CENTRAL HEALTH

APPLICANT RESPONSIBILITIES

Central Health's Medical Access Program (MAP) and MAP BASIC (collectively, Program(s)) help people access health care by paying for certain health care services. Whether you qualify for MAP or MAP BASIC depends on your income, where you live, the availability of other health care coverage, and the existence of alternate sources of payment for health care. Your ethnicity, color, religion, creed, national origin, gender, disabling condition, sexual orientation, or political belief(s) will not be considered and will not affect your eligibility for these Programs.

By my signature below, I swear that all the statements I have made in connection with my application for these Program benefits, including my answers to all questions about income, county of residence, and other payment sources are true and correct to the best of my knowledge and belief. I understand that, because my eligibility for these Programs is based on my answers to these questions, any omission, failure or refusal to provide Central Health with requested information, or giving false or misleading information in response to eligibility questions, may cause Central Health to terminate my Program benefits and to seek recovery of any payment Central Health made, on my behalf for health care services.

I agree to report any of the following life changes to Central Health within 14 days of the date of the change:

a. mailing address and telephone number
b. address where I live
c. any change in income that may affect my eligibility
d. number of people who live with me/ or a household member becomes pregnant
e. enrollment in Medicaid, CHIP, Medicare, or other private health insurance or notification that I am eligible for any coverage program that may pay for my care

If Central Health identifies an unreported change to any of these five material areas of my application, I understand that my Program benefits may be terminated and that Central Health can take any other action within its authority, including filing civil or criminal charges against me.

I understand that my enrollment in MAP and MAP Basic is conditioned on my agreement to allow Central Health to verify the statements I have made in connection with my application for Program benefits and that enrollment status may remain pending until such agreement is given and verification is obtained from a credible source (e.g., Social Security Administration or the Texas Workforce Commission). I further understand and agree that Central Health may request that I pay for a portion of the cost of my health care and that Central Health may recover any costs it paid for my health care from a third party in the event that I file a claim for personal injury damages.

Finally, I acknowledge and agree that my initials signify:

________ My authorization for my employer, the Social Security Administration, the Texas Health & Human Services Commission, the Texas Department of State Health Services, and the Texas Workforce Commission to release benefits, enrollment, claims, wage, and other records to Central Health; and

________ My authorization will be valid for a period of twelve months from the date I sign this Applicant Responsibilities form or until I revoke my authorization in a signed writing delivered to Central Health;

________ My acknowledgement that I am responsible for ensuring that my mailing address, telephone number, and any cell phone number or email address I list beneath the next paragraph are accurate and are up to date (i.e. current) at all times during my Program enrollment; and

________ (Optional) I understand there are risks associated with sending unencrypted text messages and emails, and I am providing my *consent* to receive information from Central Health regarding scheduled appointments, my application status, renewals and changes to Program coverage and benefits via—

☐ Cell phone. My current cell phone number is ___________________

☐ Email address. My current email address is ____.

-- Name of Applicant	-- Name of Personal Representative ("PR")
-- Signature of Applicant	-- Signature of Personal Representative
-- Program Identification Number	-- PR's Relationship to Applicant
-- Date	-- Date