Newborn Screening (NBS) Program Benefits

APPLICANT PACKET

Newborn Screening Program

March 2016

NEWBORN SCREENING BENEFITS
APPLICANT PACKET

DEFINITIONS

- **Applicant** – the individual identified by a physician or health care provider as having an abnormal newborn screen and for whom the application for NBS Benefits is being completed – potentially eligible for services.
- **Client** – An individual, who has been screened, has successfully completed the eligibility process and determined to be eligible for services.

You or your child must have applied and received a denial or determination letter from a benefits program or the Health and Human Services Commission (HHSC). For this reason, your doctor or contract provider is providing this Applicant Packet because you or your child may be eligible for Newborn Screening (NBS) Program Benefits.

This packet contains details and instructions to help you complete the application. Your doctor or provider will screen the application to see if you may be eligible to apply for benefits or services at no cost or reduced cost from NBS Benefits. To be eligible, an individual must:

1. Have an abnormal screening result (pending confirmation of diagnosis), or a confirmed diagnosis of a disorder screened by the program;
2. Be a Texas resident;
3. Have a family income that is at or below 350% of the federal poverty income guidelines;
4. If required, make financial participation payments in a timely manner;
5. Provide current medical, financial, and residency information and/or documentation in a timely manner, if requested by the program; and
6. Have a parent, managing conservator, or legal guardian agree to abide by the requirements in the rules if the individual is a minor (Texas Administrative Code, Sections 37.59 – 37.63).

The applicant is responsible for:

- Completing the application – give information in all the fields and boxes as instructed;
- Providing proof and documentation – see the Applicant's Checklist below:
  - If your doctor or provider asks for more documentation, then it is your responsibility to get it. Please ask for assistance from your doctor or provider if you run into problems getting the information;
  - If you fail to provide all required information it will delay a decision from NBS Benefits or result in denial of eligibility;
  - If documentation is not available or is insufficient to determine eligibility, contractor staff should ask the individual to designate a contact person to provide the information.
- Signing the required forms (***Newborn Screening Benefits Application for Services*** and ***Statement of Applicant's Rights and Responsibilities***) and attests to or swears to the information being submitted to NBS Benefits is true and correct.

INCOME

To be eligible for NBS Benefits, applicants must have a gross family income at or below 350% FPL. The table below shows types of earned and unearned income that add to the amount of gross family income.

Types of Income	
Cash Gifts and Contributions	Pensions and Annuities
Child Support Payments	Reimbursements
Disability Insurance Benefits	RSDI/Social Security Payments
Dividends, Interest, and Royalties	Self-Employment Income
Loans (Non-educational)	Unemployment Compensation
Lump-Sum Payments	Veteran Administration
Military Pay	Wages and Salaries, Commissions
Mineral Rights	Worker's Compensation
SSDI	

When your application for benefits is approved, NBS Benefits will mail the approval letter to you and your provider or doctor's office. The letter will identify your approved benefits, the date these benefits will begin, end, and instructions to apply for continued services before the end of the approval period. If the renewal application is not submitted you, as the client, will no longer be eligible for NBS Benefits.

APPEAL OF ELIGIBILITY DETERMINATION/DENIAL

If your application is 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 received the decision or denial notice. The denial notice is deemed 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 a request for a hearing is not received in the Newborn Screening Unit within 20 days, the decision is final.

CLIENT'S RESPONSIBILITY FOR REPORTING CHANGES

Please be advised that if you are approved as a client of NBS Benefits, you must report changes in the following areas:

- Income
- Family composition
- Residence, address
- Employment
- Types of medical insurance coverage
- Receipt of and/or other third-party coverage benefits

You may report changes by mail, telephone, in-person, or through someone authorized to act on your behalf. Changes must be reported no later than 30 days after you are aware of the change. If changes mean that you are no longer eligible for NBS Benefits, then you are denied continued services. By signing the required forms, you verify the information provided in the applications is true and correct.

NEWBORN SCREENING BENEFITS
APPLICANT CHECKLIST

Before applying for NBS Benefits:

☐ **Apply** for other health care benefits programs:
- Go to: www.yourtexasbenefits.com
- Click on "Should I apply"; or
- Visit your local Community Resource Center for assistance (call 2-1-1).

☐ **Obtain** an HHSC response, waiting list, approval, or denial letter from:
- Medicaid;
- Children with Special Health Care Needs (CSHCN) Services Program (*Applicants over 21 diagnosed with Cystic Fibrosis can still apply for CSHCN before applying to NBS Benefits.);*
- Children's Health Insurance Plan (CHIP); or
- Other health care benefits programs.

If you are approved for any other benefit program, you do not qualify to apply for NBS Benefits unless certain benefits were denied by the other program

The checklist below outlines the information needed for an initial or annual renewal application for NBS Benefits. If the applicant is a minor, under 18 years of age, then the application should be completed, signed and dated by a parent, guardian or representative:

☐ **Complete and sign** the ***NBS Benefits Application for Services*** – answer all questions.

☐ **Review and sign** the ***Statement of Applicant's Rights and Responsibilities***.

☐ **Attach:**
- ☐ Copy of the approval, denial or waiting list response from any one of the above benefits programs (must be dated within 60 days of NBS Benefits' receipt).
- ☐ Copies of current paystubs that equal one month of pay or other type of income:
  - o If paid weekly, provide four consecutive weekly pay stubs.
  - o If paid biweekly or bi-monthly, provide two consecutive pay stubs.
  - o If paid monthly, provide last month's pay stub.
- ☐ Copy of the health insurance card (front and back).

All documentation must be current and dated within 60 days of NBS Benefits' receipt.

☐ **Deliver** the completed, signed, application and related documentation to your contracted provider for initial screening. This begins your eligibility process for NBS Benefits.

An incomplete application will delay the review and decision for benefits.

The effective date of client eligibility is determined by the date NBS Benefits receives a complete application and approves the individual for benefits.

Thank you,

NBS Benefits Staff

NEWBORN SCREENING BENEFITS APPLICATION FOR SERVICES

Solicitud De Servicios A Prestaciones De Pruebas De Detección Temprana A Recién Nacidos

1. To be completed by Applicant or Parent/Guardian - ALL FIELDS ARE REQUIRED
El solicitante o uno de los padres o el tutor deben llenar esta sección - DEBEN LLENARSE TODOS LOS CAMPOS

Applicant Name / Nombre de Solicitante	Date of Birth/Fecha de nacimiento	Home Phone No./Teléfono de la casa	County/Condado
Mailing Address (Street or PO Box)/Dirección Postal (Calle o Apdo.)		City/Ciudad	ZIP/Zona Postal
Home Address, if different from above. Domicilio particular, si es diferente a la dirección de arriba.			
Diagnosis/Diagnostico:			
Physician Specialist's Name/Nombre del Médico Especialista		What type of benefits are you requesting? ¿Qué tipo de beneficios está solicitando?	

2. On the chart below, fill in the first line with information about applicant. Fill in the remaining lines for everyone who lives with the applicant including those who are legally responsible for the support of the other person. / En la tabla a continuación, llene la primera línea con información acerca de solicitante. Llene las líneas restantes con información de cada persona que vive con el solicitante, incluyendo a quienes son legalmente responsables de la manutención de la otra persona.

Name Nombre	Sex Sexo Male/Female Hombre / Mujer	Date of Birth Fecha de nacimiento	Texas Resident Residente de Texas Yes/ Sí or No	U.S. Citizen Ciudadano de EEUU Yes/ Sí or No	What Relation to you? ¿Parentesco con usted?
a.					Applicant Solicitante
b.					
c.					
d.					
e.					

3. Are you, or is anyone in your household, pregnant? ¿Está usted o alguien en su casa, embarazada? ☐Yes/Sí ☐No
If Yes, who?/Si contesta "Sí," ¿quién? _____

4. *Copies of latest paystubs that equal one month of pay must be submitted with this form.* List all of your household's income below. Types of income can include: Government checks; money from work; child support; workers compensation; disability benefits and unemployment. Junto con este formulario deben presentarse copias de los últimos recibos de pago de salario por una cantidad igual a un mes de salario. En la tabla abajo haga una lista de todos los ingresos en su casa. Ingresos pueden incluir: cheques del gobierno; ingresos del trabajo; manutención de menores; compensación de trabajadores; prestaciones por discapacidad y pagos por desempleo.

Name of person receiving money Nombre de la persona que recibe el 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, una vez al mes?)

5. Do you, or does anyone in your household have any of the following? ☐Yes/Sí ☐No
¿Usted o alguien en su familia tiene alguno de los siguentes?

Medicaid, Medicare, CHIP, Health Insurance/Seguro de Salud, V. A./ Administración de los Veteranos, Tricare, Other /Otro _____
If yes, circle which one: En caso afirmativo, circule cuál tiene:
If yes, please provide copy of your insurance card. En caso afirmativo, proporcione copia de su tarjeta de seguro.

The statements I have made, including my answers to all questions, are true and correct to the best of my knowledge and belief.
I agree to give eligibility staff any information necessary to prove statements about my eligibility. I understand that giving false information could result in disqualification and repayment.
Las declaraciones que he hecho, incluidas mis respuestas a todas las preguntas, son verdaderas y correctas según mi leal saber y entender. Me comprometo a dar al personal que verifica la elegibilidad toda la información necesaria para comprobar mis declaraciones sobre la elegibilidad. Entiendo que el proporcionar información falsa puede dar como resultado que me descalifiquen y tenga que devolver el dinero que recibí del Programa.

Signature – Applicant / Firma – Solicitante	Date / Fecha	Signature – Applicant's Representative / Firma - Representante del Solicitante	Date / Fecha

NBS BENEFITS APPLICATION FOR SERVICES INSTRUCTIONS

The NBS Benefits Application for Services is used to screen and determine potential eligibility for medical services assistance for NBS Benefits. The form does not determine final eligibility or ineligibility for any programs other than NBS Benefits. Clients must be referred to other programs, such as Medicaid and CHIP, to determine eligibility and apply for services.

DEFINITIONS
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Client: An individual, who has been screened, has successfully completed the eligibility process and determined to be eligible for services.

Instructions for Completing the NBS Application for Services
To the greatest extent possible, the application should be completed, signed and dated by the applicant, or the applicant's representative.

1. This section must begin with the applicant's information. Complete all the questions related to date of birth, mailing address and phone, the diagnosis for the applicant, the doctor's name and the type of NBS Benefits being requested.
2. Fill in the first line with information about the applicant. Fill in the remaining lines for everyone who lives with the applicant including those who are legally responsible for the support of the other person. For the purposes of this screening tool, consider only the parent(s), caretaker, spouse, and children under age 18 who live together as a family. (Contract providers, see ***Section II*** of the ***Contractor Procedures Manual*** for more information on family composition). United States citizenship is not a requirement for eligibility.
3. Please advise if anyone in the household is pregnant. Unborn children are also included in family size.
4. List all of the household's income in this section. Types of income can include: money from work; child support; workers compensation; disability benefits and unemployment, self-employment accounting records. The income chart should include any type of payment that is of gain to the family (see ***Types of Income*** in the ***Applicant Packet***). Provide copies of the most current paystubs that equal one month of pay. These copies must be received in NBS Benefits within 60 days of the oldest paystub.
5. Do you or does anyone in your household have other benefit coverage? If so, please provide copy of the front and back of the insurance card.

INSTRUCCIONES PARA LLENAR LA SOLICITUD A PRESTACIONES DE NBS PARA RECIBIR LOS SERVICIOS

La Solicitud a Prestaciones de NBS para recibir los Servicios se usa para seleccionar y determinar la posible elegibilidad para recibir ayuda con servicios médicos de Prestaciones de NBS. El formulario no determina la elegibilidad ni tampoco la no elegibilidad para ningún otro programa que no sea el de Prestaciones de NBS. Los clientes deben referirse a otros programas, como Medicaid y CHIP, para la determinación de su elegibilidad y la solicitud de los servicios.

DEFINICIONES
Solicitante: El individuo de quien un médico o un proveedor de atención de salud han identificado resultados anormales en una prueba de detección para recién nacidos, y para quien se está completando la solicitud a Prestaciones de NBS, pudiendo ser elegible para recibir los servicios.
Cliente: El individuo a quien se le ha hecho la prueba de detección temprana y ha completado con éxito el proceso de elegibilidad, y de quien se ha determinado que es elegible para recibir los servicios.

Instrucciones para completar la Solicitud a NBS de los Servicios
En la medida de lo posible, la solicitud debe ser llenada, firmada y fechada por el solicitante o el representante del solicitante.

1. Esta sección debe comenzar con la información del solicitante. Complete todas las preguntas relacionadas con la fecha de nacimiento, domicilio postal y teléfono, el diagnóstico que se le hizo al solicitante, el nombre del doctor y el tipo de Prestaciones de NBS que se solicitan.
2. Llene la primera línea con la información sobre el solicitante. Llene las líneas restantes con la información sobre cada persona que vive con el solicitante, incluidos aquellos que son legalmente responsables de la manutención de la otra persona. Para fines de esta herramienta de selección, considere solo el padre o la madre, el cuidador, el cónyuge y los hijos menores de 18 años de edad que viven juntos como familia. (Los proveedores contratistas deben ver ***Section II*** del ***Contractor Procedures Manual*** (***Sección II*** del ***Manual de procedimientos para contratistas***) para más información sobre la composición de la familia). El tener la ciudadanía estadounidense no es un requisito obligatorio para ser elegible.
3. Informe por favor si alguien en su familia está embarazada. Al considerar el tamaño de la familia, los niños que están por nacer también se incluyen.
4. Haga una lista de todos los ingresos de su familia en esta sección. Los diversos tipos de ingresos pueden incluir: el dinero del trabajo; manutención de menores; compensación a los trabajadores; prestaciones por discapacidad y desempleo, registros contables por autoempleo. La lista de ingresos debe incluir cualquier tipo de pago que sea una ganancia para la familia (vea ***Tipos de Ingresos*** en el ***Paquete del Solicitante***). Proporcione copias de los comprobantes de pago de salario más recientes que sumen el importe de un mes de salario. Estas copias deben recibirse en Prestaciones de NBS en un plazo no mayor de 60 días a partir de la fecha del comprobante de salario más antiguo.
5. ¿Tiene usted o alguien en su familia alguna otra cobertura de beneficios? De ser así, por favor proporcione copia del frente y el reverso de la tarjeta de seguro.

STATEMENT OF APPLICANT'S RIGHTS AND RESPONSIBILITIES

DECLARACIÓN DE LOS DERECHOS Y DEBERES DEL SOLICITANTE

By signing this application for assistance, I affirm the following:	**Al firmar esta solicitud para recibir asistencia, yo afirmo lo siguiente:**
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.	La información escrita en la solicitud y en sus anexos es verdadera y correcta. Esta solicitud es un documento legal. El deliberadamente omitir información o el proporcionar información falsa podría dar lugar a que el Proveedor cancele los servicios a uno de los miembros de mi hogar, de mi familia o los míos propios.
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 approval period (changes in income, household/family members, and residency).	Si yo omito información, dejo de proporcionar o me niego a proporcionar información o; proporciono información falsa o engañosa acerca de estos asuntos, podría requerírseme que reembolse al Estado el costo de los servicios recibidos, si acaso se determina que no califico para los servicios. Yo reportaré los cambios en la situación de mi hogar, de mi familia, que afecten la elegibilidad durante el período de aprobado (cambios en el ingreso, en los miembros del hogar, en la familia, y cambios de residencia.)
I authorize release of all information, including but not limited to, income and medical information, by and to 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.	Yo autorizo la divulgación de toda la información, incluyendo pero no limitada a, el ingreso y a la información médica, de parte de y para, el Texas Department of State Health Services (DSHS) *[Departamento Estatal de Servicios de Salud de Texas*] y, al Proveedor para poder determinar la elegibilidad, para poder cobrar o, proporcionar servicios en mi hogar, a mi familia o, a mí personalmente.
I understand I may be asked by Provider to provide proof of any of the information provided in this application.	Entiendo y acepto que podría pedirme el Proveedor que proporcione comprobantes de cualquiera de la información proporcionada en esta solicitud.
Health insurance coverage, including but not limited to individual or group health insurance, health maintenance organization membership, Medicaid, Medicare, Veterans Administration benefits, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), 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.	La cobertura de seguro de salud, incluyendo pero no limitada a seguro para un individuo o seguro de salud para un grupo de personas; los de membresía proporcionados por organizaciones para el mantenimiento de la salud [como HMO], *Medicaid*, *Medicare*; beneficios de la *Veteranos Administración;* de la CHAMPUS y *Worker's Compensation* [beneficios de Compensación Laboral], deben ser reportados al Proveedor. Los beneficios provenientes de esos seguros de salud pudieran ser considerados como la fuente principal de pago de la atención de salud recibida. Por este medio yo, asigno al Proveedor cualquiera de dichos beneficios. También asigno el pago de los beneficios y servicios recibidos de parte de y, a través del Proveedor, directamente a los proveedores de servicios.
I understand that, to maintain eligibility for NBS Benefits, I will be required to reapply for assistance at least every twelve months.	Yo entiendo y acepto que, para mantener la elegibilidad para los beneficios de NBS, se me requerirá de volver a solicitar la asistencia al menos cada doce meses.
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.	Soy residente legítimo de Texas, o dependiente del territorio. Yo vivo físicamente en Texas, mantengo residencia en Texas y, no afirmo ser residente de otro estado o país, o soy un dependiente de un residente legítimo de Texas.
Some programs provide care through program-approved providers. I understand that, to receive benefits from NBS Benefits, treatment must be received through those NBS Benefits approved providers.	Algunos programas proporcionan atención a través de proveedores aprobados por los programas. Yo entiendo y acepto que, para recibir beneficios de dichos programas, el tratamiento debe ser recibido a través de los proveedores aprobados por esos programas.
I understand that criteria for participation in NBS Benefits are the same for everyone regardless of sex, age, disability, race, or national origin.	Yo entiendo y acepto que el criterio para la participación en los beneficios de NBS es el mismo para todos sin importar sexo, edad, discapacidad, raza, o origen de nacionalidad.
I understand I have the right to file a complaint regarding the handling of my application or any action taken by NBS Benefits with the HHSC Civil Rights Office at 1-888-388-6332.	Yo entiendo y acepto que tengo el derecho de registrar una queja con relación al manejo de mi solicitud o con relación a cualquier acción tomada por los beneficios de NBS con HHSC Civil Rights Office al 1-888-388-6332.
I understand that I will receive written documentation concerning the services for which my household/family is eligible or potentially eligible.	Yo entiendo y acepto que recibiré documentación por escrito concerniente a los servicios para los cuales mi hogar, mi familia o yo calificamos o, potencialmente lleguemos a calificar.
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 www.dshs.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 522.023 and 559.004)	Tan solo por unas cuantas excepciones, usted tiene el derecho de solicitar y de ser informado sobre la información que el Estado de Texas reúne sobre usted. A usted se le debe conceder el derecho de recibir y revisar la información al requerirla. Usted también tiene el derecho de pedir que la agencia estatal corrija cualquier información que se ha determinado sea incorrecta. Diríjase a www.dshs.state.tx.us para más información sobre la Notificación sobre privacidad. (Referencia: *Government Code*, sección 552.021, 522.023 y 559.004)
I understand and agree that NBS Benefits does not provide payment for inpatient care. I understand that I must make my own arrangement for hospital care and that I am responsible for the cost of the care.	Entiendo y acepto que los beneficios de NBS no proporcionan pago por la atención de pacientes internos. Entiendo y acepto que yo debo hacer mis propios arreglos de atención en el hospital y que yo soy responsable por el costo de la atención.
Signature – Applicant / Firma – Solicitante **Date / Fecha**	**Provider Signature** **Date / Fecha**