

Atascosa County Indigent Health Care Program (CIHCP)

914 Main St., Room 116 Jourdanton, TX 78026

Required Documentation Checklist

You MUST include with your Application the following:

- A copy of you and your spouse's official picture ID (documents can NOT be expired). Examples:
 - ✓ Texas Driver's License
 - ✓ Texas ID Card
 - ✓ Permanent Resident Card (Green Card)
 - ✓ U.S. Passport

- A copy of proof of your citizenship or legal residency (documents can NOT be expired). Examples:
 - ✓ Social Security Card
 - ✓ Birth Certificate
 - ✓ Voters Registration Card
 - ✓ U.S. Passport
 - ✓ Documentation from the Dept. of Homeland Security

- Proof of current physical address in you and/or your spouse's name dated within the last 60 days. Examples:
 - ✓ Utility or other bills
 - ✓ Voting record
 - ✓ Rent or mortgage payment
 - ✓ Mail

- One month's worth of ALL of the following that applies to you and/or members of your household.
 - ✓ Pay stubs
 - ✓ Unemployment award letter
 - ✓ Child support
 - ✓ Social Security Disability
 - ✓ Social Security Income
 - ✓ Income tax return (most recent)
 - ✓ W-2 forms
 - ✓ Business tax return (most recent)
 - ✓ Court orders (settlements, divorce, etc.)
 - ✓ Cash gifts and loans
 - ✓ Alien Sponsor's income
 - ✓ RSDI payments
 - ✓ Pensions
 - ✓ VA payments
 - ✓ Self-employment income
 - ✓ Trust funds, stocks, bonds, etc.
 - ✓ Worker's compensation payments
 - ✓ Any money received by a member of the household

- Current bank statement(s) or bank print out(s), if you or your spouse have a checking and/or savings account. This includes personal and business.
- A copy of the Title(s) or Registration Form(s) on all the vehicles owned by you and/or your spouse.
- Pay off amount if you are still paying for the vehicle.
- If you or any other household member has Medicaid, include a copy of the Medicaid card.
- If you or any other household member has any form of insurance, include a copy of the insurance card.
- If you have any property, include information and value of the property. Property includes trailers, vacant lots, recreational vehicles, etc.
- If you and/or your spouse have applied for Social Security Income, include a copy of the approval/denial letter(s).

If any other information is needed after your application and documents are reviewed, you will be provided 14 days to provide the needed documentation. However, if you do not bring in the required documentation within the 14 day deadline, your case could be denied.

If you have any questions, please call: (830)-769-4174



County Indigent Health Care Program (CIHCP)
Application for Health Care Assistance

For Office Use Only

Status <input type="radio"/> Application <input type="radio"/> Review	Date Form 3064 Requested/Issued	Date Identifiable Form 3064 Received	Case Record No.	Appointment Date and Time, if applicable
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Name (Last, First, Middle)	Home Area Code and Phone No.	Other Area Code and Phone No.
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Have you ever used another name? If so, list other names you have used.
 Yes No

Mailing Address (Street or P.O. Box)	Apt. No.	City	State	ZIP Code
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Home Address, if different from above. If it is rural, give directions.

1. On the chart below, fill in the first line with information about yourself. Fill in the remaining lines for everyone who lives in the house with you, whether or not you consider them household members.

Name (Last, First, Middle)	Social Security No. (if available)	Sex (Male/ Female)	Date of Birth	Relation to You	Are you a sponsored alien?
					<input type="radio"/> Yes <input type="radio"/> No
					<input type="radio"/> Yes <input type="radio"/> No
					<input type="radio"/> Yes <input type="radio"/> No
					<input type="radio"/> Yes <input type="radio"/> No
					<input type="radio"/> Yes <input type="radio"/> No
					<input type="radio"/> Yes <input type="radio"/> No
					<input type="radio"/> Yes <input type="radio"/> No

Note: The word "household" in Questions 2 through 16 refers to you, your spouse and anyone else who lives with you and with whom you have a legal relationship. You do not need to include information on people who live with you but are not part of your "household."

2. What is your household's county and state of residence (where you make your permanent home)?
County: _____ State: _____ Do you plan to remain in this county and state? Yes No

3. Living Arrangements – Check all boxes that apply to your household.

Own or paying for home Live in a house provided by someone else No permanent residence
 Live with someone else Rent house or apartment Jail

4. List your average monthly household expenses.

Rent/Mortgage	\$
Utilities (gas, water, electric)	\$
Phone	\$
Transportation (such as gas, car payments, bus)	\$
Tax and Insurance on Home Per Year	\$
Other:	\$
Other:	\$
Other:	\$

Does anyone pay these household expenses for you? Yes No If Yes, who pays? _____

5. Are you or is anyone in your household receiving any of the following? Yes No

Temporary Assistance for Needy Families (TANF) Food Stamps Medicaid Benefits

If Yes, who? _____

6. Are you or is anyone in your household pregnant? Yes No If Yes, who? _____

7. Are you or is anyone in your household disabled? Yes No If Yes, who? _____

8. Have you or has anyone in your household applied for Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI)?

Yes No If Yes, who applied and when? _____

9. Do you or does anyone in your household have unpaid health care bills from the last three months? Yes No

If Yes, which months? _____

10. Do you or does anyone in your household have health care coverage (Medicare, health insurance, Veterans Affairs, Tricare, etc.)?

Yes No If Yes, who? _____

11. How much money do you have in your wallet, in your home, in bank accounts or other locations?

12. How many cars, trucks or other vehicles do you and anyone in your household have? List the year, make and model below.

Year	Make and Model	+
1		-
2		-
3		-
4		-

13. Do you or does anyone in your household own or pay for a home, lot, land or other things? Yes No

14. Did you or did anyone in your household sell, trade, or give away any cash or property during the last three months? Yes No

15. Have you or has anyone in your household worked in the last three months? Yes No If Yes, who? _____

16. List all of your household's income below. Include the following: government checks; money from training or work; money you collect from charging room and board; cash gifts, loans or contributions from parents, relatives, friends and others; sponsor's income; school grants or loans; child support; and unemployment.

Name of Person Receiving Money	Name of Agency, Person or Employer Providing Money	Amount Received	How Often Received?

The statements I have made, including my answers to all questions, are true and correct to the best of my knowledge and belief. I agree to give eligibility staff and the county any information necessary to prove statements about my eligibility. I agree to report any of the following changes within 14 days:

- Income
- Resources
- Number of people who live with me
- Address
- Application for or receipt of SSI, TANF or Medicaid

I have been told and understand that this application will be considered without regard to race, color, religion, creed, national origin, age, sex, disability or political belief; that I may request a review of the decision made on my application or recertification for assistance; and that I may request, orally or in writing, a fair hearing about actions affecting receipt or termination of health care assistance.

I understand that by signing this application, I am giving the county the right to recover the cost of health care services provided by the county from any third party.

I agree to give the county any information it needs to identify and locate all other sources of payment for health care services.

I have been told and understand that my failure to meet the obligations set forth may be considered intentional withholding of information and can result in the recovery of any loss by repayment or by filing civil or criminal charges against me.

Before you sign, be sure each answer is complete and correct. If the applicant is married and the spouse is a household member, the spouse may also sign and date this form, even if the spouse is a disqualified household member.

Signature — Applicant _____ Date _____ Signature — Spouse _____ Date _____

Signature — Person Helping Complete Form 3064 _____ Signature — Applicant's Representative _____ Signature — Witness (if applicant signed with "X") _____

Address of Person Helping Complete Form 3064 (Street, City, State, ZIP Code): _____ Area Code and Phone No.: _____

The County Indigent Health Care Program (CIHCP) helps people pay for needed health care. Whether you can get this help depends on your income, what you own, where you live, other help you receive or could receive and other items. Be sure to:

1. Complete your name and address;
2. Sign and date Page 3 of the application; and
3. Answer as many questions as you can on this application.

Turn in or mail back your application today even if you cannot answer all the questions.

Your Responsibilities

You may be asked to bring proof of what you write on your application or what you tell the person interviewing you. If you need help getting proof, the person interviewing you will help. Examples of some of the items you may be asked to prove and documents you can use for proof are listed below.

Where You Live and Plan to Continue Living – Mail that you received at your address; school records; voting records; property taxes, rent or mortgage receipts; Texas driver license; and other official identification.

What You Own and What it is Worth – Property tax appraisals; estimates from car dealers; ads selling similar items; statements from real estate agents; and bank statements.

Your Income – Paycheck stubs; paychecks; W-2 tax forms or income tax returns; sales records; statements from employers; award letters; legal documents; and statements from persons giving you money.

Other Health Care Coverage – Award or claim letters; insurance policies; court documents; and other legal papers. Information regarding Social Security numbers should be given if this information is available. Information regarding sex (male/female) is voluntary. This information will not affect your eligibility.

You must give information about health care insurance and any other third party financially liable for health care services paid by the county for yourself and members of your household. By signing and submitting this application, you are agreeing to give the county the right to recover the cost of health care services provided by the county from any third party.

You may be asked to apply for Medicaid, Temporary Assistance for Needy Families (TANF) or Supplemental Security Income (SSI) benefits. If you are asked to apply for one of these programs, or have applied but are waiting for an answer, your CIHCP application may be pended until you are determined ineligible for the other program. If you are not eligible for these other programs and if you have answered all the questions on the application and have given all the proof asked for, your application can be processed. Then, the CIHCP must determine if you are eligible within 14 days.

After turning in your application, you must report within 14 days any changes in your address, income, resources, people living with you, or application for or receipt of Medicaid, TANF or SSI.

Atascosa County Indigent Health Care Program

MEDICATION LIST

Medications – List ALL medications you are currently taking or have been prescribed to take. These include prescriptions, over the counter medications, and vitamins. *Medicaciones: Enumere todas las medicaciones que usted esta tomando actualmente o se han prescrito para tomar. Estos incluyen sobre las prescripciones, las medicaciones sin receta, y las vitaminas.*

	Drug <i>Medicina</i>	Strength <i>Fuerte</i>	Quantity <i>Cantidad</i>	Directions <i>Instrucciones</i>	Doctor <i>Doctor</i>	Dr. Phone # <i># Telefono Doctor</i>
	Plavix	75 mg	30	Take 1 in the a.m. Tome 1 en la tarde	Dr. Phillip Moore	(281) 555-1212
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						

*****Please be sure to bring all medications with you to your eligibility interview*****
Por favor sea seguro de traer todas las medicaciones con usted a su entrevista de la elegibilidad

Do you have any allergies to medications? If yes, please specify: (Usted tiene alergias a las medicaciones? Si si, especifique por favor.

ATASCOSA COUNTY INDIGENT HEALTH Verification of Residence

Form is to be completely filled out by a neighbor or friend. It **CANNOT** be filled out by family or people who live in the same house as applicant/client.

- If the applicant has a lease in their name or is listed on the lease as occupant, this form is not necessary. Submit current lease agreement and proof of how living expenses have been paid last 3 months.
- If the applicant lives with other persons, submit a copy of lease/utility bill (if non rental) with the other person's name and this form after it has been completed correctly.

Applicant Name & MR#	
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I hereby authorize release of the following information to Atascosa County Indigent Health Care.

(Signature of Applicant)

The purpose of this form is to verify that you are a resident to Atascosa County by verifying that you reside at the address you reported and household composition.

A resident is someone who lives and considers Atascosa County their home county. A resident is not someone who is living/ staying in Atascosa County temporarily with the intent to return to another address located outside of the County.

This form is to be completed by an independent source not residing with or related to the applicant but is aware of your living arrangements. It may also be completed by a private or community organization who has verified your residency and living arrangement.

Please note - Anyone who knowingly omits or misrepresents the truth or arranges for someone to knowingly omit or misrepresent the truth in the completion of the application process is committing a crime, which can be punished by law. If at any time false information is discovered penalties can include all of the following: loss of benefits and the inability to reapply for the benefits Indigent Healthcare Program, recovery of any loss by repayment, along with filing of criminal or civil charges.

Applicant does not/should not complete this form.

The above applicant has requested that you assist in verifying their residency to Atascosa County and household. Please complete either table A or table B, and all of table C.

Table A (ONLY IF APPLICANT IS HOMELESS)

<input type="checkbox"/> I can verify that this individual is homeless by definition that they lack adequate nighttime residence and primary residence is a public or private place not designed for sleeping accommodations. List location where the client sleeps at night.:

Table B (ALL BLANKS MUST BE FILLED OUT)

<input type="checkbox"/> I can verify that the applicant resides at:	Since:
Names and relationship of other persons residing at the same address/unit :	
What is your understanding of clients work situation?	
What assistance do you or the agency you represent provide to the client?	
If at public/ private shelter, is this a condition of probation?	If so, from what county:

Table C (ALL BLANKS MUST BE FILLED OUT)

Name of person completing this form:	Date:
Signature of person completing this form:	Phone :
Do you reside with the applicant?	Relationship to applicant:

If you have any questions, please call: (830) 769-4174

OFFICE USE ONLY: Form Sent by: _____

Atascosa County Indigent Health Care Program

ASSISTANCE PROVIDED

The following is required IF YOU PROVIDE ANY KIND OF ASSISTANCE TO A PERSON APPLYING FOR INDIGENT HEALTH CARE. Read and answer all questions carefully and return the form as soon as possible. If you do not do so, the application may be denied.

(La siguiente información es necesaria si USTED PRESENTA ALGUN TIPO DE AYUDA A LA PERSONA QUE ESTA ALPICANDO PARA SOLICITUD DE ATENCION MEDICA PARA GENTE INDIGENTE. Lee y conteste todas las preguntas con cuidado y devuelve este papel lo más antes posible. Si no lo hace, puede dar lugar a que el candidato/a sea negado lugar en el programa de atención médica para gente indigente.)

I provide _____ the following assistance:

(Yo ayudo) Name of I.H.C. applicant (*Nombre de el/la I.H.C. solicitante*) (con la asistencia siguiente)

_____ I give them \$ _____ cash each month and **do not** expect to be paid back.

*(Yo le doy \$ _____ en efectivo cada mes y **no espero** a ser reembolsado.)*

_____ I pay for medical services and prescriptions **directly** to the provider.

*(Yo pago por servicios y prescripciones médicos **directamente** al proveedor.)*

_____ I pay rent, house payments, or utility bills **directly** to the creditor.

*(Yo pago por el alquiler pagos de casa o cuentas de utilidad **directamente** al acreedor.)*

_____ I pay for food, clothing, and other personal items at the time of purchase.

(Yo pago para la comida, ropa, y otros artículos personales a la hora de compra.)

_____ I provide other assistance. Explain below.

(Yo ayudo con otra forma de asistencia. Explique abajo.)

_____ Date

(Fecha)

_____ Signature of person providing information

(Firma de la persona que proporciono la información)

_____ Phone Number

(Número de teléfono)

_____ Complete mailing address of person providing information

(Dirección postal completa de la persona que proporcionó la información)

Please call the I.H.C Office at (830)-769-4174 if you have any questions.

(Por favor llame al oficina al (830)-769-4174 si tiene alguna pregunta.)

OFFICE USE ONLY: Form Sent by _____

Atascosa County Indigent Health Care Program

EMPLOYMENT STATUS

I, _____

Name of person providing information

(El nombre de la persona que proporcione la información)

Verify that _____

Name of Applicant

(El nombre de el/la solicitante)

Lives at _____

Address **NO P.O. BOX ADDRESS**

*(Dirección física y completa del solicitante... **NO caja de correo**)*

PLEASE CHECK ONE OF THE FOLLOWING STATEMENTS:

(POR FAVOR MARQUE UNO DE LOS SIGUIENTES)

_____ to my knowledge, the person applying for the I.H.C. Program **IS NOT** currently working.

*(Que yo sepa, la persona que solicita el I.H.C. Programa **NO ESTA** trabajando.)*

_____ to my knowledge, the person applying for the I.H.C. Program **IS** currently working.

*(Que yo sepa, la persona que solicita el I.H.C Programa **ESTA** trabajando.)*

The above statements are true and correct to the best of my knowledge. I understand that this statement will be part of a government record and any attempt on my part to defraud may result in prosecution.

(Las declaraciones anteriores son verdaderos y correctas a mi mejor de mi conocimiento. Entiendo que esta declaración será parte de un documento del gobierno y cualquier intento de mi parte para defraudar puede resultar en acciones legales.)

Date

(Fecha)

Signature of person providing information

(Firma de la persona que proporciona la información)

Phone Number

(Número de teléfono)

Complete mailing address of person providing information

(Dirección postal completa de la persona que proporciona la información)

Please call the I.H.C. Office at (830)-769-4174 if you have any questions.

(Por favor llame a la oficina al (830)-769-4174 si tiene alguna pregunta.)

OFFICE USE ONLY: Form Sent by _____



County Indigent Health Care Program (CIHCP)
Case Record Information Release

Case Record Name:	Case Record No.
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I do hereby authorize persons, organizations or establishments having information or records concerning me/us or my/our circumstances, to furnish such information to a representative of the County Indigent Health Care Program. I hereby grant permission for the CIHCP to obtain information which may have a bearing on my/our eligibility for assistance. This release form is valid for six months after the date signed.

Person or Agency to Whom Information will be Released: ATASCOSA COUNTY INDIGENT HEALTH CARE PROGRAM
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Specific Request (Specify in 1 and 2 below.)

1. Information Requested _____

2. Period covered (Dates) _____

General Request (Any information available may be released.)

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Signature – Applicant or Recipient

Date

Signature – Spouse

Date

Signature – Guardian, Power of Attorney, Parent of Minor Child

Date

*Atascosa County Indigent Health Care Program
914 Main St., Rm. 116 Jourdanton, TX 78026
Office: (830)769-4174 Fax: (830) 767-2047*

**Atascosa County Indigent Health Care Program
Statement of Services (Revised 8/2021)**

- **Clients are required to seek ALL non-emergency medical care from their assigned mandated provider, Atascosa Health Center.** (If the mandated provider determines that your condition requires treatment from a specialist; he/she will issue a referral for you to see a specialist. Atascosa County will not issue payment for any non-emergency services provided without a referral from the client's mandated provider)
- **Hospital emergency rooms are not to be used except in matters of true emergency.** If a client seeks routine medical attention, such as for a common cold, from an emergency room, you could be held responsible for the hospital bill and all related emergency room physician/lab bills
- Atascosa County will pay for up to **three (3) prescriptions per month** and up to \$30,000 per year in hospital, doctor, lab, and x-ray **OR** 30 days of hospitalization, whichever comes first.
- **Clients are responsible for informing providers of their eligibility** with Atascosa County Indigent Health Care program and for informing these providers of our billing address.
- Atascosa County Indigent Health Care is not responsible for any medical claims received after our deadline (either 95 days from the date of service OR 95 days from the date of your completed application). ***If a provider sends a bill to you, you must contact that provider and give them the above information so they can bill our office***
- **Clients must notify our office within 14 days of any change of situation**, such as changes in: income, address, property (including vehicles), household members, application/receipt of SSI, TANF, or Medicaid

If a change occurs that makes you ineligible and you fail to report the change as required, you may be held responsible for payment of any medical services received after you became ineligible, or you may be subject to prosecution under the Texas Penal Code.

I HAVE READ AND UNDERSTAND ALL CONDITIONS AS STATED ABOVE:

Applicant Signature

Date

Printed Name of Applicant

**Atascosa County Indigent Health Care Program
Fraud Policy (Revised 8/2021)**

Definition

Fraud is the deliberate misrepresentation, omission, or concealment of some material fact for the purpose of acquiring or continuing benefits.

All documentation received about an applicant or eligible client will be researched for accuracy. Information obtained from applicant will be verified through independent sources such as but not limited to: TransUnion TLO, Texas Workforce Commission, documentation from other agencies, medical providers, organizations or establishments having information or records concerning the circumstances of persons in the applicant's household.

All eligible clients must report a change in situation (resources, residency, income, household composition, etc.) within 14 days of the change to the Atascosa County Indigent Health Care program office.

Procedure

When the Indigent Health Care (IHC) staff has reason to believe that fraud may have occurred, the following procedure shall be followed:

1. The IHC staff will investigate all cases of suspected fraud and will collect and document evidence.
2. In the event fraud is demonstrated and documented, the client will be administratively ineligible from IHC and any combination of the following may occur:
 - a) Administrative disqualification (ineligibility):

First offense	12 months from the date fraud was discovered
Second offense	24 months from the date fraud was discovered
Third offense	36 months + 12 months per subsequent offense
 - b) Referral to Atascosa County Attorney for prosecution.
 - c) Referral to Atascosa County Attorney for restitution.
3. The IHC staff shall contact the client who is suspected of fraud by sending a certified letter informing him/her of the withdrawal of eligibility and explaining the allegations. If the client disputes the allegations, the client will be allowed to submit in writing applicable supporting documents/verifications for further consideration to the IHC office.
4. If the dispute remains unresolved, the client has the right to appeal any unfavorable decision to the Atascosa County IHC Appeal Committee by doing the following within 60 days of the administrative ineligibility:
 1. Submit the basis/reason for your appeal in writing and notarized
 2. Submit the facts that you are basing your appeal
 3. Submit your evidence that supports your basis for the appeal
5. An administrative hearing will be scheduled with the IHC Appeal Committee, client, and possibly IHC Program Coordinator to go over all evidence. The IHC staff must disclose any evidence used to prove its case of fraud.
6. The IHC Appeal Committee will make the final decision and determine the course of action and consequences.

Applicant Signature

Date

Printed Name of Applicant



ATASCOSA COUNTY INDIGENT HEALTH CARE PROGRAM

AUTHORIZATION FOR BACKGROUND CHECKS

914 Main St., Rm 116, Jourdanton, TX 78026

PHONE: 830-769-4174

FAX: 830-767-2047

Applicant (Printed Name)

Social Security Number

Date of Birth

Spouse (Printed Name)

Social Security Number

Date of Birth

I hereby give permission to the Atascosa County Indigent Health Care Program to obtain a background check from the Texas Workforce Commission, Department of Motor Vehicles Registration, Credit Bureau, LexisNexis, Accurant, TLO Investigation Database (TransUnion), and any other sources that may need to be contacted to determine my eligibility (work history, income, resources, place of residence, etc.) for the Indigent Care Assistance Program.

I, _____; hereby authorize any public agency including the Social Security Administration, Medicaid and Medicare to furnish Atascosa County or its agent, information related to assets or any other sources of income to me held in my name and/or criminal history. I hereby release Atascosa County and all of its agents and employees, the public agencies providing such information and all employees of public agencies furnishing information, and all liability resulting from the furnishing of this information to Atascosa County. I certify that the statements made by me on this form and on my application for health care services are true, complete, and correct to the best of my knowledge and belief, and are made in good faith. I understand that any false statements made herein or on my application for health services for Atascosa County will void further consideration for eligibility in Atascosa County's Indigent Health Care Program as it relates to my application for such health services. I know and understand the Atascosa County Indigent Health Care Program Fraud Policy.

I am aware that I must reapply for Indigent Health Care benefits every six (6) months and that if I do not reapply I would lost any benefits I might have been receiving.

I have read all of the above and I understand it.

Applicant Signature

Date

Spouse Signature

Date