



Date/Fecha

Advisor/Consejero

Office Address, Area Code and Telephone No./Oficina, Clave del área y teléfono

TO: Agency/Institution Benefits Coordinator

SUBJECT: State Kids Insurance Program (SKIP) Referral

FOR: \_\_\_\_\_  
(Employee Name) (Employee Social Security No.)

Child(ren)'s Name(s)	Date of Birth	Child(ren)'s SSN(s)	Relationship to Employee

The Health and Human Services Commission (HHSC) processed an application for Medicaid for this employee of a state agency or other UGIP-participating institution. We determined that the employee's children are not eligible for Medicaid due to the following:

- Income that exceeds the limit for Medicaid – AGI ..... \$ \_\_\_\_\_ HH Size: \_\_\_\_\_
- Resources that exceed the limit for Medicaid – AGI ..... \$ \_\_\_\_\_ HH Size: \_\_\_\_\_
- Immigration Status (residency in US under 5 years – AGI ..... \$ \_\_\_\_\_ HH Size: \_\_\_\_\_

However, on the basis of the income and resource information provided by the employee, we have determined that his/her children are eligible for SKIP subsidy. We are providing you this referral letter as proof of the employee's SKIP eligibility.

If you have any questions, please contact us at the number shown above.