

HHSC Specialty Health Care Services HOUSEHOLD Eligibility Worksheet



PART I – APPLICANT INFORMATION

Name (Last, First, Middle)	Today's Date (MM-DD-YYYY)	Eligibility Effective Date (MM-DD-YYYY)
Case Record Action <input type="checkbox"/> Adjunctive <input type="checkbox"/> Presumptive <input type="checkbox"/> Supplemental <input type="checkbox"/> Approved <input type="checkbox"/> Denied	Client/Case #	Type of Determination <input type="checkbox"/> New <input type="checkbox"/> Re-certification
Texas resident <input type="checkbox"/> Yes <input type="checkbox"/> No		
Other benefits or health care coverage (Medicaid, Medicare, CHIP, private health insurance, VA, TRICARE, etc.)		
Special circumstances		

PART II – HOUSEHOLD INFORMATION

1. 2. 3. 4. 5. 6.	Notes
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PART III – INCOME INFORMATION

Income Type	Name(s) of household member(s) with income		Documentation of income (if applicable)
Gross earned income			
Cash gifts/contributions			
Child support income			
Dividends/interest/royalties			
Loans (non-educational)			
Lawsuit/lump-sum payments			
Mineral rights			
Pensions/annuities			
Reimbursements			
Social security payments			
Unemployment payments			
VA payments			
Worker's compensation			
Total countable income			
Deductions	-	-	
Net countable income			
			Household FPL %

PART IV – PROGRAM ELIGIBILITY

1. <input type="checkbox"/> BCCS <input type="checkbox"/> FP <input type="checkbox"/> PHC <input type="checkbox"/> Title V/MCH	2. <input type="checkbox"/> BCCS <input type="checkbox"/> FP <input type="checkbox"/> PHC <input type="checkbox"/> Title V/MCH	3. <input type="checkbox"/> BCCS <input type="checkbox"/> FP <input type="checkbox"/> PHC <input type="checkbox"/> Title V/MCH
4. <input type="checkbox"/> BCCS <input type="checkbox"/> FP <input type="checkbox"/> PHC <input type="checkbox"/> Title V/MCH	5. <input type="checkbox"/> BCCS <input type="checkbox"/> FP <input type="checkbox"/> PHC <input type="checkbox"/> Title V/MCH	6. <input type="checkbox"/> BCCS <input type="checkbox"/> FP <input type="checkbox"/> PHC <input type="checkbox"/> Title V/MCH
Co-Pay/Fees		

Name of Agency	Signature – Agency / Staff Member	Date
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HHSC Specialty Health Care Services HOUSEHOLD Eligibility Worksheet Instructions



PART I - APPLICANT INFORMATION

Fill in the boxes with the applicant's information.
Check the appropriate boxes.

Other benefits or health care coverage: Document other benefits received/denied. (An applicant or family member eligible for Medicare Part A/B must be referred to the Medicare Prescription Drug Plan (Part D) for prescription drug benefits.)

Special circumstances: Document any special circumstances.

PART II – HOUSEHOLD INFORMATION

Fill in the boxes with members of the household.

This number will include a person living alone or two or more persons living together where legal responsibility for support exists.

Legal responsibility for support exists between: persons who are legally married (including common-law marriage), a legal parent and a minor child (including unborn children), or a legal guardian and a minor child.

(Title V contractors may add whether household members are US citizens, eligible immigrants, or non-US citizens.)

Program Eligibility by 2018 Federal Poverty Level (FPL)

Effective April 1, 2018

Family Size	Title V - MCH	PHC BCCS	FP
	185% FPL	200% FPL	250% FPL
1	\$1,872	\$2,024	\$2,530
2	\$2,538	\$2,744	\$3,430
3	\$3,204	\$3,464	\$4,330
4	\$3,870	\$4,184	\$5,230
5	\$4,536	\$4,904	\$6,130
6	\$5,202	\$5,624	\$7,030
7	\$5,868	\$6,344	\$7,930
8	\$6,534	\$7,064	\$8,830
9	\$7,200	\$7,784	\$9,730
10	\$7,866	\$8,504	\$10,630
11	\$8,532	\$9,224	\$11,530
12	\$9,198	\$9,944	\$12,430
13	\$9,864	\$10,664	\$13,330
14	\$10,530	\$11,384	\$14,230
15	\$11,196	\$12,104	\$15,130

PART III - INCOME INFORMATION

Income may be either earned or unearned. If actual or projected income is not received monthly, convert it to a monthly amount using one of the following methods:

- weekly income is multiplied by 4.33;
- income received every two weeks is multiplied by 2.17;
- income received twice a month is multiplied by 2.

Fill in the *Income Type* table with name(s) of household member(s) and income amounts.

Calculate the *Total countable income*.

Calculate the *Deductions*:

- child support payments;
- dependent childcare;
 - up to \$200 per child per month for children under age 2;
 - up to \$175 per child per month for children age 2 and older;
- adults with disabilities;
 - up to \$175 per adult per month.

Total the *Net countable income*.

Calculate the household FPL using the applicable DSHS program policy and fill in the *Household FPL* box.

Use the *Documentation of income* box for notes (if applicable).

PART IV – PROGRAM ELIGIBILITY

Determine program eligibility for each household member using the corresponding numbers from the household information section.

Document applicable copayments and fees by program in the *Co-Pay/Fees* box.

Fill in the *Name of Agency*, sign, and date.