Emergency Application for Medication Assistance and RW Part B Services
For March 13, 2020 through December 31, 2020 ONLY

Use this application for New, Renewal (Recertification) or Self-Report (Self Attestation) applications. A Medical Certification Form (MCF) is required for New Applications.

Mail completed application to: Texas Department of State Health Services, ATTN:MSJA – MC 1873, PO Box 149347, Austin, TX 78714-9347, Fax to (512) 989-4011, or complete over the phone with your local service agency. Go to dshs.texas.gov/hivstd/meds/ for electronic copies.

This emergency application will only be accepted through December 31, 2020.

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)

3. Mailing Address - (P.O. Boxes and Rural Routes accepted here)	Apartment number

City	State	Zip Code

4. Do you have a SSN? ☐ No ☐ Yes	Social Security Number	Tax ID (only if you do **not** have a SSN)

5. Date of Birth:

6. Preferred Language: ☐ English ☐ Spanish ☐ Other:

7a. Current Gender
☐ Male ☐ Female
☐ Unknown
☐ Transgender Male
☐ Transgender Female

7b. Sex at Birth
☐ Male
☐ Female
☐ Unknown

7c. If applicable, are you currently pregnant?
☐ Yes ☐ No Due Date:

8a. Ethnicity (check one)
☐ Hispanic (Please select origin)
- ☐ Mexican, Mexican American, Chicano/a
- ☐ Puerto Rican ☐ Cuban
- ☐ Another Hispanic, Latino/a or Spanish origin

☐ Non-Hispanic

8b. Race (check all that apply)
☐ White
☐ Black/African American
☐ Asian (Please select origin)
- ☐ Asian Indian ☐ Korean ☐ Chinese
- ☐ Vietnamese ☐ Filipino ☐ Japanese
- ☐ Other

☐ Native Hawaiian/Pacific Islander (Please select origin)
- ☐ Native Hawaiian ☐ Guamian or Charmorro
- ☐ Samoan ☐ Other Pacific Islander

☐ American Indian/Alaska Native
☐ Other/Unknown

9. What is the best phone number to reach you during business hours?

9a. What are the best times to be you to be contacted? ☐ weekdays 8-12 ☐ weekdays 1-5 ☐ other	**9b.** May we leave a voice mail? ☐ Yes ☐ No

10. Were you recently released or are you currently incarcerated in a jail or prison?
☐ No *(if no, please go to question 11)* ☐ Yes (*if yes, complete 10a. through 10c. below)*

10a. Facility Name	**10b.** Correctional ID #	**10c.** Release Date

11. Are you currently married? ☐ No ☐ Yes (complete 11a.- 11b.)	**11a.** Spouse on THMP? ☐ Yes ☐ No

11b. Spouse Name	Spouse SSN (if applicable)	Spouse Date of Birth

12. How many of your own children or stepchildren under age 18 live with you?

13. Did a local agency help you this this application? ☐ No ☐ Yes (If yes, please fill out below):

Agency Name:	Agency Fax Number:

Section 2: Proof of Residency and Income

Residency: (List your current address below, even if it is the same as your mailing address written in Section 1):

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

15. Income: Must be from the last 30 days (If you have no income, write "0")

What is the total monthly income for **yourself** from all sources? $_____

What is the total monthly income for **your spouse** from all sources? $_____

16. Please check one box below:

☐ I have included copies of current documents showing my income and address listed above.

☐ My income and current address above are correct. I am unable to send in copies of my documents.

(Note: your application will still be processed if you are unable to send in copies of documents showing where you live or your income. Physical proof of residency and income is encouraged when available, but not required currently.)

Section 3: Authorization of Release

17. Personal contacts: If you would like us to speak to family or friends regarding your application or program status, please list them below. **Please note, this is not required.**

Name of Person	Relation to You	Phone Number

Section 4: Health Insurance (if you have insurance, provide copy of front and back of insurance card)

18. I am currently enrolled in one of the following THMP Assistance Programs:
☐ **SPAP** ☐ **TIAP or** ☐ **TIAP COBRA:** ☐ **Yes (please skip to Section 5)** ☐ **No (continue to numbers 19 and 20)**

19. I have the following (check any that apply): ☐ Medicaid ☐ Medicare Part D ☐ ACA health plan

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 5)**
☐ Yes **(please 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 ☐ Yes (If yes, complete 21a-21b below and attach copies of your COBRA paperwork and payment coupon book)

21a. Have you already submitted your COBRA paperwork?
☐ No ☐ Yes date submitted:
COBRA Administrator's Phone Number:
COBRA Election/Enrollment Due Date:
COBRA Initial 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 5: Certification (signature and date are required)

I verify that the above information is true and correct to the best of my knowledge:

X.	
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)*	Date *(required)*

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