**STATEMENT OF HEALTH INSURANCE AVAILABILITY**

**CAUSE NUMBER:**

**CAPTION:**

This statement is made by      ,      , in accordance with section 154.181 of the Texas Family Code.

**1. CHILDREN** – The following child(ren) are subject of this suit:

|  |  |  |
| --- | --- | --- |
| **NAME** | **DATE OF BIRTH** | **SOCIAL SECURITY NO.** |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |

**2. HEALTH INSURANCE AVAILABILITY** (check the applicable column)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **NAME** | **FATHER’S EMPLOYER PROVIDES HEALTH INS.** | **MOTHER’S EMPLOYER PROVIDES HEALTH INS.** | **PRIVATE HEALTH INS. PROVIDED**  | **MEDICAID** | **CHIP** | **NONE** |
|       | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
|       | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
|       | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
|       | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
|       | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |

**3. INFORMATION ABOUT PRIVATE INSURANCE SOURCE** (if applicable)

1. **Name of insurance carrier:**
2. **Group policy ID number:**
3. **Policy holder name:**
4. **Policy holder ID number:**
5. **Name of each child covered:**
6. **Cost per month of coverage for child(ren):**

(To determine coverage for the child(ren), determine the total cost for family coverage and subtract from this amount to insure all covered individuals except the children)

1. **Party responsible for paying the premium:**
2. **Insurance is provided through** (check one)**:**

**[ ]** Father’s Employer

**[ ]** Mother’s Employer

**[ ]** Other Source

1. Please specify the source:
2. Please specify who obtained the insurance:

**4. INFORMATION ABOUT PUBLIC INSURANCE SOURCE** (if applicable)

1. **The premium for child(ren) covered by CHIP is: $**
2. **The person responsible for paying the above premium is:**

**5. INFORMATION ABOUT REASONS WHY HEALTH INSURANCE IS NOT CURRENTLY PROVIDED** (if applicable)

1. (Father) **[ ]  does** **[ ] does not have access to private health insurance.**
2. (Mother) **[ ]  does [ ] does not have access to private health insurance.**
3. (Name of Party) **has applied for coverage under**      (Name of insurance carrier/program)**.**
4. **The status of the above application is:**

**Date:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature Printed Name**