Sí ☐ No
Name of Insurance Plan / Nombre del Plan de Seguro:	Policy Number / Número de Póliza:

- If you have private health insurance, you must send a copy of your insurance identification card.
- Si tiene un seguro de salud privado, debe enviar una copia de su tarjeta de identificación.

ACKNOWLEDGEMENT / ENTIENDO QUE

I understand that this application is a legal document. By signing, I attest that the facts in the application are true and correct. I understand that if the application is not complete, it may delay the approval of benefits.

Entiendo que está solicitud es un documento legal. Al firmar, certifico que los hechos en la solicitud son verdaderos y correctos. Entiendo que, si la solicitud no está completa, puede retrasar la aprobación de los beneficios.

Signature – Applicant/Parent/Guardian/Representative Firma – Solicitante/Padre/Guardian/Representante	Date / Fecha

You must send your application and supporting documents to your Physician's Specialist Office.
Debe enviar su solicitud y los documentos de respaldo a la Oficina de su Médico Especialista.

TEXAS Health and Human Services

Texas Department of State Health Services

STATEMENT OF APPLICANT'S RIGHTS AND RESPONSIBILITIES

DECLARACIÓN DE LOS DERECHOS Y DEBERES DEL SOLICITANTE

Rights and Responsibilities in English	Derechos y Deberes en Español
I understand I have the right to request, receive and review information the State of Texas collects about me. I have the right to ask the state agency to correct any information that is incorrect. For more information on Privacy Notification, see www.dshs.texas.gov. (Reference: Government Code, Section 552.021, 522.023 and 559.004)	Yo entiendo que tengo derecho a solicitar, recibir y revisar la información que el estado de Texas colecciona sobre mí. Tengo derecho de pedir que la agencia estatal corrija cualquier información que es incorrecta. Para obtener más información sobre la Notificación de Privacidad, visite www.dshs.texas.gov. (Referencia: Código Gubernamental Sección 552.021, 522.023 y 559.004)
I understand I have the right to be treated fairly, equally, and without regard to race, color, creed, religion, national origin, gender, age, political beliefs, or disability. I understand I have the right to file a complaint with the Office of Civil Rights of the United States Department of Health and Human Services at (888) 388-6332 TDD Toll-free: (877) 432-7232	Yo entiendo que tengo derecho a recibir un trato justo, igualitario y sin distinción de raza, color, credo, religión, origen nacional, sexo, edad, creencias políticas o discapacidad. Entiendo que tengo derecho a presentar una queja ante la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de los Estados Unidos al (888) 388-6332 TDD Llamada gratuita: (877) 432-7232
I understand that the Program is a program of last resort, and that the Program will pay for services only after all other insurance or health care program coverages have refused to pay for them.	Yo entiendo que el Programa es un programa de último recurso, y que el Programa solo pagará los servicios después de que todas las otras coberturas de seguro o de programas de atención médica se hayan negado pagarlos.
I authorize the Program and Provider to share all information, including but not limited to, income and medical information, to determine eligibility, bill, or give services to my household/family or me.	Yo autorizo al Programa y al Proveedor que compartan toda información, incluyendo, pero no limitada a, ingresos e información médica, para determinar la elegibilidad, cobrar o, dar servicios a mi hogar, mi familia o, a mí.
I understand I will receive Program benefits after Program has approved the services and only from doctors and others who are contracted by the Program.	Yo entiendo que recibiré los beneficios del Programa después de que el Programa haya aprobado los servicios y solo de médicos y otras personas contratadas por el Programa.
I must be a bona fide resident of Texas, be physically present within the geographic boundaries of Texas, and not claim residency in any other state or country.	Debo ser residente de buena fe de Texas, estar presente físicamente dentro los límites geográficos de Texas, y no reclamar residencia en ningún otro estado o país.
I must apply for Program benefits at least every 12 months. I must give proof of any information provided in the application.	Yo debo solicitar para beneficios del Programa al menos cada 12 meses. Yo debo dar prueba de cualquier información provista en la aplicación.
I must report any changes that occur in my household. These include changes in home address, income, health care coverage, and family size.	Yo debo reportar cualquier cambio que ocurra en mi hogar. Estos incluyen cambios de domicilio, ingresos, cobertura de atención médica y tamaño de la familia.
By signing the Statement of Rights and Responsibilities, I affirm that the information on the application and its attachments are true and correct. This application is a legal document. Deliberately omitting information or giving false information may cause the Program to terminate services to a member of my household, family or me. If I omit, give false or misleading information; I may be required to pay back the State for the benefits if it is found that I am not eligible.	Al firmar la Declaración de Derechos y Responsabilidades, afirmo que la información y sus anexos son verdaderos y correctos. Esta aplicación es un documento legal. Omitir deliberadamente información o dar información falsa puede causar que el programa termine los servicios a un miembro de mi hogar, de mi familia o a mí. Si omito, doy información falsa o engañosa; puedo ser obligado de pagar al Estado los beneficios si se encuentra que no soy elegible.

Signature of Applicant / Guardian / Representative Firma de Solicitante/Padre/Guardian/Representante	**Date** Fecha
Signature of Contracted Provider Firma del Proveedor Contratado	**Date** Fecha