

TxHmL Financial Eligibility Information

Date _____

Mail to: Department of Aging and Disability Services, Access and Intake
Utilization Management and Review Section
IDD Waivers, Program Enrollment Utilization Review
P. O. Box 149030, Mail Code W-355
Austin, TX 78714-9030

or Fax to: 512-438-4249

From: LA Name	Comp Code
LA Contact Name	Area Code and Telephone No.

Financial Eligibility Status for:

Re: Applicant Name		
Client Assignment and REgistration (CARE) System Identification No.	Medicaid No. (if applicable)	Date of Birth
Mailing Address		

The above-named applicant has been offered enrollment in the Texas Home Living (TxHmL) Program. The local authority (LA) has been informed that the applicant does not meet financial eligibility criteria required for this program.

Complete this form if the applicant has been denied Supplemental Security Income (SSI) or Medicaid.

Please attach a copy of the SSI denial letter from the Social Security Administration or the Medicaid denial letter from the Health and Human Services Commission.

To the best of my knowledge, the above information about _____'s financial eligibility status is accurate.
Applicant's Name

Signature – Applicant or Applicant's LAR Printed Name – Applicant or Applicant's LAR Date Signed

Signature – LA Contact (name listed above) Job Title

FOR STATE USE ONLY	
Signature – PE Reviewer: _____	Date: _____