

How to Apply for Discounted Services

Primary Healthcare

You may make an appointment at the AccessHealth Richmond, Stafford, Missouri City or Brookshire clinics to apply for discounted services. To apply as a patient, our state funding requires you to bring in:

1. **Proof of Identification:** (1 for each family member):

- Birth Certificate, **or**
- Baptismal Certificate, **or**
- School Records, **or**
- Valid Texas Driver's License, **or**
- USCIS Documentation, **or**
- Passport.

2. **Proof of Address:**

- Current water, electric or gas bill statement from utility department, **or**
- Lease/Rent Receipt, **or**
- Medicaid Letter, **or**
- Motor Vehicle Registration, **or**
- Property Tax Receipt.

3. **Proof of Gross Income:** (needed for every family member who is employed)

- **2 MOST CURRENT** paystubs no more than 60 days old, **or**
- If you are paid in cash, you will need an Employment Verification Form (available at any of our locations), **or**
- If you are not working, you will need a Supporter Statement with a copy of ID of the person who helps you (available at any of our locations), **or**
- Current Tax return.

4. **If anyone in your household receives any of following , please bring a current copy:**

VA Benefits, Social Security Income, Worker's Compensation, Unemployment Benefits, Child Support, or Self-Employment Records.

5. **If anyone in your household receives Medicare, CHIP or Medicaid, Please bring your ID card or letter.**

****If you are applying for the Healthy Texas Women's Program, please bring in your birth certificate along with another form or identification****

To schedule an appointment for registration, please call 281-342-4530.



www.myaccesshealth.org

400 Austin St Richmond, Texas 77469

Household Composition Form

HEAD OF HOUSEHOLD

Full Name: _____ Date of Birth: _____

Telephone Number: _____ SSN: _____

Address: _____ City: _____ State: _____

Zip Code: _____ County: _____ E-Mail: _____

Sex: (circle) F / M US Citizen: (circle) Yes / No Race: _____

(Office Use Only) Acct No:

SPOUSE

Full Name: _____ Date of Birth: _____

Telephone Number: _____ SSN: _____

Sex: (circle) F / M US Citizen: (circle) Yes / No Race: _____

E-Mail: _____

(Office Use Only) Acct No:

Fill in the other lines for everyone who lives with you for whom you are legally responsible.

	Name (Last, First, Middle)	SSN (optional)	Date of Birth	Sex	Race	US Citizen	Relationship	(Office Use Only) Acct #
1				F / M		Yes / No		
2				F / M		Yes / No		
3				F / M		Yes / No		
4				F / M		Yes / No		
5				F / M		Yes / No		
6				F / M		Yes / No		
7				F / M		Yes / No		
8				F / M		Yes / No		
9				F / M		Yes / No		

List all of you household's income below. Include the following: government checks; money from work; money you collect from charging room and board; gifted money; child support; or unemployment income.

Name of person receiving money	Agency, person, employer who provides the money	Amount received per month

Do you or any of your family members have medical health insurance? Yes / No : _____

Dental Service Agreement



Stafford Center Hours of Operation

Monday through Friday: 7am – 7pm

Every Saturday: 8am – 12pm



Services Provided: AccessHealth provides dental services for registered patients at the Stafford Dental Clinic. Services will be limited to exams, cleanings, simple fillings and simple extractions. Patients who require a procedure that cannot be performed at the Stafford Dental Clinic will be referred to an outside, non-contracted specialist.

_____ **Initials**

Responsibilities: It is very important that you keep the appointment you have made. You must call the Dental Clinic 24 hours in advance if you are unable to keep your appointment. Calling in advance provides us sufficient time to give the appointment to the next person who is waiting for an appointment.

If you miss three (3) dental appointments without calling to cancel, you will not be eligible to schedule an appointment for six (6) months from the date of your last missed appointment. You will have the option of seeing a dental provider on a walk-in basis during this time, depending on provider availability.

_____ **Initials**

Late Arrivals: You are expected to arrive on time to your appointment (or earlier if possible). If you arrive late to your appointment you will lose your reserved spot and will be placed on a standby list, which is subject to availability on the providers' schedule. You may also reschedule your appointment for another day. Please note, if you are unable to be seen on the same day, the appointment will be considered a No-Show and will count towards the No-Show policy.

_____ **Initials**

Parents / Guardians: Help us maintain happy, healthy smiles for you and your children.

Patients under the age of 18 years have to be accompanied by a parent/guardian at all times. This policy WILL be enforced by the Dental Department for legal and safety reasons. If you as the parent/guardian leaves the building for any reason, your child will not be rendered the dental services that he or she needs for that day.

_____ **Initials**

I certify that I have read and understand the above agreement

Print Name

DOB: _____

Patient/Parent/Guardian Signature

Date: _____

Tel: 281.261.0182

Fax: 281.969.1838

Visit us at: www.myaccesshealth.org

10435 Greenbough Dr. Suite 300
Stafford, Texas 77477





Employment Verification

LOCAL OFFICE	
ACCESSHEALTH	
TELEPHONE NUMBER 281-342-4530	FAX NUMBER
PATIENT NUMBER	DATE

Please use blue or black ink and print or type.

Section 1: To be filled out by the client/employee.			
I authorize my employer to release information to the Department of Social and Health Services.			
EMPLOYEE'S SIGNATURE X		SOCIAL SECURITY NUMBER (OPTIONAL)	DATE
Section 2: To be filled out by the employer.			
EMPLOYEE'S NAME		EMPLOYER'S NAME	
EMPLOYEE'S JOB TITLE		EMPLOYER'S ADDRESS	
Is this a new job? <input type="checkbox"/> No <input type="checkbox"/> Yes		DATE EMPLOYEE STARTED WORK	DATE FIRST CHECK WAS RECEIVED
AVERAGE HOURS PER WEEK	RATE OF PAY OR SALARY (HOURLY, DAILY OR PIECE RATE)	Has job ended? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, when: why:	
Pay frequency: <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Every two weeks <input type="checkbox"/> Two times a month <input type="checkbox"/> Monthly			
Is this job Work Study? <input type="checkbox"/> Yes <input type="checkbox"/> No		IF YES, PROVIDE VERIFICATION OF TOTAL FINANCIAL AID AWARD	WHEN WILL YOUR POSITION END?
Actual gross income (or attach payroll printout) for last three months:			
MONTH: \$	MONTH: \$	MONTH: \$	
Actual gross income for current month and anticipated gross income for next two months:			
CURRENT MONTH: \$	MONTH: \$	MONTH: \$	
Tips	<input type="checkbox"/> No <input type="checkbox"/> Yes; if yes, how often and how much?	_____	
Commissions	<input type="checkbox"/> No <input type="checkbox"/> Yes; if yes, how often and how much?	_____	
Bonuses	<input type="checkbox"/> No <input type="checkbox"/> Yes; if yes, how often and how much?	_____	
Overtime	<input type="checkbox"/> No <input type="checkbox"/> Yes; if yes, how often and how much?	_____	
Work schedule (include exact times when possible):			
MONDAY	TUESDAY	WEDNESDAY	THURSDAY
FRIDAY	SATURDAY	SUNDAY	
Is Health Insurance available? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, is employee enrolled in the health plan? <input type="checkbox"/> Yes <input type="checkbox"/> No			
When does the coverage begin?			
What is the employee's portion of premiums?			
EMPLOYER/REPRESENTATIVE'S SIGNATURE X			DATE X
EMPLOYER/REPRESENTATIVE'S PRINTED NAME AND TITLE X			PHONE NUMBER X

If you or any member of your household has any kind of self-employment income, fill out this form and attach it to your application. You may attach a copy of the latest income tax forms in place of this form. If your accounting system is not the same as this form, you may substitute a copy of your accounting statement. You must answer all questions and sign and date at the bottom. **Use additional sheets of paper if you need to.** Sign and date each sheet. Remember, this is your sworn statement. You will need to bring with you to the interview: bills, receipts, checks or stubs, and any other business records you have. Your worker will need to see them. **Your records will be returned to you.**

Self-employment Income. This is any money you earn working for yourself. It is not money you earn working for someone else. If you are in doubt, ask your caseworker.

Questions 1, 2, and 3. These questions are self-explanatory.

Question 4. List your business income and expenses. In the boxes on the left side of the form, list your business **expenses** (see the information below). Write in the dates you paid the expenses and the amount of each expense. Add the amounts, and enter your total in the box "total self-employment expenses." In the boxes on the right side of the form, list your **income** (see the information below). List the dates you received the income, your sources of income, and the amounts. Add the amounts, and enter your total in the box "total self-employment income." Subtract your expenses from your total self-employment income, and enter your "net self-employment income."

Expenses are your costs of doing business. Examples of expenses are supplies, repairs, rent, utilities, seed, feed, business insurance, licenses, fees, payments on principal of loans for income-producing property, capital asset purchases (such as real property, equipment, machinery, and other durable goods and capital asset improvements), your social security contribution for people who worked for you, and labor (not salaries you pay yourself). If you claim labor costs, list each person and the amount you paid them. If you have any other kinds of business expenses, be sure to list them and the date they were paid.

You may not claim:

- Rent, mortgage, taxes, or utilities on your business if it operates out of your home (unless these costs are separate from the costs of your home);
- Cost of goods you buy for the business but use yourself;
- Net business loss from a prior period and
- Depreciation.

If you are in doubt, bring proof of the expense and ask your worker.

Income includes money from sales, cash receipts, crops, commissions, leases, fees, or whatever you do or sell for money. If you have any other kind of income from your business, be sure to list it. Be sure to list the dates income was received.

Who must sign. The form must be signed by the applicant, spouse, or authorized representative. Anyone may help you complete the form, but that person must also sign and date the form. Ask your worker if anyone else needs to sign the form.

Si usted u otra persona de su casa tiene algún tipo de ingresos de negocio propio, llene esta forma y adjúntela a su solicitud. En lugar de esta forma, puede adjuntar una copia de la declaración de impuestos sobre ingresos más reciente. Si el sistema de contabilidad que usa no es igual al de esta forma, puede substituir la forma con una copia de su registro de contabilidad. Tiene que contestar todas las preguntas y firmar y fechar la forma al final. **Use hojas adicionales si las necesita.** Firme y feche cada hoja. Recuerde que ésta es una declaración jurada. Tiene que llevar a la entrevista: cuentas, recibos, cheques o talones de cheques y cualquier otra documentación que tenga del negocio. El trabajador tendrá que verlos. **Estos documentos le serán devueltos.**

Ingresos del Negocio Propio. Este término se refiere al dinero que gana cuando trabaja por su propia cuenta. No es el dinero que recibe cuando trabaja para otra persona. Si tiene alguna duda, consulte con su trabajador de casos.

Preguntas 1, 2, y 3. Estas preguntas no necesitan más explicación.

Pregunta 4. Apunte los ingresos y gastos de su negocio. En las cajas del lado izquierdo de la forma, enumere los **gastos** de su negocio (vea la información abajo). Ponga la fecha en que pagó los gastos y la cantidad de cada gasto. Sume las cantidades y ponga el total en la caja que dice "total de gastos del negocio propio". En las cajas a la derecha de la forma, enumere los **ingresos** (vea la información abajo). Ponga la fecha en que recibió cada ingreso, la fuente del ingreso y la cantidad. Sume las cantidades y ponga el total en la caja que dice "total de ingresos del negocio propio". Reste los gastos del total de ingresos del negocio propio y anote sus "ingresos netos del negocio propio".

Los gastos son los costos de un negocio. Algunos ejemplos de posibles gastos son: provisiones, reparaciones, renta, servicios públicos, semilla, forraje, seguro del negocio, licencias, cuotas, pagos del capital de préstamos para propiedades que generan ingresos, compras de bienes de capital (como bienes raíces, equipo, maquinaria y otros bienes duraderos y mejoras de bienes de capital), su aportación al seguro social de las personas que trabajan para usted y sueldos (pero no los que se paga a sí mismo). Si declara el costo de sueldos, ponga el nombre de cada persona y la cantidad que le pagó a cada quien. Si tiene cualquier otro tipo de gastos del negocio, asegúrese de anotarlos y poner la fecha en que los pagó.

No puede declarar:

- El pago de la renta, la hipoteca, los impuestos o los servicios públicos del negocio si lo opera de su casa (a no ser que estos costos son aparte de los costos de la casa);
- El costo de artículos que compra para el negocio pero que usa personalmente;
- La pérdida neta del negocio de un periodo anterior; and
- La depreciación.

Si tiene alguna duda, lleve comprobantes del gasto y consulte con el trabajador.

Los ingresos son, entre otros, el dinero de ventas, el ingreso de caja, las cosechas, las comisiones, las rentas, las cuotas o cualquier cosa que hace o que vende por dinero. Si usted tiene cualquier otro tipo de ingresos del negocio, asegúrese de anotarlos. No olvide poner las fechas en que recibió el ingreso.

Quién debe firmar. El solicitante, su cónyuge o su representante autorizado para firmar la forma. Cualquier persona puede ayudarle a llenar la forma, pero esa persona también tiene que firmar y poner la fecha en la forma. Consulte con el trabajador para saber si alguien más tiene que firmar.

With a few exceptions, you have the right to request and be informed about the information that the county obtains about you. You are entitled to receive and review the information upon request. You also have the right to ask the county to correct information that is determined to be incorrect (Government Code, Sections 552.021, 552.023, 559.004). To find out about your information and your right to request correction, please contact your local county office. / Con algunas excepciones, usted tiene el derecho de saber qué información obtiene sobre usted el condado de pedir dicha información. Si desea recibir y estudiar la información, tiene el derecho de solicitarla. También tiene el derecho de pedir que el condado corrija cualquier información incorrecta (Código Gubernamental, Secciones 552.021, 552.023, 559.004). Para enterarse sobre la información y el derecho de pedir que la corrijan, favor de ponerse en contacto con la oficina local del condado.

SUPPORTER STATEMENT

If an applicant has no income or is unable to provide any documentation showing how they manage, this form can be used as documentation. This form must be completed and signed by the person providing support; it **should not** be filled out by the person applying for the program. Please bring a copy of the ID of the person who is completing this form.

I, _____, certify that I currently support
(printed name of supporter)

_____, who resides at the following
(printed name of person you support)

address: _____
(person you support's street address, city, state, & zip code)

I have supported him/her since _____ . My relationship to the applicant
(Date)

is _____ .
(examples: parent, spouse, roommate, friend, sister, etc.)

The type of support I provide is (check all that apply):

Room Food/Clothing Rent/Mortgage Utility Bills

Cash Assistance in the amount of \$ _____ per month

Other:

Additional explanation (if necessary):

I can be reached at the following number(s) to verify this information:

By signing this form, I affirm that the above information is an accurate statement of assistance being provided to the applicant. I understand that if I deliberately omit or give false information the applicant may be removed from the program and/or criminally prosecuted.

X

X

Signature of Supporter *(please print and sign)*

Date

Please note: If there are special circumstances surrounding your household situation that would need to be explained or verified by a social worker, case manager, or public health nurse, please have them provide a detailed support statement on your behalf and attach it to your application when applying for assistance.