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
  - ✓ Permanent Resident Card (Green Card)
  - ✓ Texas ID Card
  - ✓ U.S. Passport
- A copy of proof of your citizenship or legal residency (documents can NOT be expired). Examples:
  - ✓ Social Security Card
  - ✓ Voters Registration Card
  - ✓ Documentation from the Dept. of Homeland Security
  - ✓ Birth Certificate
  - ✓ U.S. Passport
- Proof of current physical address in you and/or your spouse's name dated within the last 60 days. Examples:
  - ✓ Utility or other bills
  - ✓ Rent or mortgage payment
  - ✓ Voting record
  - ✓ Mail
- One month's worth of ALL of the following that applies to you and/or members of your household.
  - ✓ Pay stubs
  - ✓ Child support
  - ✓ Social Security Income
  - ✓ W-2 forms
  - ✓ Court orders (settlements, divorce, etc.)
  - ✓ Alien Sponsor's income
  - ✓ Pensions
  - ✓ Self-employment income
  - ✓ Worker's compensation payments
  - ✓ Unemployment award letter
  - ✓ Social Security Disability
  - ✓ Income tax return (most recent)
  - ✓ Business tax return (most recent)
  - ✓ Cash gifts and loans
  - ✓ RSDI payments
  - ✓ VA payments
  - ✓ Trust funds, stocks, bonds, etc.
  - ✓ 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

TEXAS
Health and Human Services

Form 3064
January 2020-E

County Indigent Health Care Program (CIHCP)

Application for Health Care Assistance

For Office Use Only

Status	Date Form 3064 Requested/Issued	Date Identifiable Form 3064 Received	Case Record No.	Appointment Date and Time, if applicable
◯ Application ◯ Review				

Name (Last, First, Middle)	Home Area Code and Phone No.	Other Area Code and Phone No.

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

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?
					◯ Yes ◯ No
					◯ Yes ◯ No
					◯ Yes ◯ No
					◯ Yes ◯ No
					◯ Yes ◯ No
					◯ Yes ◯ No
					◯ Yes ◯ 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 3604 _____ 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 *Medicina*	**Strength** *Fuerte*	**Quantity** *Cantidad*	**Directions** *Instrucciones*	**Doctor** *Doctor*	**Dr. Phone #** *# Telephono Doctor*
	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 medicacions? Si si, especifique por favor.

OFFICE USE ONLY: Form Sent by_____

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#	

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)

□ 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)

□ 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 _____