

## STATEMENT OF HEALTH INSURANCE AVAILABILITY

**CAUSE NUMBER:** \_\_\_\_\_

**CAPTION:** \_\_\_\_\_

This statement is made by \_\_\_\_\_ (Petitioner),  
\_\_\_\_\_ (Petitioner), 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
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

- a. Name of insurance carrier: \_\_\_\_\_
- b. Group policy ID number: \_\_\_\_\_
- c. Policy holder name: \_\_\_\_\_
- d. Policy holder ID number: \_\_\_\_\_
- e. Name of each child covered: \_\_\_\_\_
- f. 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)
- g. Party responsible for paying the premium: \_\_\_\_\_
- h. Insurance is provided through (check one):
  - Father's Employer
  - Mother's Employer
  - Other Source
    - i. Please specify the source: \_\_\_\_\_
    - ii. Please specify who obtained the insurance: \_\_\_\_\_

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

- a. The premium for child(ren) covered by CHIP is: \$ \_\_\_\_\_
- b. The person responsible for paying the above premium is: \_\_\_\_\_

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

- a. \_\_\_\_\_ (Father)  does  does not have access to private health insurance.
- b. \_\_\_\_\_ (Mother)  does  does not have access to private health insurance.
- c. \_\_\_\_\_ (Name of Party) has applied for coverage under \_\_\_\_\_ (Name of insurance carrier/program).
- d. The status of the above application is: \_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name