TEXAS Health and Human Services | Texas Department of State Health Services

Application for Newborn Screening Benefits Services

Notes:

1. All applicants must apply for Medicaid, CHIP, and Children with Special Health Care Needs (CHSCN) services prior to submitting an application for the NBS Benefits Program.
2. Provide verification of applying for Medicaid, CHIP and CHSCN (certification or denial letter, waitlist notification, or verification of submitted application).
3. Applications submitted without first applying for other program benefits will result in denial.
4. If you want to give someone the right to act on your behalf as an authorized representative, complete the Authorized Representative Form. Your authorized representative must provide verification of identity.
5. Provide verification of identity, residence, income, expenses, other program benefits, and private health insurance with your completed application. Accepted verification sources are located on the last page of your application.
6. You must send your application and supporting documents to your Physician's Specialist Office. Your physician's specialist office will email or fax the completed application and documents to the NBS Benefits Program at NBSBenefits@dshs.texas.gov or (512)776-7593.

Applicant Information

If applicant is under age 18, the parent, guardian, or representative must complete the application in full.

First Name:

Middle Name:

Last Name:

Date of Birth:

Gender:

- Female
- Male

NBS Benefits Account#:

Diagnosis:

Physician Specialist's Name:

What type of benefits are you requesting?

- Low Protein Foods
- Medication/Vitamins/Formula/Dietary Supplements
- Doctor Office Visits
- Confirmatory Lab Testing

Residence Information

Home Address:

Home City:

Home State:

Home Zip Code:

Telephone:

Mailing Address (if different):

Mailing City:

Mailing State:

Mailing Zip Code:

Email Communication

May we send communication to you via email?

- Yes
- No

Email Address:

Household Information

List all household members living in the home. "Add an additional page for more household members and attach to this document."

First and Last Name	Date of Birth	Gender	Live in Texas?	Relationship to Applicant

Pregnancy Information

If the applicant or anyone in the household is pregnant, the unborn child will be counted as part of the household.

Is the applicant or is anyone in the household pregnant?

Yes

No

If "Yes," who?

Expected Due Date:

Income Information

Name of person receiving money	Name of agency, person, or employer who provides the money	Gross Amount received	How often received? (daily, weekly, every two weeks, monthly)

Expenses

Does anyone pay legally obligated child support, childcare, or medical expenses? If so, please list. We may be able to deduct the amount from your gross income.

Name of person paying expense	Type of expense paid (legally obligated child support, child care, medical expenses)	Amount paid	How often paid? (daily, weekly, every two weeks, monthly)

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Other Program Benefits

Does the applicant have Medicaid?

- Yes
- No

Medicaid Number:

Does the applicant have CHIP?

- Yes
- No

CHIP Client Number:

Does the applicant have CSHCN benefits?

- Yes
- No

CSHCN Client Number:

Does the applicant have Medicare Part B?

- Yes
- No

Private Health Insurance Information

Does the applicant have any kind of private health insurance?

- ◯ Yes
- ◯ No

Name of Insurance Plan:

Policy Number:

Acknowledgement

I understand that this application is a legal document. By signing, I attest that the facts in the application are true and correct. I understand that if the application is not complete, it may delay the approval of benefits.

Signature – Applicant/Parent/Guardian/Representative

Print Name:

Signature:

Date: