SSN: _____

First Name: _____

Middle Name: _____

Last Name: _____

Preferred Name: _____

Address: _____

Zip Code: _____

Sex: M F

Gender Identity: **CHOOSE ONE**
- M – Male
- F – Female
- FTM - Transgender Male/ Female-to-male
- MTF - Transgender Female / Male-to-Female
- G - Genderqueer; Neither Exclusively Male nor Female
- D – Declined
- O – Other

Sexual Orientation: **CHOOSE ONE**
- S – Straight
- G – Gay
- L – Lesbian
- B – Bisexual
- O – Other
- U – Unknown
- D – Declined

DOB: _____

Marital Status: **CHOOSE ONE**
- S – Single
- M – Married
- D – Divorced
- W- Widowed
- X – Legally Separated
- U – Unknown
- C – Common Law Wife/Husband

Race: **CHOOSE ONE**
- C – Caucasian (White)
- B – Black/African American
- A – Asian
- G – Native American
- F – Asian Pacific American
- P – Pacific Islander
- D – Subcontinent Asian American
- I – American Indian or Alaskan Native
- J – Native Hawaiian
- E – Other Race
- N1 – Refusal

Ethnicity: **CHOOSE ONE**
- L – Latino/Hispanic
- X – Not Hispanic or Latino
- O – Other
- N - Refused
- S – Scotish
- R – Irish
- G – German

Language: **CHOOSE ONE**
- ENG – English
- SPA – Castilian/Spanish
- DEU – German
- Other: _____

Employment Status: **CHOOSE ONE**
- E – Employed
- S – Self-Employed
- U – Unemployed
- D – Disabled
- R – Retired
- P – Part-Time Student
- F – Full-Time Student

Email Address: _____

Phone Number: _____

Home: _____

Cell: _____

Preferred Phone: Home Cell

Can We Send you Text Messages to cell:
- Yes
- No

_____ _____ _____

Print Full Name Signature Date

SPRHS
South Plains Rural Health Services, Inc.
...for family health

PATIENT AND CENTER RIGHTS AND RESPONSIBILITIES

Welcome to South Plain Rural Health Services, Inc. (SPRHS)!

When it comes to health care, whether you're seeking wellness, recovering from illness or managing a chronic condition. It's a cycle of staying well, getting well and being well. If you deal with these health situations in a long-term relationship with a trusted medical provider, then you've found your Patient Centered Medical Home (PCMH) here with us.

Our goal is to provide quality health care to people in this community, regardless of their ability to pay. As a patient, you have rights and responsibilities. SPRHS (hereafter "the center") also has rights and responsibilities. We want you to understand these rights and responsibilities so you can help us provide better health care for you. Please read and sign this statement and ask us questions you might have.

A. Human Rights

You have a right to be treated with respect regardless of race, color, marital status, religion, sex, national origin, ancestry, physical or mental handicap or disability, age, Vietnam era veteran status, or other grounds as applicable federal, state and local laws or regulations.

B. Payment For Services

1. You are responsible for giving staff accurate information about your present financial status and any changes in your financial status. The staff need this information to decide how much to charge you and/or so they can bill private insurance, Medicaid, Medicare, or other benefits for which you may be eligible. If your income is less than the federal poverty guidelines, you will be charged a discounted fee.

2. You have a right to receive explanations of the center's bill. You must pay, or arrange to pay, all agreed fees for medical services, with the exception of dental services, which are provided on a prepaid basis. If you cannot pay right away, please let staff know so they can provide care for you now and work out a payment plan.

3. Federal law[1] prohibits the center from denying you primary health care services which are medically necessary solely because you cannot pay for these services.

C. Privacy

You have a right to have your interviews, examinations and treatment in privacy. Your medical records are also private. Only legally authorized persons may see your medical records unless you request in writing for us to show them to, or copy them for, someone else. In certain instances, the center may be required to report to the Texas Department of State Health Services regarding your health condition or disease status. A complete discussion of your privacy rights will be given to you along with this document and is named the center's Notice of Privacy Practices. Staff will request that you acknowledge your receipt of our Notice of Privacy Practices. The Notice of Privacy Practices sets forth the ways in which your medical records may be used or disclosed by the center and the rights granted to you under the Health Insurance Portability and Accountability Act ("HIPAA").

D. Health Care[2]

1. You are responsible for providing the center complete and current information about your health or illness, so that we can give you proper health care. You have a right, and are encouraged, to participate in decisions about your treatment.

2. You have a right to information and explanations in the language you normally speak and in words that you understand. You have a right to information about your health or illness, treatment plan, including the nature of your treatment; its expected benefits; its inherent risks and hazards (and the consequences of refusing treatment); the reasonable alternatives, if any (and their risks and benefits); and the expected outcome, if know. This information is called obtaining your informed consent.

3. You have the right to receive information regarding "Advance Directives." If you do not wish to receive this information, or if it is not medically advisable to share that information with you, we will provide it to your legally authorized representative.

4. You are responsible for appropriate use of center services, which includes following staff instructions, making and keeping scheduled appointments, and requesting a "walk in" appointment only when you are ill. Center professionals may not be able to see you unless you have an appointment. If you are unable to follow instructions from the staff, please tell them so they can help you.

5. If you are an adult, you have a right to refuse treatment or procedures to the extent permitted by applicable laws and regulations. In this regard, you have the right to be informed of the risks, hazards, and consequences of your refusing such treatment or procedures. Your receipt of this information is necessary so that your refusal will be "informed." You are responsible for the consequences and outcome of refusing recommended treatment or procedures. If you refuse treatment or procedures that your healthcare providers believe is in your best interest, you may be asked to sign a Refusal to Permit Medical Treatment or Services form or Against Medical Advice form (as appropriate).

[1] For more on the Sliding Fee Scale see chapter 9 of the Health Center Compliance Manual and the relevant Sliding Fee Discount Program protocol.

6. You have a right to health care and treatment that is reasonable for your condition and within our capability, however, the center is not an emergency care facility. You have a right to be transferred or referred to another facility for services that the center cannot provide. The center does not pay for services that you receive from another healthcare provider.

7. If you are in pain, you have a right to receive an appropriate assessment and pain management, as necessary.

E. Center Rules

1. You have a right to receive information on how to appropriately use the center's services. You are responsible for using the center's services in an appropriate manner. If you have any questions, please ask us.

2. You are responsible for the supervision of children you bring with you to the center. You are responsible for your children's safety and the protection of other patients and our property.

3. You have a responsibility to keep your scheduled appointments. Missed scheduled appointments cause delay in treating other patients. If you do not keep scheduled appointments you may be subject to disciplinary action pursuant to the center's policies and procedures.

F. Complaints

1. If you are not satisfied with our services, please tell us. We want suggestions so we can improve our services. Staff will tell you how to file a complaint. If you are not satisfied with how the staff handles your complaint, you may complain to the center's Board of Directors.

2. If you make a complaint, no center representative will punish, discriminate or retaliate against you for filing a complaint, and the center will continue to provide you services.

3. To file a complaint with the Center, contact the Center's Compliance Officer at (806) 894-7842 or by email at Complaints@sprhs.org

G. Termination

If the center decides that we must stop treating you as a patient, you have a right to advance written notice that explains the reason for the decision, and you will be given thirty (30) days to find other health care services. However, the center can decide to stop treating you immediately, and without written notice, if you have created a threat to the safety of the staff and/or other patients. You have a right to receive a copy of the center's Termination of the Patient and Center Relationship Policy and Procedure.

Reasons for which we may stop seeing you include:

1. Failure to obey center rules and policies, such as keeping scheduled appointments;
2. Intentional failure to accurately report your financial status;
3. Intentional failure to report accurate information concerning your health or illness;
4. Intentional failure to follow the health care program, such instructions about taking medications, personal health practices, or follow up appointments, as recommended by your healthcare provider(s), and/or
5. Creating a threat to the safety of the staff and/or other patients.

H. Appeals

If the center has given you notice of termination of the patient and center relationship, you have the right to appeal the decision to the Board. Unless you have a medical emergency, we will not continue to see you as a patient while you are appealing the decision.

CONSENT TO TREATMENT FOR SPRHS NETWORK CLINIC(S): I grant the physician(s)/dentist(s), employees and such associates, assistants, and other health care providers as my physician(s)/dentist(s) deem necessary attending me/my child the authority to treat and examine me/my child and order the examinations, test, treatments and other services necessary for my care and treatment. I understand that this consent to treatment will be valid and remain in effect as long as I attend the Network Clinic(s) unless revoked by me in writing.

RELEASE OF INFORMATION FOR SPRHS NETWORK CLINIC(S): SPRHS Network Clinic(s) may disclose all of any part of my medical/dental record to each other and to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member of the patient for all or part of the clinic's charges, including but not limited to DSHS, HRSA and any other partners of SPRHS.

ASSIGNMENT OF BENEFITS/FINACIAL RESPONSIBILITY FOR SPRHS, NETWORK CLINIC(S): I hereby authorize payment directly to the SPRHS Network Clinic(s) for surgical, medical, or dental benefits, including major medical/dental but not to exceed regular charges for these services, I understand that I am financially responsible to the SPRHS Network Clinic(s) for charges incurred.

RELEASE FROM LIABILITY: SPRHS Network Clinic(s) and its agents representatives, and employees from any and all liability associated with the release of confidential patient information in accordance with this authorization. I understand SPRHS Network Clinic(s) cannot be responsible for use or re-disclosure of information by third parties.

MEDICARE/MEDICAID ASSIGNMENT FOR SPRHS NETWORK CLINIC(S): I request that payment of authorized Medicare/Medicaid benefits be made either to me or on my behalf to the SPRHS Network Clinic(s) or other third party payor for any services furnished me by the SPRHS Network Clinic(s) health care provider. I authorize any holder of medical information about me released to the Health Care Financing
Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature Page

1	Have you or a member of your family ever worked in agriculture/ farming?	□ **Yes –** if the answer is Yes, this establishes them as an agricultural worker and you should ask questions 2-4. □ **No –** If the answer is NO, client is not an agricultural worker and there is no need to complete questions 2 and 3.
2	Have you or a member of your family moved in the past two years to another area (established a temporary home) in order to work in agriculture?	□ **Yes –** If the answer is YES, this establishes them as a migrant farmworker –**STOP** □ **No -** If the answer is NO, go to questions 3 and 4
3	Have you or a member of your family, worked in the past two years in agriculture, without moving away from your home?	□ **Yes -** If the answer is YES, this establishes them as a seasonal farmworker **–STOP** □ **No –** If the answer is NO, go to question 4
4	Have you or a member of your family stopped traveling to work in agriculture because of disability or old age?	□ **Yes** – If yes, this qualifies them as an aged/disabled farmworker. □ **No**
5	Homeless Status?	□ **Yes** □ **No**
6	Public Housing?	□ **Yes** □ **No**
7	Veteran?	□ **Yes** □ **No**
8	Disabled?	□ **Yes** □ **No**

I have read and/or received a copy of:

- ✓ Acknowledgement of review/availability of HIPAA Final Rule Notice of Privacy Practices 9/23/2022
- ✓ Patient Record of Disclosures
- ✓ Patient and Center Rights and Responsibilities
- ✓ Consent to Treatment
- ✓ Consent to Share information with other health and human service agencies such as
  - Medicare, Medicaid, State/Federal Grants, Share the Care, AZ&Me, etc.
- ✓ Identifying Migrant and Seasonal Farmworkers
- ✓ Statement of Applicant's Rights and Responsibilities
- ✓ PCMH Informational Sheet
- ✓ I give consent to SPRHS agencies to share demographic and financial information about myself and my family with other health and human service agencies to help me qualify for services. I understand that identifiable information I give will only be shared when I ask another agency for services.

Print Full Name _____ Signature _____ Date _____

SPRHS
South Plains Rural Health Services, Inc.
...for family health

Informed Consent for Telemedicine and/or Telehealth

In order to better serve the needs of the community, some health care services are available from **South Plains Rural Health Services, Inc.** (hereafter "the center") via telemedicine and telehealth. Telemedicine medical services and telehealth services are health care services delivered by physicians and health professionals to patients located at a different physical location using telecommunications or other information technology. Telecommunications or other information technology may also be used for virtual check-ins, e-visits, initial evaluations, screenings, and pre and post visit communication by center staff. Providers may include, but are not limited to, Physicians, Advanced Practice Registered Nurses, Physician Assistants, Professional Counselors, Marriage and Family Therapists, Clinical Social Workers, and Psychologists.

Information shared may include patient medical records, medical images, medical audio or video files, two-way audio and video, and output data from medical devices. The systems used by the center to transmit and receive this information will incorporate network and software security protocols intended to protect the confidentiality of the patient's identity and information.

I hereby and voluntarily consent to authorize the center's healthcare providers to provide health care services to me via telemedicine and/or telehealth.

I understand the following:

- The same standard of care applies to health care services delivered via telemedicine and/or telehealth as applies to an in-person visit.
- The laws that protect the privacy and confidentiality of health care information apply to health care services delivered via telemedicine and/or telehealth.
- I will not be physically in the same room as my healthcare provider. I will be notified of, and my consent obtained, for anyone other than my healthcare provider present in the room.
- There are certain hazards and risks connected with all forms of treatment, regardless of the medium used, and my consent is given knowing this.
- There are potential risks to using technology, including service interruptions, interception, and technical difficulties. If it is determined that the telecommunications or information technology is not adequate, the visit may be discontinued.
- I have the right to refuse to participate or decide to stop participating in a telemedicine/telehealth visit at any time.
- I understand that this visit may need to be converted into an in-person visit for situations and/or cases that require a physical exam in order to determine a diagnosis and for appropriate treatment and care.
- The center and the center's healthcare providers have no liability or responsibility for the accuracy or completeness of the medical information submitted to them or for any errors in its electronic transmission.
- I may consent to my medical record or a report containing an explanation of the treatment provided being sent to my primary care physician.
- This informed consent for telemedicine and/or telehealth is valid and remains in effect as long as I am a patient of the center, until I withdraw my consent, or until the center changes its services and asks me to complete a new consent form.

Consent Provisions

My signature on this form indicates that:

1. I certify that I have read and fully understand the foregoing consent and that the facts indicated above are true.
2. I realize that although every effort will be made to keep all risks to a minimum, risks can be unpredictable both in nature and severity.
3. I understand that midlevel providers (Physician Assistants and Advanced Practice Registered Nurses) may be involved in my treatment and I consent thereto.
4. I understand that I may be asked to sign a separate informed consent form for certain Treatment(s) that require such.
5. I hereby voluntarily give my consent to receive health care services via telemedicine and/or telehealth.

NOTICE CONCERNING COMPLAINTS

Complaints about physicians, as well as other licensees and registrants of the Texas Medical Board, including physician assistants, acupuncturists, and surgical assistants may be reported for investigation at the following address:

Texas Medical Board
Attention: Investigations
333 Guadalupe, Tower 3, Suite 610
P.O. Box 2018, MC-263
Austin, Texas 78768-2018

Assistance in filing a complaint is available by calling the following telephone number: **1-800-201-9353**

For more information, please visit our website at **www.tmb.state.tx.us**.

I have read and understand the information provided above regarding telemedicine/ telehealth and have had the opportunity to ask questions about the use of telemedicine/ telehealth. I hereby give my informed consent for the use of telemedicine/ telehealth in my care and authorize **South Plains Rural Health Services, Inc.** to use telemedicine/ telehealth in the course of my diagnosis and treatment. I may withdraw authorization to use telemedicine/ telehealth at any time.

Print Full Name	Signature	Date

SPRHS
South Plains Rural Health Services, Inc.
...for family health

PERMISSION TO RELEASE PATIENT INFORMATION / CONSENT AUTORIZATION

If you have a spouse, friend or relative that may call on your behalf to obtain appointment dates and times, test results, etc., we **will not** give that information out unless his/her/their name(s) is written below and signed by you.

I hereby give permission to the South Plains Community Health Center to allow receipt of the following to those listed below:

____ Prescriptions
____ Medical test results
____ Medical test requisitions
____ Medications
____ Permission for Provider to discuss my care
____ Lab results
____ Give permission to bring in the child for health care or dental care
____ Give permission to have access to my patient portal

Name: _____ Phone:_____ Relationship:_____
Name: _____ Phone:_____ Relationship:_____
Name: _____ Phone:_____ Relationship:_____

~OR~

____ I do not wish to allow any information to be released.

Please Note: This release of information does not include record request to/from other doctor's offices, requests by insurance or other outside agencies. Specific releases will need to be obtained by the patient for these purposes.

_____	_____	_____
Patient Printed Name	Signature	Date
_____	_____	_____
Witness Printed Name	Signature	Date

RX HISTORY CONSENT AUTHORIZATION

By signing this RX History Consent, you are agreeing that your provider at South Plains Rural Health Services, Inc. may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

_____	_____	_____
Patient Printed Name	Signature	Date

SPRHS
South Plains Rural Health Services, Inc.
...for family health

PATIENT CANCELLATION/NO-SHOW POLICY ACKNOWLEDGEMENT

I understand that South Plains Rural Health Services, Inc. has a cancellation/no-show/late arrival policy, and that I may be charged for any appointment I cancel or miss with less than 24 hour notice. Cancellations are reserved for emergencies only, and require a minimum of a 24 hour notice.

All cancellations are to be rescheduled to ensure continuity of care. Any arrival 15 minutes or more after the scheduled start time of your appointment will be considered a late arrival, and may need to wait longer. Thus, South Plains Rural Health Services, Inc. may reserve the right to charge a fee of $5.00 for each scheduled appointment that is cancelled with less than 24 hour notice, as well as for no-shows. I also understand that I may be asked to see a provider from South Plains Rural Health Services, Inc. on a walk-in basis if I have no-shows more than 3 times.

For Dental No-Shows:

Please understand that if you miss an appointment and/or cancel the same day of the appointment, the computer scheduling system will automatically cancel the rest of your multiple dental appointments, if any. The multiple dental treatment appointments are set up for you after the dental exam upon your request; it is to better your oral health by eliminating dental caries as soon as possible. ANY NO SHOW AND/OR CANCELLATION on the DAY OF appointment will show that oral health is not a priority at this time. The available dental appointments are limited, and there is a long wait list for the next opening, therefore be courteous to other patients who need appointments, and give us AT LEAST 48 hours/ 2 days' notice when cancelling an appointment. For children who have Medicaid, Texas Health and Human Services Medicaid Department requires dental providers to notify them of any no shows, so they can visit with you to see how they can assist you in any way for making appointments.

By signing below, I understand and agree to the above policy.

Patient Name (Print):_____ Signature: _____

Patient Legal Guardian Print Name: _____ Signature: _____

Witness Name/Title: _____ Witness Signature: _____

Date:_____

TEXAS Department of State Health Services

STATEMENT OF APPLICANT'S RIGHTS AND RESPONSIBILITIES FORM 101

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 certification 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 certificación (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, 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.	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 *Veterans Administration;* de la TRICARE 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 program eligibility, I will be required to reapply for assistance at least every twelve months.	Yo entiendo y acepto que, para mantener la elegibilidad para el programa, se me va a requerir que vuelva a solicitar para recibir asistencia, por lo 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 bien, dependiente del territorio. Yo vivo físicamente en Texas, mantengo residencia en Texas y, no afirmo ser residente de otro estado o país o bien, soy un dependiente de un residente legítimo de Texas.
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.	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 esos proveedores aprobados por el programa.
I understand that criteria for participation in the program 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 el programa es el mismo para todos sin importar sexo, edad, discapacidad, raza o bien, origen de nacionalidad.
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.	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 el programa con HHSC Civil Rights Office de 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.	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 http://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 http://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 the program 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 el programa no proporciona 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 Staff Signature** **Date**
X	

TEXAS Health and Human Services

Office of Primary and Specialty Health

Application for Program Benefits

Form 3029
September 2021-E

This form can be used to apply for health care assistance through the Primary Health Care (PHC) Services Program, the Title V Fee-for-Service Program, and/or the Epilepsy Program. Please complete every field unless instructions are to "Check all that apply."

Section I. Primary Responsible Adult and/or Adult Applicant Information

*If applicant is applying on behalf of a child, they will be named in Section II.

Name (Last, First, Middle)	Sex ◯ Male ◯ Female	Date of Birth	Race/Ethnicity	
Home Address (Street, Apt. or P.O. Box)	City	County	State	ZIP Code
Home Area Code and Phone No.		Mobile Area Code and Phone No.		
Email Address				

Communication Preferences

The following form fields are optional and do not affect eligibility.

Preferred method of contact (check all that apply): ..... ☐ Email ☐ Phone ☐ Mail

Preferred Spoken Language: ..... ☐ English ☐ Spanish ☐ Other _____

Preferred Written Correspondence: ..... ☐ English ☐ Spanish ☐ Other _____

☐ By checking this box, I authorize my health care provider to contact me via voice mail or text messaging to the mobile phone number listed above.

Do you or another applicant have an immediate medical need? ◯ Yes ◯ No

Important Information for Former Military Services Members – Women and men who served in any branch of the United States Armed Forces, including Army, Navy, Marines, Air Force, Coast Guard, Reserves or National Guard, may be eligible for additional benefits and services. For more information, visit the Texas Veterans Portal at **https://veterans.portal.texas.gov**.

Are you a veteran? ◯ Yes ◯ No

Section II. Household Information

Number of People in the Household: _____

This number will include you and anyone who lives with you for whom you are legally responsible. Minors should include parent(s)/legal guardian(s):

Household Members (including Primary Responsible Adult and/or Adult Applicant)

Name (Last, First, Middle)	Date of Birth	Sex	Race/Ethnicity	Relationship	OPSH Program Applying For (PHC, Epilepsy or Title V)	Has Comprehensive Health Care Coverage? (Y/N)*
						◯ Yes ◯ No
						◯ Yes ◯ No
						◯ Yes ◯ No
						◯ Yes ◯ No
						◯ Yes ◯ No
						◯ Yes ◯ No
						◯ Yes ◯ No

* Comprehensive health care coverage includes Medicare, Medicaid, Children's Health Insurance Program (CHIP), veteran's benefits, TRICARE, private insurance, etc. An authorized program representative will submit a claim for reimbursement from insurer for any benefit, service or assistance received by member with comprehensive coverage. Nutrition services (WIC, SNAP) are not comprehensive health care.

Do you, or does anyone in your household, have any special circumstances? ..... ◯ Yes ◯ No

If Yes, provide a detailed explanation of special circumstances below (Special circumstances would be an unusual situation that you rarely encounter.):

Section III. Other Benefits

Check all benefits that you receive. If you receive one of these benefits and can provide proof, you may be automatically (adjunctively) eligible for the PHC program:

- ☐ Children's Health Insurance Program (CHIP) Perinatal
- ☐ Supplemental Nutrition Assistance Program (SNAP)
- ☐ Women, Infants and Children (WIC) Program
- ☐ Medicaid for Pregnant Women
- ☐ Healthy Texas Women (HTW)
- ☐ None of these

Were you referred to Primary Health Care from a Healthy Texas Women provider? ..... ◯ Yes ◯ No

Section IV. Acknowledgment

The statement 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 agree to report all changes in income, family composition, residence, current address, employment and all types of health care coverage or benefits no later than 30 days after I become aware of the change. I understand that giving false information could result in disqualification and repayment.

Privacy Notification

With few exceptions, you have the right to request 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. (Government Code, Section 552.021, 552.023, 559.003 and 559.004.)

Acknowledgment

I understand that this application is a legal document and that by signing this form, I am stating that from my personal knowledge, all facts included are true and correct. I understand that giving false information could result in disqualification or reimbursement for the cost of services and that if I am approved to receive program services, I will be held accountable for complying with program policies, including maintaining eligibility and fulfilling all other beneficiary responsibilities.

Statement of Release of Information

I authorize the release of income and medical information to and by the Texas Health and Human Services Commission and the provider, as necessary, to determine eligibility and to coordinate, render and bill for services.

Coverage Attestation

I attest that I, the primary applicant, have no other health insurance coverage than what is listed in Section III, Health Care Information, of this application. I authorize the program to bill the coverage sources listed for any services provided.

Applicant Signature _____ Date _____

Relationship to Applicant _____ Signature of Person Assisting Applicant _____ Date _____

For Facility Office Use Only

Name of Applicant	Type of Determination ◯ New ◯ Re-Certification	Client/Case No.
Case Record Action ◯ Approved ◯ Presumptive ◯ Supplemental ◯ Denied		Eligibility Effective Date

Section V. Household Income Information

List the applicant's household income below. Be sure to include the following types of income: Gross earned income; cash gifts or contributions; investment dividends, interest or royalties; non-educational loans; lawsuit or lump sum payments; mineral rights; pensions or annuities; reimbursements; Social Security benefit payments; unemployment payments; Veterans Affairs (VA); and workers' compensation. Refer to "OPSH Definition of Income" for additional information about different types of income.

Name of Household Member Receiving Money	Name of Agency, Person or Employer Who Provides Money	Type of Income	Amount Received	How Often Received (daily, weekly, every two weeks, twice a month, monthly)	Monthly Income Total
				Total Countable Monthly Income	
				Deductions	-
				Net Countable Monthly Income	

Verification of Income:

Section VI. Program Eligibility

Household Member	Meets Program Eligibility		
	☐ PHC	☐ Title V/MCH	☐ Epilepsy
	☐ PHC	☐ Title V/MCH	☐ Epilepsy
	☐ PHC	☐ Title V/MCH	☐ Epilepsy
	☐ PHC	☐ Title V/MCH	☐ Epilepsy
	☐ PHC	☐ Title V/MCH	☐ Epilepsy
	☐ PHC	☐ Title V/MCH	☐ Epilepsy

Section VII. Contractor Eligibility Certification

Eligibility Effective Date: _____

1. Are all household members eligible as Texas residents? ..... ◯ Yes ◯ No

2. Net Countable Monthly Household Income: ..... _____

3. Household Federal Poverty Level: ..... _____

4a. Proof of Income: ..... ◯ Yes ◯ Waived

4b. Reason for Waiver of Proof of Income: _____

5. Verification of Adjunctive Eligibility (PHC only): ..... ◯ Yes ◯ No ◯ N/A

6a. Check each program below if you assessed the applicant's potential eligibility:

☐ Medicare ☐ Medicaid ☐ CHIP ☐ CHIP Perinatal

☐ Private insurance ☐ VA benefits ☐ TRICARE ☐ Workers' Compensation

6b. If the applicant is potentially eligible for another program, did you assist the applicant with that application? ..... ◯ Yes ◯ No

7. Presumptive Eligibility: ..... ◯ Yes ◯ No ◯ N/A

8. Presumptive Eligibility End Date: ..... _____

Copayment Amount (if applicable): Primary Health Care Services Program _____

Title V Fee-For-Service Program _____

Epilepsy Program _____

Notes:

_____ Name of Facility

_____ Facility/Staff Member Signature

_____ Date

Form should be kept with client's record. Form should not be submitted to state office.

TEXAS Health and Human Services | Texas Department of State Health Services

Texas Immunization Registry (ImmTrac2)

Minor Consent Form

A parent, legal guardian or managing conservator must sign this form if the client is younger than 18 years of age.

Child's First Name _____ Child's Middle Name _____ Child's Last Name _____

Child's Date of Birth (mm/dd/yyyy) _____/_____/_____ Child's Gender: ☐ Male ☐ Female

Telephone _____ - _____ - _____ Email address _____

Child's Address _____ Apartment # / Building # _____

City _____ State _____ Zip Code _____ County _____

Mother's First Name _____ Mother's Maiden Name _____

Race (select all that apply)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African-American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other Race
☐ Recipient Refused

Ethnicity (select only one)

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Other

The Texas Immunization Registry (ImmTrac2) is a free service of the Texas Department of State Health Services (DSHS). The Texas Immunization Registry is a secure and confidential service that consolidates and stores your child's (younger than 18 years of age) immunization records. With your consent, your child's immunization information will be included in the Texas Immunization Registry. Doctors, public health departments, schools, and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed. For more information, see Texas Health and Safety Code Sec. 161.007 (d). *https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.007*.

Consent for Registration of Child and Release of Immunization Records to Authorized Persons/Entities

I understand that, by granting the consent below, I am authorizing release of the child's immunization information to DSHS and I further understand that DSHS will include this information in the Texas Immunization Registry. Once in the Texas Immunization Registry, the child's immunization information may by law be accessed by a public health district or local health department, for public health purposes within their areas of jurisdiction; a physician, or other health-care provider legally authorized to administer vaccines, for treating the child as a patient; a state agency having legal custody of the child; a Texas school or child-care facility in which the child is enrolled; and a payor, currently authorized by the Texas Department of Insurance to operate in Texas, regarding coverage for the child. I understand that I may withdraw this consent at any time by submitting a completed Withdrawal of Consent Form in writing to the Texas Department of State Health Services, Texas Immunization Registry.

State law permits the inclusion of immunization records for First Responders and their immediate family members in the Texas Immunization Registry. A "First Responder" is defined as a public safety employee or volunteer whose duties include responding rapidly to an emergency. An "immediate family member" is defined as a parent, spouse, child, or sibling who resides in the same household as the First Responder. For more information, see Texas Health and Safety Code Sec. 161.00705. *https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.00705*.

Please mark the box below to indicate whether your child is an Immediate Family Member of a First Responder.

☐ **I am an IMMEDIATE FAMILY MEMBER of a First Responder.**

By my signature below, I GRANT consent for registration. I wish to INCLUDE my child's information in the Texas Immunization Registry.

Parent, legal guardian, or managing conservator:

Printed Name _____ Signature _____ Date _____

Privacy Notification: 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.texas.gov* for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

PROVIDERS REGISTERED WITH the Texas Immunization Registry: Please enter client information in the Texas Immunization Registry and affirm that consent has been granted. **DO NOT** fax to the Texas Immunization Registry. **Retain this form in your client's record.**

Questions? Tel: (800) 252-9152 • Fax: (512) 776-7790 • *https://www.dshs.texas.gov/immunize/immtrac/*
Texas Department of State Health Services • Immunizations • Texas Immunization Registry – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

TEXAS Health and Human Services | Texas Department of State Health Services

Texas Immunization Registry (ImmTrac2)
Adult Consent Form

First Name _____ Middle Name _____ Last Name _____

Date of Birth (mm/dd/yyyy) ____/____/____ Gender: ☐ Male ☐ Female Telephone ____-____-____ Email address _____

Address _____ Apartment # / Building # _____

City _____ State _____ Zip Code _____ County _____

Mother's First Name _____ Mother's Maiden Name _____

Race (select all that apply)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African-American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other Race
☐ Recipient Refused

Ethnicity (select only one)

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Other

The Texas Immunization Registry (ImmTrac2) is a free service of the Texas Department of State Health Services (DSHS). The Texas Immunization Registry is a secure and confidential service that consolidates and stores your immunization records. With your consent, your immunization information will be included in the Texas Immunization Registry. Doctors, public health departments, schools, and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed. For more information, see Texas Health and Safety Code Sec. 161.007 (d). *https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.007*.

Consent for Registration and Release of Immunization Records to Authorized Persons / Entities

I understand that, by granting the consent below, I am authorizing release of my immunization information to DSHS and I further understand that DSHS will include this information in the Texas Immunization Registry. Once in the Texas Immunization Registry, my immunization information may by law be accessed by: a Texas physician, or other health-care provider legally authorized to administer vaccines, for treatment of the individual as a patient; a Texas school in which the individual is enrolled; a Texas public health district or local health department, for public health purposes within their areas of jurisdiction; a state agency having legal custody of the individual; a payor, currently authorized by the Texas Department of Insurance to operate in Texas for immunization records relating to the specific individual covered under the payor's policy. I understand that I may withdraw this consent at any time by submitting a completed Withdrawal of Consent Form in writing to the Texas Department of State Health Services, Texas Immunization Registry.

State law permits the inclusion of immunization records for First Responders and their immediate family members in the Texas Immunization Registry. A "First Responder" is defined as a public safety employee or volunteer whose duties include responding rapidly to an emergency. An "immediate family member" is defined as a parent, spouse, child, or sibling who resides in the same household as the First Responder. For more information, see Texas Health and Safety Code Sec. 161.00705. *https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.00705*.

Please mark the appropriate box to indicate whether you are a First Responder or an Immediate Family Member.

☐ **I am a FIRST RESPONDER.** ☐ **I am an IMMEDIATE FAMILY MEMBER (older than 18 years of age) of a First Responder.**

By my signature below, I GRANT consent for registration. I wish to INCLUDE my information in the Texas Immunization Registry.

Individual (or individual's legally authorized representative):

Printed Name _____ Signature _____ Date _____

Privacy Notification: 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.texas.gov* for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

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Questions? Tel: (800) 252-9152 • Fax: (512) 776-7790 • *https://www.dshs.texas.gov/immunize/immtrac/*
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Texas Department of State Health Services
Immunizations

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