



NorthSTAR Application Form

11-07

Application Type <input type="checkbox"/> New <input type="checkbox"/> Update <input type="checkbox"/> Emergency	Priority <input type="checkbox"/> ACT <input type="checkbox"/> Detox <input type="checkbox"/> Diversion	Application Date	NorthSTAR No.
Enrolling Facility	Location	Eligibility Specialist	

Applicant	First Name	Middle Name	Last Name	
	Social Security Number	Birth Date	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Home Address	Address	City	State	Zip
Telephones	Home Phone	Work Phone	Other Phone	
Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Married			Length of separation (if separated)
Living Situation	<input type="checkbox"/> Living alone <input type="checkbox"/> Living w/family <input type="checkbox"/> Living w/friends <input type="checkbox"/> Homeless <input type="checkbox"/> Foster home <input type="checkbox"/> Psychiatric facility <input type="checkbox"/> Substance abuse facility <input type="checkbox"/> Assisted living facility <input type="checkbox"/> Incarcerated <input type="checkbox"/> Other <input type="checkbox"/> Unknown			
Race	<input type="checkbox"/> White (non Hispanic) <input type="checkbox"/> Black / African-American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian / Alaskan Native <input type="checkbox"/> Hispanic - Mexican <input type="checkbox"/> Hispanic - Puerto Rican <input type="checkbox"/> Hispanic - Cuban <input type="checkbox"/> Other Hispanic <input type="checkbox"/> Native Hawaiian / Pacific Islander <input type="checkbox"/> More that one race reported <input type="checkbox"/> Other <input type="checkbox"/> Unknown			
Parent/Legal Guardian	First Name	Last Name		
	Home Address	City	State	Zip
Health Insurance	<input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP <input type="checkbox"/> Veteran <input type="checkbox"/> Private <input type="checkbox"/> None			
	Insurance Company Name	Insurance Co. Phone Number	Policy / Enrollment Number	
	Policy Holder Name	Relation to Applicant	Policy Holder Employer	

Monthly Household Income Include family members living with applicant

Names of Household Members	Applicant	#2	#3	#4	#5	#6	#7	#8
Relation to Applicant	Self							
Gross Wages & Tips	\$	\$	\$	\$	\$	\$	\$	\$
Net Self Employment	\$	\$	\$	\$	\$	\$	\$	\$
Contributions & Gifts	\$	\$	\$	\$	\$	\$	\$	\$
Unemployment Income	\$	\$	\$	\$	\$	\$	\$	\$
Trust Fund Income	\$	\$	\$	\$	\$	\$	\$	\$
Child Support Income	\$	\$	\$	\$	\$	\$	\$	\$
Veteran Benefits Income	\$	\$	\$	\$	\$	\$	\$	\$
SSI Income	\$	\$	\$	\$	\$	\$	\$	\$
Social Security Income	\$	\$	\$	\$	\$	\$	\$	\$
Other Income	\$	\$	\$	\$	\$	\$	\$	\$
Total Monthly Household Income Attach Documentation	\$ 0.00							

Extraordinary Monthly Household Expenses For household members listed above	
Monthly Payment on major medical or health related expenses incurred in past 12 months	\$
Monthly Payment on major casualty losses incurred in past 12 months	\$
Monthly Child Support Expenses	\$
Monthly Child Care Expenses	\$
Monthly Self Employment Expenses	\$
Total Countable Expenses (Documentation attached)	\$ 0.00
Additional Explanation / Details	
Miscellaneous	
Receiving Food Stamps <input type="checkbox"/> Yes <input type="checkbox"/> No	Annual Health Assessment <input type="checkbox"/> Yes <input type="checkbox"/> No
Reason if none	Katrina Evacuee <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Original Parish Name	
Rights, Responsibilities, Agreements	
<p>I have the right to:</p> <ul style="list-style-type: none"> • Appeal a denial of NorthSTAR enrollment to ValueOptions at 888-800-6799. • File a secondary appeal to the State NorthSTAR administration at 512-206-5470. 	
<p>I have the responsibility to:</p> <ul style="list-style-type: none"> • Provide complete information and give true facts on this application, or my NorthSTAR benefits may be denied. • Assure that the information on this financial application is true and correct to the best of my knowledge. • Submit an updated financial eligibility assessment form to my provider annually. • Promptly inform ValueOptions within 30 days from the date of this application. 	
<p>I understand that:</p> <ul style="list-style-type: none"> • ValueOptions may use credit reporting resources to verify the information provided in this application, and that I may not qualify for benefits under NorthSTAR. • ValueOptions must report any information that is deemed fraudulent to the State of Texas HHS Fraud Hotline. • The information contained in this application is used to determine eligibility for the NorthSTAR program. • I have the right to appeal denied enrollment as described above. 	
<p>You have the right to ask us about this form. You also have the right to review the information you give us on the form. (There are a few exceptions.) If the information is wrong, you can ask us to correct it. The Health and Human Service Commission has a method for asking for corrections. You can find it in Title 1 of the Texas Administrative Code, sections 351.17 through 351.23. To talk to someone about this form or ask for corrections, please contact ValueOptions at 1199 South Beltline Road, Suite 100, Coppell, TX 75019 or by calling them at 1-888-800-6799.</p>	
Applicant Signature (or parent/guardian if applicant is under age 16)	Date