

Texas Application For Medication Assistance (Required)

Please mail your completed application to: Texas Department of State Health Services, ATTN: MSJA - MC 1873, PO Box 149347, Austin, TX 78714-9347 **-OR- Fax to (512) 989-4011.**

If you need help with this form, call your local community agency. Call 2-1-1 for information on local agencies. **Call THMP at 1-800-255-1090 with questions about this application.**

Section 1: Personal Information

1. Last Name	First Name	Middle Name	Suffix (Jr., Sr., III)
2. Previous names (including maiden name, aliases, and name changes)		2a. Preferred name/pronouns	
3. Do you have a SSN? <input type="checkbox"/> No <input type="checkbox"/> Yes	Social Security Number or Tax ID (if no SSN):		4. Date of Birth:
5. Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish Other:			
6a. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/> Transgender M/F <input type="checkbox"/> Transgender F/M		6b. Sex assigned at Birth <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	
		6c. If applicable, are you currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No Due Date:	
7a. Ethnicity (check one) <input type="checkbox"/> Hispanic (check origin below) <input type="checkbox"/> Mexican, Mexican American, Chicano/a <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Another Hispanic, Latino/a or Spanish origin <input type="checkbox"/> Non-Hispanic		7b. Race (check all that apply) <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian (check origin below) <input type="checkbox"/> Asian Indian <input type="checkbox"/> Korean <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Other <input type="checkbox"/> Native Hawaiian/Pacific Islander (check origin) <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Other/Unknown	
8. Provide 1st phone number		2nd phone number THMP can use to contact you	
8a. May we leave a voice mail message? <input type="checkbox"/> Yes <input type="checkbox"/> No			
9. Are you currently married? <input type="checkbox"/> No <input type="checkbox"/> Yes (complete 9a- 9b)		9a. Spouse on THMP? <input type="checkbox"/> Yes <input type="checkbox"/> No	
9b. Spouse Name	Spouse SSN (if applicable)		Spouse Date of Birth
10. Were you recently released or are you currently incarcerated in a jail or prison? <input type="checkbox"/> No (if no, please go to Section 2) <input type="checkbox"/> Yes (if yes, complete 10a. through 10c. below)			
10a. Facility Name	10b. Correctional ID #		10c. Release Date

Section 2: Proof of Residency

Please send copies of documents that prove how you support yourself (your income) and where you live (residency) with this application. The **THMP List of Acceptable Documents** lists these documents.

11. Residency: Please list the address you live at below. Check the document you are providing to verify your address: ☐ Texas driver's license ☐ electric, water, or other utility bill ☐ voter registration
☐ motor vehicle registration ☐ postmarked mail with date ☐ signed lease agreement
☐ letter from homeless shelter ☐ other:

11a. Current Street Address where you live now (No P.O. Boxes or Rural Routes)		Apartment Number:
City:	State:	Zip Code:

Section 3: Contact Information			
12. Can we send mail to your residential address, where you live? <input type="checkbox"/> Yes (skip to #13) <input type="checkbox"/> No			
12a. THMP will send updates to you in the mail. Please provide your mailing address below:			
Mailing Address - (P.O. Boxes and Rural Routes accepted here)			Apartment Number
City	State	Zip Code	
Section 4: Household Information			
13. How many of your own children or stepchildren under age 18 live with you?			
14. Are you currently under the age of 18 ? <input type="checkbox"/> No (skip to 16) <input type="checkbox"/> Yes (if yes, Household and Income information must be completed for each parent, stepparent, or legal guardian who lives with you). If you are under 18 and do not live with your parent(s), please contact THMP or your local agency for help.			
15a. Name of Parent or Guardian		15b. Name of Second Parent or Guardian (if applicable)	
Social Security Number	Date of Birth	Social Security Number	Date of Birth
Section 5: Proof of Income			
<i>Income eligibility is based on your income and your spouse's income, if you are married.</i>			
16. How do you support yourself? Please check ALL that apply below, for you and your spouse.			
16a. My income (attach all that apply)		16b. My spouse's income (attach all that apply)	
<input type="checkbox"/> I receive income from employment <input type="checkbox"/> paystubs from the last 30 days <input type="checkbox"/> personal income tax returns <input type="checkbox"/> other:		<input type="checkbox"/> My spouse receives income from employment <input type="checkbox"/> paystubs from the last 30 days <input type="checkbox"/> personal income tax returns <input type="checkbox"/> other:	
Name of Employer:		Name of Employer:	
Name of Second Employer:		Name of Second Employer:	
<input type="checkbox"/> I receive income that is not from employment <input type="checkbox"/> social security award letter <input type="checkbox"/> unemployment benefit award letter <input type="checkbox"/> other:		<input type="checkbox"/> My spouse receives income not from employment <input type="checkbox"/> social security award letter <input type="checkbox"/> unemployment benefit award letter <input type="checkbox"/> other:	
<input type="checkbox"/> I have no income and I have attached <input type="checkbox"/> Form: Income or Support Without Documents <input type="checkbox"/> other:		<input type="checkbox"/> My spouse has no income (no document required)	
<input type="checkbox"/> I am paid in cash and I have attached <input type="checkbox"/> Form: Income or Support Without Documents <input type="checkbox"/> other:		<input type="checkbox"/> My spouse is paid in cash and I have attached <input type="checkbox"/> Form: Income or Support Without Documents <input type="checkbox"/> other:	
17a. What is the total monthly income for yourself from all sources listed above?			\$
17b. What is the total monthly income for your spouse from all sources listed above?			\$
18. If you or your spouse left a job within the last 90 days, please complete below.			
Name of employer:			End date of job:

Section 6: Health Insurance Information (provide copy of front and back of insurance card)

- 19.** ☐ I **do not have** any type of health insurance. **(please skip to Section 7)**
☐ I **am currently enrolled** in one of the following: ☐ **Medicare (Part A, B, C or D)**
☐ **Medicaid** ☐ **Private Health Insurance** ☐ **ACA Plan** ☐ **COBRA**

Please answer statements **20 and 21** about your insurance and COBRA.

20. I am **enrolled in a private insurance plan OR** I have **lost my insurance within the last 90 days:** ☐ **NO (please skip to Section 7)** ☐ **YES (provide plan information below):**

Insurance Name:

Individual Policy Number:

Insurance Phone Number:

End Date (or Current):

21. I have **COBRA**, or I lost my Employer Health Insurance and I am interested in COBRA: ☐ **No (skip to section 7)** ☐ **Yes (complete 21a-21b and submit copies of COBRA paperwork and payment coupon)**

21a. Have you already submitted your COBRA paperwork?

☐ No ☐ Yes date submitted:

COBRA Administrator's Phone Number:

COBRA Election/Enrollment Due Date:

COBRA First Payment Due Date:

COBRA Account #:

21b. To apply for COBRA assistance, you must call your plan and authorize "The Texas Department of State Health Services Texas Insurance Assistance Program" to speak to your health insurance plan directly on your behalf.

Date completed:

Section 7: Certification (applicant or agency worker signature and date are required)

By signing below or allowing an agency worker to sign on my behalf, I agree:

- To let DSHS and other state, federal, and local agencies check, share, and get facts about me or my spouse.
- To let other people, businesses, and organizations share facts they have about me or my spouse with DSHS
- The facts to be checked and shared include anything that helps decide if I am eligible for medication assistance through the THMP, including any insurance or Medicare plan I may be enrolled in.
- These facts may be checked to process my application and at any time in the future while I am enrolled in THMP to see if I remain eligible for medication assistance through THMP.

I also understand:

- THMP may change enrollment, eligibility criteria, or services covered based on funding in the future.
- If I do not order medications from THMP on a regular basis or maintain my eligibility by reapplying every six months, I will be dis-enrolled from the program.
- I understand that my information will be shared with my HIV service providers and Agency Workers. I will contact THMP if I want an exception to be made.

My Answers Are True: I certify under penalty of perjury that the information I have provided on this application is true and complete to the best of my knowledge. If it is not, I may be subject to criminal prosecution. I have signed below to show I agree:

X.

Date Required mm/dd/yyyy

Signature of Applicant (or Parent/Guardian if applicant is under 18 years old), or Agency Worker if completed with client over the phone *(please print and sign)*

Clients completing applications in person must sign the application.

Applications completed over the phone must include the name of the agency, worker completing the form on behalf of the client, worker signature, and agency name.

Applications submitted electronically should include the agency worker's typed name in the "worker name" field below as the electronic signature.

Worker Name

Agency/Program

Phone

Fax

To be completed by	Primary Reviewer	Date
	Secondary Reviewer	Date

Form: Income or Support Without Documents

(optional, only complete if applicable)

Last Name	First Name	Middle Name	Suffix (Jr., Sr., III)
Do you have a SSN? <input type="checkbox"/> No <input type="checkbox"/> Yes	Social Security Number (if you have one)		Date of Birth (mm/dd/yyyy)

In the last 30 days I/We received the following income or support. I do not have any supporting documents.

Section 1: Income

My income:	My spouse's income:
<input type="checkbox"/> I work, and my employer pays me in cash	<input type="checkbox"/> My spouse works, and is paid in cash
Supervisor name:	Supervisor name:
Contact phone number:	Contact phone number:
Name of business:	Name of business:
City and state:	City and state:
<input type="checkbox"/> I am self-employed	<input type="checkbox"/> My spouse is self-employed
Name of business:	Name of business:
I am paid \$	My spouse is paid \$
<input type="checkbox"/> every day <input type="checkbox"/> every week <input type="checkbox"/> every two weeks <input type="checkbox"/> twice a month <input type="checkbox"/> once a month.	<input type="checkbox"/> every day <input type="checkbox"/> every week <input type="checkbox"/> every two weeks <input type="checkbox"/> twice a month <input type="checkbox"/> once a month.

If you need to explain your or your spouse's financial situation in more detail, please use the **Income Verification Form** or the **Self-Employment Log** available from THMP website at dshs.texas.gov/hivstd/meds/.

Section 2: Support

<input type="checkbox"/> I do not work, but instead receive support from a relative or friend (supporter), listed below.	
Supporter Last Name	Supporter First Name
Supporter Phone Number	
Relationship: (examples: parent, spouse, roommate, friend, sister, etc.)	Date support began

This person helps me by providing: ☐ Room ☐ Utility Bills ☐ Cash assistance in the amount of \$ per month ☐ Food/Clothing ☐ Rent/Mortgage ☐ Other:

If you need to explain your support in more detail or you need to submit proof of support and Texas residency please use the **Supporter Statement** available from THMP website at dshs.texas.gov/hivstd/meds/.

Section 3: Certification

I verify that the above information is true and correct to the best of my knowledge. THMP may request verification of information I have provided at any time:

X.	Date Required mm/dd/yyyy
Signature of Applicant (or Parent/Guardian if applicant is under 18 years old) <i>(please print and sign)</i>	
In person applications must be signed by the client. Phone applications must include the name of the agency worker completing the form, their signature, and agency name. If submitted electronically, agency worker's typed name in the "worker name" field below constitutes an electronic signature.	
Worker Name	Agency/Program
Phone	Fax



DOCUMENTS THMP WILL ACCEPT

Please see back of page for what THMP will take. This list does not contain all documents that THMP will take. Please see the application for more information. Call your local agency or THMP with questions about documents.

The whole application must be filled out. We need the most up-to-date information. Please sign and date Section 7 before you turn it in. Your Agency Worker can also sign the application on your behalf.

You can find the most current application here: dshs.texas.gov/hivstd/meds/document

(1) THMP needs proof of where you live. This proof must have your full name and be current and valid. If you are a **student living outside of Texas** to attend school, you may apply for THMP if you have: **a) A denial letter from ADAP in your school's state, b) proof with the address where you live in Texas and c) Proof of school enrollment**

(2) THMP needs proof of your current income. We need to know how much money you earn and how often you get paid. If you are married, we also need this for your spouse. This includes if you are common-law married. We also need to know how many children under the age of 18 live with you. This includes children you are the legal parent of and your stepchildren. We use this to figure out your family income.

If you do not earn income, we can accept other proof:

If you are a student	We can take a letter that shows you are in school and your current financial aid award letter. This needs to be from your school, not from FAFSA.
If you pay your bills with savings	We can take a copy of your most recent bank account statement. This should show both deposits and withdrawals.
If you pay your bills with child support	We need your child support letter from the OAG. If your child support is an informal agreement, we can take a letter from yourself <u>and</u> the other parent. Your child support document needs to say how much you get and how often.
If you are homeless	Provide a letter from the shelter or agency worker about you and where you get mail.
If somebody else supports you	We can take a copy of the THMP Supporter Statement. This needs to be filled out and signed by the person who supports you.

(3) If you are new to the program, ask your doctor to fill out a "Medical Certification Form" (MCF). This will tell us what medication you need.

*****THMP may ask for more information, if needed, such as a copy of your most recent IRS Tax Return Transcript or IRS Proof of non-filing.**

Examples of Documents THMP will take:

Proof of Residency Choose one. Must be where you live and include your name.	Proof of Income Choose one. Must show a month's worth of income.	Proof of Insurance
<p>Motor vehicle records:</p> <ul style="list-style-type: none"> Valid vehicle registration Valid Texas Driver's license Auto insurance <p>State Documents:</p> <ul style="list-style-type: none"> Valid Texas Driver's License, Texas State ID card Active Medicaid/SNAP/TANF benefit award letters Unemployment letter <p>Federal Documents:</p> <ul style="list-style-type: none"> Current Social Security, Medicaid/Medicare benefit letters, USPS receipt showing you changed your address, IRS Tax Return Transcript, or IRS Verification of Non-Filing, W2 Current voter registration <p>Copies of bills (within 30 days from your signature date on application):</p> <ul style="list-style-type: none"> Mortgage or rental agreement with signature page Property tax documents electric/gas, land-line phone, cable) <p>Other documents (within 30 days from the client signature date on application):</p> <ul style="list-style-type: none"> Current employment records (pay stubs), proof of school enrollment, financial aid approval letter Mail addressed to you that is date-stamped with post-mark or meter mark from USPS A letter from shelter or agency worker (signed and dated) for verification of Homelessness 	<p>Current Pay Stubs from Employment:</p> <ul style="list-style-type: none"> Paystubs (30 continuous days of payment within the last 60 days) <p>Award letter:</p> <ul style="list-style-type: none"> Social Security Disability Social Security Income Veteran's benefits Retirement benefits Alimony benefits Unemployment benefits <p>Wage Verification Form :</p> <ul style="list-style-type: none"> Paid in cash or proof of a new job (for new job, include paystubs received, even if you've only received one) <p>Copy of Tax Return:</p> <ul style="list-style-type: none"> If self-employed, a copy of most recent Tax Return forms Your tax return must be signed by you, or a taxpreparer, or must include IRS Proof of E-filing <p>If you do not have a copy of your personal tax return, you may ask for a copy of your IRS Tax Return Transcript from the IRS. Ask for your Tax Return 30 days before your THMP application is due</p> <p>Self-Employment Log:</p> <ul style="list-style-type: none"> DSHS self-employment log that shows earned income from the last 30 days. The log should include the type of work you do, how often you get paid, and the form of payment you receive (example: cash, written check, barter) Must be signed and dated. 	<p>If you have health insurance:</p> <ul style="list-style-type: none"> Include proof of coverage, completed Copayment Assistance Form (Section 6 of the THMP application) Include a copy of your insurance card (front and back) <p>If your insurance policy ended less than 90 days ago, submit proof policy ended such as a Certificate of Creditable Coverage or Certificate of Prior Coverage</p> <p>If you want to apply for COBRA help, provide the following:</p> <ul style="list-style-type: none"> Proof of health insurance policy termination and Section 6 of the THMP application Copies of COBRA paperwork, and a copy of insurance card (front and back), including copy of your prescription benefit card If you are eligible, THMP will pay your COBRA premium, prescription deductibles, and medication copayments.