

|                                   |  |                               |   |
|-----------------------------------|--|-------------------------------|---|
| <b>Application date</b>           |  |                               |   |
| <b>Enrolling Facility</b>         |  | <b>Location</b>               |   |
| <b>Applicant Name</b>             | (First)  | (Last)                        | <b>Gender</b>   |
| <b>Birthdate</b>                  |  | <b>Social Security Number</b> |   |
| <b>NorthSTAR Number</b>           |  | <b>New/ Update/ Emergency</b> | (Circle appropriate description)                                      |
| <b>Address</b>                    |  |                               | <b>homeless/ living with friends</b> (Circle appropriate description) |
| <b>City</b>                       |  | <b>State</b>                  | <b>Zip</b>  |
| <b>Home Phone</b>                 |  | <b>Work Phone</b>             | <b>Other</b>  |
| <b>Marital Status</b>             | <b>Single/ Divorced/ Widowed/ Married</b> (Circle appropriate description) |                               | <b>If separated length of separation</b>                              |
| <b>Race</b>                       | White (non-Hispanic)   | Black/African American        | Asian American  |
|                                   | Hispanic-Cuban   | Other Hispanic                | Indian/Alaskan Native   |
|                                   | Hispanic/Mexican   | Hispanic/Puerto Rican         | Other (Circle appropriate description)                                |
|                                   | More that one race reported  | unknown                       | Native Hawaiian/Pacific Islander                                      |
| <b>Parent/Legal Guardian Name</b> | (First)  | (Last)                        |   |
| <b>Address</b>                    |  |                               |   |
| <b>City</b>                       |  | <b>State</b>                  | <b>Zip</b>  |
| <b>Health Insurance</b>           | Medicare/ Medicaid/ Veteran/ Private (Circle appropriate description)      |                               |   |
| <b>Employer</b>                   |  |                               |   |
| <b>Insurance company name</b>     |  | <b>Phone number</b>           |   |
| <b>Policy number</b>              |  |                               |   |
| <b>Policy Holder Name</b>         |  |                               |   |
| <b>Policy holder relationship</b> |  |                               |   |

|  |   |
|--|---|
| <b>Monthly Gross Household Income</b> <small>(including applicant, spouse, and or guardians)</small>   |   |
| <b>Applicant Wages</b> <small>(If applicant wages are zero, how are expenses being paid?)</small>  | \$  |
| <b>Spouses wages</b>   | \$  |
| <b>Guardian Wages</b> <small>(for minor applicants only)</small>   | \$  |
| <b>Other income</b> <small>(ssl/dissability/child support/alimony/pension)</small>   | \$  |
| <b>Total Monthly Income</b>  | \$  |
|  |   |
| <b>Approximate balance in checking</b>   | \$  |
| <b>Approximate balance in savings</b>  | \$  |
| <b>Approximate balance in trust fund</b>   | \$ <span style="float: right; background-color: #cccccc;"><b>Monthly payment to member</b></span> |
| <b>Approximate cash on hand</b>  | \$  |
| <b>Total cash</b>  | \$  |
|  |   |
| <b>Extraordinary Expenses</b> <small>(documentation attached)</small>  |   |
| Major Medical or health related  | \$  |
| Major Casualty losses past year  | \$  |
| Child Support  | \$  |
| Child Care   | \$  |
| Total expenses   | \$  |
| <b>Number of family members living at your home address/ in household</b><br><small>(applicant, spouse, dependent, and or guardians)</small> |   |
| <b>Additional Explanation / Details</b> <small>(for staff use only)</small>  |   |
|  |   |

**Rights, Responsibilities, Agreements**

**I have the right to:**

- Appeal a denial of NorthSTAR enrollment to ValueOptions at 888-800-6799.
- File a secondary appeal to the State NorthSTAR administration at 512-206-5470.

**I have the responsibility to:**

- Not purposely withhold information, or give false facts on this application, or my
- Assure that the information on this financial application is true and correct to the
- Submit an updated financial eligibility assessment form to my provider annually.
- Promptly inform ValueOptions within 30 days from the date of this application.

**I understand that:**

- ValueOptions may use credit reporting resources to verify the information
- ValueOptions is required to report any information that is deemed fraudulent in
- The information contained in this application is used to determine eligibility for
- I have the right to appeal denied enrollment as described above.

**Applicant Signature (or guardian if applicant is under age 16)**

**Date**

You have the right to ask us about this form. You also have the right to review the information you give us on the form. (There are some exceptions.) If the information is wrong, you can ask us to correct it. The Health and Human Service Commission has a method for corrections. You can find it in Title 1 of the Texas Administrative Code, sections 351.17 through 351.23. To talk to someone on the form or ask for corrections, please contact ValueOptions at 1199 South Beltline Road, Suite 100, Coppell, TX 75019 or by calling 888-800-6799.

Tiene el derecho de preguntarnos sobre esta forma. También tiene el derecho de revisar la información que nos da en la forma (hay algunas excepciones). Si la información no está correcta, puede pedir que la corrijamos. La Comisión de Salud y Servicios Humanos tiene un método para pedir correcciones. Se encuentra en el Título 1 del Código Administrativo de Texas, secciones 351.17 a 351.23. Para hablar con alguien tocante de esta forma, o para pedir que se corrija, favor de comunicarse con ValueOptions. Puede escribir al 1-888-800-6799 o ir a South Beltline Road, Suite 100, Coppell, Texas 75019. También puede llamar al 1-888-800-6799.









