EPILEPSY FOUNDATION
END EPILEPSY TOGETHER
TEXAS - HOUSTON/
DALLAS-FORT WORTH/
WEST TEXAS
2401 Fountain View Drive, Suite 900, Houston, Texas 77057

TO: New Clinic Patient Applicants
RE: Enrollment in Clinic Program Benefits

- **Texas HHS Application for Program Benefits**
- **Texas HHS Application for Program Benefits Household Income Information**
- **Emergency Contact and Consent to Treat**
- **Authorization for Health Information**: Please use a copy of this form to request your medical records from doctors and hospital where you have been treated for seizures or epilepsy.
- **Initial Visit Questionnaire**
- **Patient Assistance Questionnaire**
- **Income Verification**: Most recent year's tax return is the best proof of verification and ensures you are not asked to provide additional documents later in the year. Proof of income is required for enrolling patients into various medication programs and it has to be current at each renewal. If EFTX has your tax return, you will not have to provide it again until next year. Other proof of income includes: Social Security Disability Awards Letter, one month of paycheck stubs, or a letter stating that you have no income.
- **Copy of Driver's License or Photo ID**
- **Medicaid Denial Letter** (if applicable)
- **Proof of Texas Residency**: Utility Bill, Phone Bill, Mail with your Name, Tax Return
- **Copies of your Medicare, Medicaid, or Private Insurance Card** (if insured)

Once you have gathered the above information and completed the paperwork, email, mail or fax it to our office:

Epilepsy Foundation of Texas
Clinical Services
2401 Fountain View, Suite 900
Houston, Texas 77057

clinic@eftx.org 713-789-4944

When paperwork has been received and approved, an appointment will be scheduled. **The Texas HHS Application for Program Benefits and Household Income Verification has to be completed each year per our grant agreement with Texas Health and Human Services.**

If you have any questions about this process, please feel free to contact the clinic 888-548-9716.

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

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WEST TEXAS

Emergency Contact

Name: _____

Relationship: _____

Address:

_____

_____

Phone: _____

Secondary Phone Number: _____

Consent to Treat

I, _____, consent to be treated by the Epilepsy Foundation Texas.

Patient's Signature: _____

Guardian's Signature: _____

Date: _____

Statement of Truth

I, _____, attest that the information in this application is correct to the best of my knowledge.

Patient's Signature: _____

Guardian's Signature

Date: _____

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2401 Fountain View Drive, Suite 900, Houston, Texas 77057

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name: _____

Date of Birth: _____ Social Security # (Last 4 digits): _____

Mailing Address: _____

Telephone Number: _____ Alternate Telephone Number: _____

I hereby authorize The Epilepsy Foundation Texas - Houston/Dallas-Fort Worth/West Texas to receive the specified information below:

From (Physician or Hospital):

_____

Telephone Number:

_____

Fax Number:

_____

Health Information to be disclosed (please check below):

Date(s) of service: _____

( ) Complete Medical Record	( ) Discharge Summary	( ) Radiology Reports	( ) Pictures
( ) Operative/Procedure Report	( ) Consultation Report	( ) Laboratory Results	( ) Films
( ) History and Physical	( ) Pathology Slides/Blocks	( ) ER Record	

( ) Other (specify): _____

This protected health information is being revealed or disclosed for the following purposes:

( ) Continuum of care or ( ) Other (specify): _____

I understand the information used or disclosed may include information relating to Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), sexually transmitted diseases, behavioral or mental health services, and/or treatment for alcohol and drug abuse.

I understand I may cancel this request at any time by written notification to the disclosing facility noted above unless the disclosure process has already occurred. I understand the information used or disclosed may no longer be protected by federal regulations and thus subject to re-disclosure by the recipient. I understand that treatment or payment may not be conditioned upon my completion of this form. I understand I will be asked to provide proof of my identity and/or guardianship (if applicable) with this authorization. A photocopy or fax of this authorization form is as valid as the original. Fees/charges for obtaining copies of records will comply with all applicable state laws and regulations. Payment is due either before or at the time of disclosure.

_____

Signature of Patient or Personal Representative

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Date:_____

Medical/Social History

Name:_____
Last First MI

Date of Birth (MM/DD/YYYY):_____/_____/_____

Who referred you for evaluation?

_____

Why were you referred for evaluation?

_____

What is it about your condition that concerns you?

_____

_____

_____

_____

How do you think we might be able to help you? Be specific.

_____

_____

If you have seen someone else for these or other problems, who has seen you? (Also, indicate when and what you were told about these problems)

_____

_____

How old were you when you had your first seizure? _____

Describe:

_____

_____

_____

Describe your current seizures: Length, frequency of occurrence, and post-seizure response:

_____

_____

_____

_____

_____

Medications

Are you currently taking seizure medications? _____ Yes _____No

Present medication(s) if applicable:

Name of Medication	Dosage (mg of tablet)	How often is it given per day?	At what time is it given?	How long have you been taking it?

Last blood test: Date: _____ Location:_____

What other seizure medications have you taken?

Medication Dosage How long did you take this medication?

What is the longest period you have been seizure free?_____

What medication(s) were you taking during this period? (Include dose)

Diagnostic Testing

	Date	Location
EEG		
MRI		
CT Scan		
Other		

Hospitalizations

Date	Hospital (Name & City)	Reason

Describe other medical problems:_____

_____

_____

List known (drug and other) allergies and sensitivities: _____

_____

Indicate any serious medical problems, etc. for the following:

Father:_____

Mother:_____

Siblings:_____

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Patient Assistance Program (PAP) Questionnaire

Please fill out and return with proof of income

Patient Name: _____
(LAST) (FIRST) (MI)

The pharmaceutical companies also need some additional questions answered:

1. How many people, besides yourself, live where you reside? _____
   1a) Please list their relationship to you for each person: _____
   _____
   _____
   _____
2. Is anyone in the household employed? ☐ Yes ☐ No
   If yes, how many? _____
3. Does anyone receive Social Security? ☐ Yes ☐ No
   3a) If yes, how many? _____
4. Does anyone receive disability (SSI)? ☐ Yes ☐ No
   4a) If yes, how many? _____
   4b) Have they been disabled for more than 2 years? ☐ Yes ☐ No
5. Does anyone receive unemployment benefits? ☐ Yes ☐ No
   5a) If yes, how many? _____
6. If there is no income coming into the household, how are you surviving? _____
   _____
   _____
7. Do you have medical coverage/insurance (including Medicare/Medicaid)? ☐ Yes ☐ No
   7a) If yes, do you have drug/prescription coverage? ☐ Yes ☐ No
   7b) Please provide: Name of Insurance Company: _____
   Policyholder's Name: _____
   Group# (if applicable): _____
   Member ID#: _____

(*Reminder: Please provide a copy of your insurance card's front and back side mailed or faxed to us)

Signature: _____ Date: ____/____/_____