TEXAS Department of State Health Services

# Texas Women's Health Program Application Form

The Texas Women's Health Program provides an annual exam, health screenings, treatment for certain sexually transmitted diseases, and birth control for 12 months.

Fill in facts about yourself – the woman who is applying for benefits.

| First Name | Last Name | MI | Date of Birth (mm/dd/yyyy) | Social Security number | Agency Use Only Date Received |
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| Home Address – Street | City , Texas | ZIP Code | County |
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Fill in a mailing address below if it's different from your home address. If you fill in a mailing address, we will send letters about your case there and not to your home.

| Mailing Address – Street | City | State | ZIP Code | County |
|---|---|---|---|---|
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| Phone number we can call if we need to talk about your case or coverage. Area code and phone number | Driver's License or ID number | Ethnicity (optional) ☐ Hispanic/Latino ☐ Not Hispanic |
|---|---|---|
| | | |

If you're not Hispanic, what race are you? (You don't have to answer.)

☐ American Indian/Alaska Native ☐ Black/African American ☐ White ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Unknown

Are you a U.S. citizen? ..... ☐ Yes ☐ No (If yes, give proof)

Are you a legal immigrant? ..... ☐ Yes ☐ No (If yes, give proof)

Does anyone in your home get WIC benefits right now? ..... ☐ Yes ☐ No (If yes, give proof)

Are you pregnant? ..... ☐ Yes ☐ No

Have you: (1) had a sterilization procedure (like a tubal ligation or Essure) **and** (2) are you now sterile? ..... ☐ Yes ☐ No

Do you have health insurance that covers family planning services? ..... ☐ Yes ☐ No

- **If yes**: If we file a claim on your health insurance, will it cause you physical, emotional or other harm from your spouse, parents or other person? ..... ☐ Yes ☐ No
  - **If yes:** Tell us why filing a claim with your health insurance would cause you harm. If you need to use extra pages, make sure each page has your name and Social Security number.

Do you have CHIP or Medicare Part A or B? ..... ☐ Yes ☐ No

Tell us about everyone who lives in your home.

**Do not** re-enter facts about the woman listed above. Use extra pages if you run out of space.

| Name (First, Last, MI) | Date of Birth (mm/dd/yyyy) | Social Security number* | Sex* | Race* | Relationship to you |
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Tell us about the money coming into your home (income). Be sure to tell us about (1) money everyone gets from training or work; (2) cash, gifts, loans or money from parents, relatives or others; (3) child support; and (4) unemployment or government checks. You need to give proof of the money each person gets.

| Name of person who gets the money | Name of employer, person or agency that gives or pays the money | How often is the money given or paid? (every week, every other week, twice per month, every month) | Amount paid or given |
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Tell us about costs everyone in your home pays for: (1) day care for children and adults, alimony, (2) court-ordered child support, or (3) getting your children to and from day care. You need to give proof of the money you pay for these costs.

| How much do you pay? | How often do you pay? (every week, every other week, twice a month, every month) | Name, address and phone number of person you pay |
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| | | |

Signing up to vote:

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

**If you are not registered to vote where you live now, would you like to apply to register to vote here today?** ..... ☐ Yes ☐ No

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME. If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private. If you believe that someone has interfered with your right to register or to decline to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Elections Division, Secretary of State, P.O. Box 12060, Austin, TX 78711. Phone: 1-800-252-8683.

The facts you provide in connection with this application may be checked by the Texas Health and Human Services Commission (HHSC) and other state agencies. By signing this, you agree that the facts you have given may be used to determine if you qualify for the Texas Women's Health Program, run by HHSC.

"I certify under penalty of perjury that the information I have provided on this application is true and complete to the best of my knowledge. If it is not, I may be subject to criminal prosecution. I understand that this is application is not used to determine if I qualify for Medicaid, but I can apply for Medicaid at any time."

| Signature — Applicant | Date Signed | Signature — Witness (Required if applicant signed with an "X") | Date Signed |
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