



TEXAS
Health and Human
Services

TEXAS HEALTH AND HUMAN SERVICES COMMISSION
P O BOX 149029
AUSTIN, TEXAS 78714-9029

DATE: 12/01/2023

CASE NO: 1015926174

Call: 2-1-1 toll-free (if you can't connect, call 1-877-541-7905)

Fax: 1-877-447-2839 toll-free.

If you are deaf, hard of hearing, or speech impaired, you can call any number by calling 7-1-1 or 1-800-735-2989

DOMINIQUE DAMORE STHRAN
APT B
915 ALLEGHENY CIR
RICHARDSON TX 75080-6508

It is time to renew your benefits.

The benefits you need to renew have a check-mark next to them:

SNAP

TANF

Health Care

You can renew benefits online or by returning the form that came with this letter.

To renew online: Go to YourTexasBenefits.com, log in and click 'Manage'. Find the case that says 'Ready for renewal' and click 'Details'. Click 'Renew Benefits' to begin.

To renew using the form that came with this letter: Return the form by mail using the pre-paid envelope or by fax. The fax number is listed above. Don't forget to sign the form.

Due dates:

Send your online renewal form or the form with this letter as soon as you can. If we don't get your renewal in time, your benefits might end.

| | |
|-----------------------------------|---|
| SNAP food benefits (EDG 90767369) | Your current SNAP food benefits end 01/2024. It's best to return this form as soon as you can. It must be returned by 01/15/2024 if you want SNAP benefits 02/2024. |
|-----------------------------------|---|

Need help filling out the form? **Call 2-1-1 (toll free).**

You might not get benefits if: (1) We don't get your form by the date listed above, (2) you don't meet program rules, or (3) you don't give us all of the items we need from you (see below).

Items we need from you: Bring or mail copies of the items that apply to your case.

- Identity (only for new people added to your case): Current driver's license or Department of Public Safety ID card. If a person has the right to make decisions for you (as an authorized representative), that person also needs to give proof of identity.
 - Bank accounts: Current statement for all accounts.
 - Proof of income: Last 4 pay stubs or a statement from your employer, or self-employment records.
 - Social Security, Supplemental Security Income (SSI), pension benefits, Veteran benefits, Workers compensation, and unemployment: Award letter or pay stubs.
 - Child support you get: District clerk record or letter from the parent who pays showing how much was paid and when. Must show the name, address, phone number, signature, and date of the parent who pays.
 - Child support you pay: Court papers that show what you must pay for child support. For example: divorce decree, court order or district clerk record.
 - Dependent care expenses: Cancelled checks or receipts or a signed statement from the person you pay.
 - Health Insurance (only if: (1) it is new or has changed since you last applied, and (2) you are applying for health care or TANF): Copy of the front and back of the insurance card or policy.
 - Housing costs (only if you are applying for SNAP): Recent checks, check stubs, or statement from the mortgage bank or landlord. Most recent utility bills showing your name and current address.
 - Medical Costs (only if you are applying for SNAP) Proof of costs you have: now and costs you expect to have in the future. You can send bills, receipts, or statements from health care providers (doctors, hospitals, drug stores, etc.).
 - Proof of child related to you (only if you are applying TANF): Legal birth, hospital, or baptismal certification.
 - Proof of child lives with you (only if you are applying TANF): A signed statement from your landlord or a non-relative neighbor that includes his or her name, address, and phone number.
 - Child vaccines (only if you are applying TANF): Vaccine records for each child.
-

Your Rights:

- Get an application when you ask for it and have someone help you fill it out.
- Turn in your application on the same day you get it as long as your name and address can be read and it is signed.
- After you turn in your application, we will tell you within a certain number of days if you can get benefits:
 - SNAP- within 30 days;
 - Children's Medicaid- by whichever date is later, within 30 days or by the agency review date. The review date is usually in the middle of the last month of your benefit period;
 - CHIP- by whichever date is later, within 30 days or by the agency review date. The review date is usually in the middle of the 11th month of the child's 12-month benefit period, and
 - All other benefits- within 45 days
- Get Medicaid coverage, if approved, for 3 months before you applied.
- Ask for a meeting with your caseworker's supervisor.
- Have a fair hearing if you don't agree with an action HHSC took or didn't take in your SNAP, TANF or Medicaid case.
- Have a case review if you don't agree with an action HHSC took or didn't take in your CHIP case.
- To be treated fairly (not be discriminated against) no matter your race, color, religion, sex, age, national origin, political beliefs, or disability.

Additional SNAP Food Benefit Rights

In addition to your rights, which are listed on Form 1805, Explanation of SNAP Rights and Responsibilities, you have the following rights:

- You or your authorized representative may file an application in person or by mail. To receive uninterrupted benefits, you must complete an interview and provide all required verifications.
- You may apply or reapply for food benefits at your SNAP office or Social Security office, if everyone in your household receives or is applying for SSI. If you have no one to represent you at your SNAP office, you may be interviewed at your home or by telephone.

If you believe any of these rights have been denied, you may call the Office of the Ombudsman at **1-877-787-8999**.



Your Texas Benefits: Renewal Form

Case number: 1015926174

| | |
|--|---|
| <p>How to renew</p> <p style="text-align: center;">You can renew online at www.YourTexasBenefits.com.</p> <p>If you don't want to renew online, fill out this form:</p> <ol style="list-style-type: none"> 1. If you need to correct anything on this form: (a) cross it out, and (b) update it. 2. Sign and date page 12. 3. Attach the items we need. Items are listed next to the questions. 4. Send in this form by fax, mail, or in person: <p>Fax: 1-877-447-2839. If the form is 2-sided fax both sides.</p> <p>Mail: TEXAS HEALTH AND HUMAN SERVICES COMMISSION P O BOX 149025 AUSTIN, TEXAS 78714-9025</p> <p>In person: At a benefit office. Call 2-1-1 to find one near you.</p> <p>All phone and fax numbers on this form are free to call.</p> <p>You have the right to file this application immediately if it has your name, address, and signature.</p> | <p>Questions?</p> <p>Call 2-1-1 or 1-877-541-7905. After you pick a language, press 2 to:</p> <ul style="list-style-type: none"> • Ask questions about this form. • Find where to get help filling out this form. • Check the status of this form. • Ask questions about benefit programs. <p>To learn more about benefits, you also can go to www.hhsc.state.tx.us and www.CHIPMedicaid.org.</p> <p>Report waste, fraud, and abuse If you think anyone is misusing HHSC benefits, call 1-800-436-6184.</p> <p>Medicaid for people age 65 or older and for adults who have a disability: If you want to apply for Medicaid for the Elderly and People with Disabilities, call 2-1-1. Ask for a different form.</p> |
|--|---|

| | | | | |
|---|----------------------------|--|---------------------|-------------------------|
| First name Dominique | Middle initial D | Last name Sthran | | |
| Home address (street and apartment number) 10640 Steppington Apt 3212 | City Dallas | State TX | ZIP 75230 | County Dallas |
| Home phone (214) 584-7323 | | Cell or daytime phone (214) 584-7323 | | |
| Mailing address (if different from home address) 915 Allegheny Apt B | City Richardson | State TX | ZIP 75080 | |

Most people applying for benefits must be interviewed. We often interview people on the phone. It helps to know if any of the following reasons make it hard for you to get to a benefits office:

| | |
|--|--|
| <ul style="list-style-type: none"> • You live more than 30 miles from the closest benefits office. • You can't get a ride. • The weather is bad. • You are sick. • You take care of someone in your home. | <ul style="list-style-type: none"> • Your work or training hours don't allow you to get to a benefits office when it's open. • You can't travel because you are age 60 or older, or you have a disability. • You are a victim of family violence. |
|--|--|

| | |
|---|--|
| Do any of the above reasons apply to you? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|---|--|

| | |
|---|---|
| You said you speak English during your interview. If you want to speak a different language, which one? _____ | Do you need an interpreter? We can get one for free. <input type="checkbox"/> Yes <input type="checkbox"/> No |
|---|---|





The people on your case get the benefits marked below. If you want to apply for another program, check the box next to that program.

- SNAP food benefits TANF cash help for families Health care for: Children
 Adult caring for a child
 Pregnant women
 Healthy Texas Women

People renewing their benefits

Everyone on your benefits case should be listed below.

| First name | Last name | This person's relationship to you | Birth date | Is this person still living in your home? | Hispanic or Latino? |
|------------|-----------|-----------------------------------|------------|--|--|
| Ethan | Sthran | | 4/24/2013 | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No Mark one or more: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African-American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White |
| Elijah | Sthran | | 11/30/2016 | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No Mark one or more: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African-American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White |
| Dominique | Sthran | | 7/8/1990 | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No Mark one or more: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African-American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White |
| Elizabeth | Sthran | | 6/6/2014 | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No Mark one or more: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African-American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White |
| Emma | Sthran | | 11/30/2016 | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No Mark one or more: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African-American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White |

List anyone who lives with you, but isn't listed above.

| Name (first and last) | Male or female? <input type="checkbox"/> M <input type="checkbox"/> F | This person's relationship to you | Social Security number | Birth date | U.S. citizen <input type="checkbox"/> Yes <input type="checkbox"/> No | If not a U.S. citizen, tell us: | | Is this person applying for benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No | Hispanic or Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No Mark one or more: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African-American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White |
|-----------------------|---|-----------------------------------|------------------------|------------|---|---------------------------------|--|--|---|
| | | | | | | Immigrant registration number | Date this person entered the United States | | |
| | <input type="checkbox"/> M <input type="checkbox"/> F | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No Mark one or more: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African-American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White |





Other facts

| | |
|---|--|
| Has anyone been convicted of a felony for conduct that: (1) took place after August 22, 1996, and (2) involved illegal drugs? If yes, who? _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Is anyone getting cash help, food, or health-care benefits from another state? If yes, who? _____ Which state? _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |

| | |
|--|--|
| Is anyone living in the home: (1) age 18 years or older, and (2) a student? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Is anyone in your home pregnant? If yes, who? _____ Is this their first pregnancy? Due date (mm/dd/yyyy) _____ Number of babies expected _____ What is the first and last name of the unborn child's father? First: _____ Last: _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Was anyone in your home pregnant during the last 12 months? If yes, who was pregnant? _____ When did the pregnancy end?(mm/dd/yyyy): _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Does anyone have a disability? If yes, who? _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Health insurance

| | |
|---|--|
| Does anyone have health insurance other than Medicare, Medicaid, or CHIP? If yes, who? _____ Send a copy (front and back) of the insurance card. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Does the health insurance cover family planning services? 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 persons? If yes, tell us why filing a claim with your health insurance company would cause you harm. _____ _____ _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No |





Things you are paying for or own

| | |
|---|--|
| Does anyone own or is anyone paying for a: car, truck, boat, motorcycle, or other vehicle? If yes, give facts below: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|---|--|

| Year | Make | Model | Monthly payment | Monthly insurance payment | Money still owed |
|------|------|-------|-----------------|---------------------------|------------------|
| | | | \$ | \$ | \$ |
| | | | \$ | \$ | \$ |
| | | | \$ | \$ | \$ |

| | |
|---|--|
| Does anyone have cash, bank accounts, homes, or other property? If yes, write the amount or value below. Write "none" if no one has any of these items. Send the most recent statement for all accounts. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cash: \$ _____ Other: \$ _____ Bank accounts: All savings \$ _____ All Checking \$ _____ Property if you don't live on it: \$ _____ Homes if you don't live in them: \$ _____ | |

Preferred Method of Contact by Health Plan Providers or Managed Care Organizations

If you get health benefits from us, your health plan provider or managed care organization (MCO) may contact you for the following.

- Appointment reminders
- Information about your health care matters
- Other important notices

You can choose to receive this contact by phone, text message or email.

Text message and e-mail are not encrypted and may not be secure. The risks include an unauthorized third party intercepting confidential or private information. If one of these is your preferred method of communication for your health care, be aware of these risks when sending your personal information by text or email.

Your MCO or health plan provider must take reasonable steps to make sure that your health care information stays private.

By completing the information below, you acknowledge that you understand the risks associated with receiving electronic communications and consent to HHSC sharing your preferred method of contact with your MCO or health plan provider.

Select your preferred contact method from the list below.

Name: _____

Language you prefer to be contacted in: _____

| | |
|--|--|
| <input type="checkbox"/> By Telephone | Telephone Number: _____ <small>(if contacted by cell phone, the call may be auto-dialed or pre-recorded, and your carrier's usage rates may apply)</small> |
| <input type="checkbox"/> By Text message | Cell phone number: _____ <small>(Carrier message and data rates may apply)</small> |
| <input type="checkbox"/> By e-mail | E-mail address: _____ |





Money coming into your home

List all money everyone living in your home gets or will get. Include money from jobs or self-employment, unemployment benefits, Social Security, Supplemental Security Income (SSI), child support, student financial aid, Veteran's Benefits, or cash loans.

Send pay stubs or statement from the last 60 days. If you work for yourself, attach proof of money you get (income), taxes and job costs. Add more pages if you need more room.

| Name of person getting this money | Person, company, or agency paying the money. If you were working for yourself, write "self." | Hours worked per week | How often paid? | Amount you get paid (before taxes and deductions are taken out) | Total Pretax Contributions Per Pay Period | How often is it contributed? | Date Contributed |
|-----------------------------------|--|-----------------------|---|---|---|---|------------------|
| | | | <input type="checkbox"/> no longer working <input type="checkbox"/> every 2 weeks <input type="checkbox"/> daily <input type="checkbox"/> once a week <input type="checkbox"/> once a month <input type="checkbox"/> other | | | <input type="checkbox"/> no longer working <input type="checkbox"/> every 2 weeks <input type="checkbox"/> daily <input type="checkbox"/> once a week <input type="checkbox"/> once a month <input type="checkbox"/> other | |
| | | | <input type="checkbox"/> no longer working <input type="checkbox"/> every 2 weeks <input type="checkbox"/> daily <input type="checkbox"/> once a week <input type="checkbox"/> once a month <input type="checkbox"/> other | | | <input type="checkbox"/> no longer working <input type="checkbox"/> every 2 weeks <input type="checkbox"/> daily <input type="checkbox"/> once a week <input type="checkbox"/> once a month <input type="checkbox"/> other | |
| | | | <input type="checkbox"/> no longer working <input type="checkbox"/> every 2 weeks <input type="checkbox"/> daily <input type="checkbox"/> once a week <input type="checkbox"/> once a month <input type="checkbox"/> other | | | <input type="checkbox"/> no longer working <input type="checkbox"/> every 2 weeks <input type="checkbox"/> daily <input type="checkbox"/> once a week <input type="checkbox"/> once a month <input type="checkbox"/> other | |
| | | | <input type="checkbox"/> no longer working <input type="checkbox"/> every 2 weeks <input type="checkbox"/> daily <input type="checkbox"/> once a week <input type="checkbox"/> once a month <input type="checkbox"/> other | | | <input type="checkbox"/> no longer working <input type="checkbox"/> every 2 weeks <input type="checkbox"/> daily <input type="checkbox"/> once a week <input type="checkbox"/> once a month <input type="checkbox"/> other | |

Housing costs

| | | | |
|---|------------------------------|------------------------|--|
| Does anyone pay any of the costs listed below for the home they are living in? Or for a home they plan to return to? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Rent or home payment \$ _____ | Natural gas/propane \$ _____ | Taxes on home \$ _____ | |
| Phone \$ _____ | Water or sewer \$ _____ | Electricity \$ _____ | |
| Insurance on home \$ _____ | TV cable \$ _____ | Other \$ _____ | |
| Send statements or bills showing your name and address. | | | |





Costs for people who depend on you

| | |
|--|--|
| Does anyone pay child care costs so they can work, look for work, go to training or go to school? If yes, \$ _____ Send statements or bills showing your name and address. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Does anyone pay child support payments, medical bills, and health insurance for a child outside your home? If yes, \$ _____ Send statements or bills showing your name and address. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Does anyone pay for costs for people with disabilities or adults who can't take care of themselves? If yes, \$ _____ Send statements or bills showing your name and address. | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Other costs

| | |
|---|--|
| Does anyone in the home pay alimony? If yes, how much do you pay each month? \$ _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Was the divorce or separation agreement executed or last modified on or before Dec. 31, 2018? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Does anyone in the home pay credit card costs? If yes, how much do you pay each month? \$ _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Does anyone in the home pay other regular monthly costs? If yes, how much do you pay each month? \$ _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Does another person not on your case help anyone on your case pay for any of the above costs? If yes, who? _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Medical costs

| | |
|--|--|
| Does anyone in the home age 60 or older, or anyone with a disability, pay medical costs: doctor, hospital, or medicine? If yes, send bills, receipts, or statements. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|--|--|





Legal Information

Nondiscrimination:

This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and in some cases religion or political beliefs.

The U.S. Department of Agriculture also prohibits discrimination based on race, color, national origin, sex, religious creed, disability, age, political beliefs or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

Supplemental Nutrition Assistance Program (SNAP)

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027), found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

- (1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410
- (2) fax: (202) 690-7442; or
- (3) email: program.intake@usda.gov.

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the State Information/Hotline Numbers (click the link for a listing of hotline numbers by State); found online at: http://www.fns.usda.gov/snap/contact_info/hotlines.htm.

Medicaid and Temporary Assistance for Needy Families

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 509F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (800) 368-1019 (voice) or (800) 537-7697 (TTY).

This institution is an equal opportunity provider.

You also can file a complaint with the Texas Health and Human Services Commission, Civil Rights Office. Email HHSCivilRightsOffice@hhsc.state.tx.us, call 1-888-388-6332, fax (512) 438-5885, or write Texas Health and Human Services Commission, Civil Rights Office, 701 W. 51st St., MC W206, Austin, Texas 78751.

Social Security numbers:

You only need to give the Social Security numbers (SSN) for people who want benefits. Giving or applying for an SSN is voluntary; however, anyone who doesn't apply for an SSN or doesn't give an SSN can't get benefits. If you don't have an SSN, we can help you apply for one if you are a U.S. citizen or a legal immigrant. You must be a U.S. citizen or a legal immigrant to get an SSN. You can get benefits for your children if they have SSNs and you don't. We will not give SSNs to the U.S. Immigration and Citizenship Services. We will use SSNs to check the amount of money you get (income), if you can get benefits, and the amount of benefits you can get. (7 C.F.R 273.6 for food benefits; 45 C.F.R 205.52 for TANF; and 42 C.F.R 435.910 for health care.)





Citizenship and Immigration status:

You can get benefits for your children who are U.S. citizens or legal immigrants even if you are not a U.S. citizen or a legal immigrant. You do not have to give your citizenship or immigration status to get benefits for your children. You only have to give the citizenship or immigration status of people who want benefits. If you are not a U.S. citizen or a legal immigrant, the only benefits you might be able to get are emergency Medicaid services. Getting long-term care (Medicaid for the Elderly and People with Disabilities) or cash help (TANF) could affect your immigration status and your chances of getting a Permanent Resident Card (green card). Getting other benefits will not affect your immigration status and your chances of getting a Permanent Resident Card. You might want to talk to an agency that helps immigrants with legal questions before you apply. If you are a refugee or have been given asylum, getting benefits will not affect your chances of getting a Permanent Resident Card or becoming a citizen.

Statement of Understanding

Read the box marked "All Benefit Programs." Then read the boxes about each of the benefits anyone is applying for.

All Benefit Programs

Facts HHSC has about me

HHSC uses facts about people applying for benefits to decide: (1) who can get benefits, and (2) the amount of benefits.

HHSC checks facts with the federal Income and Eligibility Verification System. If any facts don't match, HHSC will check other sources (banks, employers, etc.).

If anyone applying for benefits has an immigration registration number, HHSC must check with the U.S. Citizenship and Immigration Service (USCIS) system. HHSC will not give anyone's facts to USCIS.

In most cases, I can see and get facts HHSC has about me. This includes facts I give HHSC and facts HHSC gets from other sources (medical records, employment records, etc.).

I might have to pay to get a copy of these facts. I can ask HHSC to fix anything that is wrong. I do not have to pay to fix a mistake. To ask for a copy or to fix a mistake, I can call 2-1-1 or my local HHSC benefits office.

Keeping my facts private

HHSC will keep my facts private if they were collected:

- By HHSC staff or contracted provider staff.
- To find out if I can get state benefits.

HHSC can share facts about me:

- When needed for me to get state health care benefits.
- With phone and utility companies. They will find out if my bill amount can be lowered. HHSC will give them my name, address, and phone number.

SNAP food benefits:

Read this box if you are applying for food benefits.

Telling the truth

Anyone who applies for or gets SNAP must:

- Tell the truth.
- Never trade or sell SNAP benefits, Lone Star Cards, or other devices that allow people to get SNAP.

Anyone who chooses not to tell the truth might:

- Not get SNAP for a year or more.
- Be fined up to \$250,000, jailed up to 20 years, or both.
- Lose income tax refunds.
- Be charged with other crimes.
- Have to repay benefits.
- Never get SNAP again.

Facts anyone tells or gives HHSC

HHSC uses the facts anyone tells or gives HHSC, including Social Security numbers to:

- Check if that person can get benefits.
- Make sure that person is following benefit program rules.
- Help other agencies check if that person can get other benefits.
- Recover benefits that person wasn't supposed to get.
- Share facts about that person with other state and federal agencies (for example, the Texas Workforce Commission, the Social Security Administration, and the Internal Revenue Service).





If a court of law finds you guilty of using or receiving benefits in a transaction involving the sale of a controlled substance, you will not be eligible for benefits for two years for the first offense, and permanently for the second offense.

If a court of law finds you guilty of having used or received benefits in a transaction involving the sale of firearms, ammunition or explosives, you will be permanently ineligible to participate in the program upon the first occasion of such violation.

If a court of law finds you guilty of having trafficked benefits for an aggregate amount of \$500 or more, you will be permanently ineligible to participate in the Program upon the first occasion of such violation.

An individual found to have made a fraudulent statement or representation with respect to the identity or place of residence of the individual in order to receive multiple SNAP benefits simultaneously shall be ineligible to participate in the program for a period of 10 years.

The same is true if anyone lets someone else use their Lone Star Card.

- Share facts with law enforcement officials so they can find people on that person's benefits case (the household) who are wanted for fleeing the law.
- Share facts with federal, state, and private claims collecting agencies for food benefit overpayment claims collection action.
- Check that person's facts with computer matching programs and credit reporting agencies.

(Food Stamp Act of 1977, as amended, 7 U.S.C. 2011-2036.)

Medicaid:

Read this box if you are applying for Medicaid benefits.

Giving out facts about me

I agree to let Medicaid health care providers (doctors, drug stores, hospitals, etc.) give out any facts about me to HHSC. This will allow the providers to be paid by Medicaid.

If I give false information

If I choose not to tell the truth, I might:

- Be charged with a crime.
- Have to repay benefits.

The same is true if I let someone else use my medical card or Medicaid ID.

If I'm afraid to give facts about someone because it could cause harm (physical or emotional) to me or my child:

Medical and child support payments

Depending on my benefits case, the Attorney General (the state) might check that I am getting the right amount of child or medical support payments and coverage.

- If only my child gets Medicaid, I can decide if I want the state to help get any payments and coverage we should get, but don't get right now.
- If my child and I both get Medicaid, I must:
- Help the state get any payments and coverage we should get, but don't right now. If I don't help the state, my child can get Medicaid, but I might not.
- Identify who the child's other parent is.
- Allow the state to keep any medical support payments.





| | |
|--|---|
| <p>I can ask to not give facts about that person. I will need to work with HHSC and a family violence center to get a "Family Violence Exemption."</p> | <p>If I get Medicaid, HHSC will keep medical service payments I can get from other sources, such as:</p> <ul style="list-style-type: none"> • My health insurance. • Money I got because of injuries. • Money collected for me or my children by the Office of Attorney General. <p>I must tell HHSC about these sources. If I don't, I am breaking the law.</p> <p>HHSC will only keep the amount of medical support and service payments allowed by law. I will work with HHSC to get these funds.</p> |
|--|---|

TANF cash help for families:
Read this box if you are applying for TANF.

| | |
|--|--|
| <p>Child support or alimony</p> <p>I agree to:</p> <ul style="list-style-type: none"> • Let the state keep any child support or alimony money owed to anyone during the time they get TANF. • Let the state keep this money after TANF benefits end, if the TANF amount anyone got still needs to be paid off. • Tell HHSC about money anyone gets. • Work with HHSC to get this money; if I don't, I am breaking the law. <p>The state will only keep the amount allowed by law.</p> | <p>If I give false information</p> <p>If I choose to not tell the truth, I might:</p> <ul style="list-style-type: none"> • Be charged with and punished for a crime. (This could include going to prison for up to 10 years or community supervision.) • Have to repay benefits. • Never get TANF again. |
|--|--|

People helping you

Did someone help you fill out this form? Yes No

If yes, tell us about that person:

Name

_____ (_____) _____ - _____

Relationship or organization Phone

Address

Women 15-44 years old who do not qualify for Medicaid or CHIP are automatically tested for Healthy Texas Women (HTW) eligibility. Check the box below if you want to waive HTW testing.

Name _____ I do not want to be tested for HTW.

Name _____ I do not want to be tested for HTW.

Name _____ I do not want to be tested for HTW.





Authorized Representative

If you want, you can give someone the right to act for you (an authorized representative).

That person can:

- Give and get facts for this application.
- Take any action needed for the application process. This includes appealing an HHSC decision.
- Take any action needed to enroll in Medicaid or CHIP. This includes picking a health plan.
- Take any action needed to get benefits. This includes reporting changes and renewing benefits.

If you give someone the right to act for you, that person agrees to:

- fulfill all your responsibilities related to Medicaid;
- keep information about you private;
- obey state and federal laws about conflict of interest and keeping information private, including:
 - laws that protect information on people who apply for or receive Medicaid (42 CFR part 431, subpart F);
 - laws about the privacy and safety of personally identifiable information (45 CFR §155.260(f)); and
 - laws barring the state from paying anyone other than your provider or you for Medicaid services, except in a few circumstances (42 CFR §447.10).

You can have only one authorized representative for all your benefits from HHSC. If you want to change your authorized representative: (1) log in to your account on YourTexasBenefits.com and report a change, or (2) call 2-1-1 (after you pick a language, press 2). If you're a legally appointed representative for someone on this application, send proof with the application.

Do you want to give someone the right to act for you to be your authorized representative?

If yes, tell us about that person (the authorized representative)

Yes No

Name of authorized representative

Organization

Address

(_____) _____ - _____

Phone

***** You must sign and date the next page.*****

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, PO Box 12060, Austin, TX 78711.

Phone: 1-800-252-8683





| | |
|--|-------|
| Agency Use Only: Voter Registration Status | |
| <input type="checkbox"/> Agency registered <input type="checkbox"/> Client declined <input type="checkbox"/> Agency transmitted <input type="checkbox"/> Client to mail <input type="checkbox"/> Mailed to client <input type="checkbox"/> Other | |
| Agency staff signature | _____ |

By signing below, I agree:

- To let HHSC and other state, federal, and local agencies check, share, and get facts about anyone on my benefits case (the household).
- To let other people, businesses, and organizations share facts they have about anyone on my benefits case (the household) with HHSC.
- The facts to be checked and shared include anything that helps decide: (1) who can get benefits, and (2) amount of benefits.

My answers are true: 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.

Sign here to show you agree:

Person applying or the authorized representative for the person applying for benefits:

_____ Sign here _____ Date

Witness (only needed if anyone above signed with an "X" or other mark):

_____ Sign here _____ Date

_____ Printed name of witness

Parent, guardian, or power of attorney for the person applying (you must give proof of this right):

_____ Sign here

_____ Phone number _____ Date





Help you can get without filling out this form

| | | |
|--|--|---|
| <p>Services in your Area</p> <p>Do you need help finding services?</p> <p>Call 2-1-1 (if you can't connect, call 1-877-541-7905). After you pick a language, press 1.</p> | <p>Family Violence Program</p> <p>Are you afraid for your children's or your safety?</p> <p>You can get help to:</p> <ul style="list-style-type: none"> • Getting a ride to a safe place. • Finding shelter, legal help, and a job. • Getting counseling. <p>Call the hotline anytime at 1-800-799-7233 (1-800-799-SAFE) (TTY 1-800-787-3224).</p> | <p>Alcohol and Drug Abuse Prevention Program</p> <p>Do you or someone you know want to stop using alcohol or drugs?</p> <p>You can get help:</p> <ul style="list-style-type: none"> • Quitting. • Dealing with a crisis. • Keeping others from using drugs or alcohol. <p>Call 1-877-966-3784 (1-877-9-NO DRUG).</p> |
| <p>Texas Workforce Network</p> <p>Are you looking for work?</p> <p>You can get help:</p> <ul style="list-style-type: none"> • Applying for a job. • Finding a job. <p>Call 2-1-1 to find a Texas Workforce Center.</p> | <p>Adult Education and Family Literacy Program</p> <p>Do you want help learning to read or getting a GED? Do you need help with job skills? Or learning to speak English?</p> <p>Call 1-800-441-7323 (1-800-441-READ).</p> | <p>Health Insurance Premium Payment Program</p> <p>Do you need help paying for your health insurance?</p> <p>Call 1-800-440-0493.</p> <p>Or write: Texas Health and Human Services Commission TMHP-HIPP PO Box 201120 Austin, Texas 78720-1120</p> |
| <p>Family Planning</p> <p>Do you need help with family planning?</p> <p>Men and women can get help with:</p> <ul style="list-style-type: none"> • Birth control supplies. • Other health care. <p>Call 2-1-1 to find a clinic.</p> <p>Women age 15 to 44 who can't get Medicaid or CHIP might be able to get services in the Healthy Texas Women program. A parent or legal guardian must apply for young women age 15 to 17. To learn more, go to HealthyTexasWomen.org or call 1-866-993-9972.</p> | <p>Women, Infants and Children program (WIC)</p> <p>Are you pregnant or a new mother?</p> <p>You can get help:</p> <ol style="list-style-type: none"> 1. Getting food for you and your children. 2. Getting vaccines. <p>Call 1-800-942-3678.</p> | <p>Important Information for Former Military Service Members</p> <p>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, please visit the Texas Veterans Portal at https://veterans.portal.texas.gov.</p> |



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Documents To Send With Your Application



| Food Stamps | Temporary Assistance for Needy Families (TANF) | Health Care (Medicaid, CHIP, or Healthy Texas Women) | Medicaid for the Elderly and People with Disabilities | DOCUMENTS NEEDED TO SHOW PROOF Send the documents that are check marked under the program (s) for which you are applying. You only need to send documents that apply to your situation. For example, if you are applying for food stamps, but you do not have a bank account, we do not need bank statements. |
|-------------|--|--|---|---|
| ✓ | ✓ | ✓ | ✓ | Identity - Valid driver's license or Department of Public Safety ID card. Note: If you have an representative, your representative will need to provide proof of his or her identity, plus proof of your identity. |
| ✓ | ✓ | ✓ | ✓ | Social Security - Social Security card/ statement from the Social Security Administration for each person |
| | ✓ | ✓ | ✓ | Citizenship - U.S. passport, Certificate of Naturalization, U.S. birth certificate, hospital record of birth or Medicare card. |
| ✓ | ✓ | ✓ | ✓ | Qualified Alien/Non-Citizenship Status - Alien registration card, documentation from the Bureau for Citizenship and Immigration Services (formerly INS). |
| ✓ | ✓ | ✓ | ✓ | Legal Representative - Power of attorney, guardianship order, court order or similar court documents. |
| ✓ | ✓ | ✓ | ✓ | Earnings - Pay stubs , copy of checks , a statement from employer or self-employment records. |
| ✓ | ✓ | ✓ | ✓ | Social Security, Pension, Veterans Administration, Supplemental Security Income, Workers' Compensation or Unemployment Benefits - Award letter or pay stubs. |
| ✓ | ✓ | ✓ | ✓ | Child Support You Obligations - Divorce decree, court order or copy of district clerk record. |
| ✓ | ✓ | ✓ | ✓ | Child Support Payment - Copy of district clerk record or letter from parent who pays showing any child support amounts and dates paid, including the person's name, address, telephone number, signature and date. |
| ✓ | ✓ | ✓ | ✓ | Loans, Gifts, Contributions - Promissory note, loan agreement, statement from person providing the money that includes the person's name, address, telephone number, signature and date. |
| ✓ | ✓ | ✓ | ✓ | Bank Accounts - Current statements for all accounts. |
| ✓ | ✓ | ✓ | ✓ | Stocks, Bonds, Trusts, Annuities - Trust agreement, annuity contract, stock certificate, bond instrument or current statements. |
| ✓ | ✓ | ✓ | ✓ | Real Estate, Oil, Gas, Mineral Rights - Current tax statements, division orders, deeds or royalty statements. |
| ✓ | | ✓ | ✓ | Medical Expenses - Medical bills, receipts or statements from the provider. |
| | ✓ | ✓ | ✓ | Insurance Policies - Copies of life, burial and health insurance policies; statements from the insurance provider showing the current value. We may also need your spouse or ex-spouse's job related health insurance information and policies. |
| ✓ | | | ✓ | Rent/Mortgage - Copies of checks or check stubs, statement from mortgage lender or landlord. Also, if you rent your home, please provide the name, address and telephone number of your landlord. |

| Food Stamps | Temporary Assistance for Needy Families (TANF) | Health Care (Medicaid, CHIP, or Healthy Texas Women) | Medicaid for the Elderly and People with Disabilities | DOCUMENTS NEEDED TO SHOW PROOF Send the documents that are check marked under the program (s) for which you are applying or renewing. You only need to send documents that apply to your situation. For example, if you are applying or renewing for SNAP, but do not have a bank account, we do not need bank statements. |
|-------------|--|--|---|--|
| ✓ | | | ✓ | Utilities - Your most recent utility bills showing your name and current address. |
| ✓ | | ✓ | | Dependent Care Expenses - Copies of check or check stubs showing when and how often you pay. Include a signed and dated statement from the person you pay showing that person's address and telephone number, as well as when and how often you pay. |
| ✓ | | ✓ | | Pregnancy - Medical records confirming the pregnancy, or call 2-1-1 and request Form H3037, Report of Pregnancy, or ask for more information about how you can provide proof. |
| | ✓ | | | Birth of Children - Legal birth certificate, hospital certificate or baptismal certificate. We also must have proof that the child lives with you, such as signed statement from your landlord or a non-relative neighbor that includes his or her name , address and telephone number. |
| | ✓ | | | Child Immunizations - Provide immunization records or proof of immunizations for each TANF child under the age of six. If you believe you are exempt from this requirement because of your religious or conscientious beliefs, call 2-1-1 for the information we will need. |

What can I buy with SNAP?

SNAP food benefits are used to buy food and garden seeds. Most grocery stores accept SNAP.

You **can't** use SNAP to:

- Buy tobacco.
- Buy alcoholic drinks.
- Buy things you can't eat or drink.
- Pay for food bills you already owe.

How will I get my SNAP benefits?

You will get a plastic card called the Lone Star Card. Every month your SNAP amount will be put in your Lone Star Card account. You will use this card like a credit card at the cash register. To get help with your card, call 1-800-777-7328 (toll-free).

Can I get SNAP?

You might be able to get SNAP if the money you get (income) and the things you own are under a set limit.

Some things you own are not counted, for example:

- Your home
- Personal items
- Life insurance policies

How will I know how much I have in my SNAP account?

We will send you a letter telling you how much you will get each month. You can check your balance by logging into your account at YourTexasBenefits.com or by calling the Lone Star Card help line at 1-800-777-7328 (toll-free).

How long will I get SNAP?

We will send you a letter telling you how long your benefit period is. Most adults age 18 to 49 who do not have a child in the home can get SNAP benefits for only 3 months in a 3-year period. The benefit period can be longer if the adult works at least 20 hours a week or is in an approved work program. Some might not have to work or be in a work program to get benefits, such as those who have a disability or are pregnant.

How do I apply?

- **Online:** YourTexasBenefits.com.
- **At a benefits office:** To find a Texas Health and Human Services Commission (HHSC) benefits office near you, go to YourTexasBenefits.com or call 2-1-1 (after you pick a language, press 1).
- **Paper form (H1010):** To get a form, you can either:
 - Call 2-1-1 (after you pick a language, press 2);
 - Call toll-free 1-877-541-7905 (after you pick a language, press 2); or
 - Visit an HHSC benefits office.

Can someone else buy food for me?

You can get a Lone Star Card for another person. That person can use the card to buy food for you. You are responsible for what that person buys with that card. If a card is lost or stolen, you must call us right away at 1-800-777-7328 (toll-free). We will not replace any SNAP benefits used before you report the loss or theft of the card.

Your Rights

1. In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotope, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the [USDA Program Discrimination Complaint Form](#), (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by mail at U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov.

This institution is an equal opportunity provider.

You also can write to Texas Health and Human Services, Civil Rights Office, 701 W. 51st St., MC W206, Austin, Texas 78751, or call 1-888-388-6332.

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the [State information/Hotline Numbers](#) (click the link for a listing of hotline numbers by State); found online at http://www.fns.usda.gov/snap/contact_info/hotlines.htm.

2. You can give us your application form in person or by mail. Another person can give us the form for you. You don't have to go to an interview before giving us your form. You can give us the form the same day you get it. We must accept your form if we can read your name and address, and it has been signed.
If you need help filling out the form or applying, we will help you.
3. You can request a paper or electronic copy of any application you filled out and gave to us, regardless of the original method of submission by calling 211, visiting your local office, or logging in to your YourTexasBenefits.com account.
4. We must give you benefits within 30 days after you give us your application if you: (a) give us everything on time, and (b) we find you meet SNAP program limits. Some people with very little money might get benefits the next workday after they apply.
5. You can talk to the office supervisor if: (a) you have questions that your caseworker can't answer, or (b) you disagree with a decision your caseworker makes.
6. You can file a complaint by calling 2-1-1. If you don't get the help you need there, you can call the HHSC Office of the Ombudsman at 1-877-787-8999. Both numbers are free to call.
7. If you think any action taken on your case is wrong, you can ask for a hearing to appeal. A hearing is a chance for you to tell a hearing officer the reasons you think the action is wrong. The hearing officer will decide if the right action was taken.
8. A child who gets SNAP will get free school lunches. The child must: (a) go to a public or private school, and (b) be in grades pre-school to high school. Contact your child's school if:
 - You don't want your child to get free school lunches.
 - You think your child should get free school lunches but doesn't.
 - You have questions about the free school lunch program.

Program Rules

1. Anyone who applies for or gets SNAP must tell the truth about their benefits case.
2. It is against the law for anyone to do or try to do any of the following:
 - Trade, sell, or steal SNAP benefits or Lone Star Cards.
 - Share their Lone Star Card PIN (password).
 - Use Lone Star Cards that don't belong to them.
 - Sell food they make with items bought with SNAP benefits.
 - Buy items in refundable containers with SNAP benefits to get refunds and not use the items.
 - Re-sell items bought with SNAP benefits.
3. Most people age 16 to 59 must follow work rules to get SNAP benefits. Work rules mean a person must look for a job or be in an approved work program. If the person has a job, they can't quit without good cause. A person who doesn't follow the work rules will be penalized.

If your SNAP case has more than one parent or caretaker with a child (age 17 or younger), you must decide which parent or caretaker will be listed as the "primary wage earner." If you don't decide who will be the primary wage earner, HHSC will decide for you. If the primary wage earner doesn't follow the work rules, **everyone** on the SNAP case will be penalized. Penalties:

- **1st time:** No SNAP benefits for 1 month or longer (until the person follows the rules).
 - **2nd time:** No SNAP benefits for 3 months or longer (until the person follows the rules).
 - **3rd time:** No SNAP benefits for 6 months or longer (until the person follows the rules).
4. You must tell us about changes to your case within 10 days of the change. We gave you a list that shows the changes we need to know about (see Form H1019, Report of Change).
 5. If you get more SNAP benefits than you should, you must pay them back.
 6. If you move out of the state before using all the benefits in your account, you can use your Lone Star Card at stores that accept SNAP benefits in other states.
 7. These are the penalties for people who break SNAP rules on purpose:
 - **1st time:** Can't get SNAP for 1 year.
 - **2nd time:** Can't get SNAP for 2 years.
 - **3rd time:** Can never get SNAP again.If a court of law decides you can't get benefits, the court will decide for how long.
 8. If you have a felony drug conviction on or after September 1, 2015 and:
 - If you don't follow parole or community supervision rules, you might not get SNAP for 2 years.
 - If you get another felony drug conviction while you are getting SNAP, you can't ever get SNAP again.

If you have any questions, call 2-1-1.

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