ECMH

ELIGIBILITY ON OUR PROGRAMS DO NOT QUALIFY AS HAVING A QUALIFIED HEALTH INSURANCE PLAN

INSTRUCTIONS FOR INDIGENT / CHARITY HEALTH CARE APPLICATION

BEFORE YOUR APPLICATION WILL BE CONSIDERED, YOU WILL NEED TO PROVIDE THE FOLLOWING INFORMATION:

(1) Copy of your last 6 (six) paycheck stubs.

(2) Copy of Current Income Tax Return (forms 1040) and All W-2's

(3) Copy of Current Utility Bill to verify your home address

(4) Current Driver's License or I.D. Card

(5) Social Security Card

(6) Birth Certificate

(7) Unemployment Award Letter

(8) Workman's Comp Award Letter

(9) Social Security Award Letters

(10) Food Stamp / TANF / Medicaid Award Letters and Copy of Medicaid/CHIPS Cards

(11) Copy of Current Checking / Savings Accounts Bank Statements (including IRA's, CD's, etc.)

(12) Copy of all Vehicle Titles or Copy of Vehicle Loan contracts.

(13) Proof of All other household Income (Spouses' Income, Child Support, Odd Jobs, etc)

If you have any questions, please call Coordinator at (979) 578-5194 or (979) 578-5262.

ALL INFORMATION MUST BE CURRENT and SUBMITTED WITH THE APPLICATION

Rev. September 2014

ECMH

Instrucciones para Aplicar para Assistencia con Cobros Medicos de Indigencia / Beneficencia

ANTES DE QUE SE REVISA SU APLICACION, NECESITA ENTREGAR LOS SIGUIENTES DATOS:

1. Copia de Talones de los ultimos (6) seis cheques de pago, o una declaracion de su patron de sus ingresos sin la rebaja de impuestos por los pasados tres meses.
2. Declaracion de Impuestos mas reciente.
3. Recibo reciente de gas, agua, o luz con la dirreccion donde Ud. Vive.
4. Licencia de manejar, o tarjeta de identificacion.
5. Tarjeta del Seguro Social.
6. Acta de Nacimiento.
7. Carta de aprobacion para desempleo o copia del cheque del desempleo, si esta recibiendo . fondos.
8. Carta de aprobacion para Compensacion de trabajador.
9. Carta de aprobacion para Compensacion para Seguro Social o Suplemento, o copias de los cheques, si esta recibiendo fondos.
10. Tarjeta de Medicaid, o documentos , cartas de TANF, MEDICAID, ESTAMPILLAS
11. Estado mensual de cuenta de cheques, estado de cuenta de ahorros. (inversion de retiro, certificado de deposito).
12. Comprobacion del pago del carro y el titulo del auto.
13. Prueba de cualquier otro ingreso.

Toda la informacion tiene que ser al corriente.

Rev. 5 / 2012

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

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 Income (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			−

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.

MEDICATION PROGRAM APPLICATION

Patient Information

Social Security # _____ Date of Birth: _____ Male ____ Female ___

First Name: _____ MI _____ Last Name: _____

Address _____ Apt # _____

City _____ County _____ State _____ Zip _____

Phone _____ Cell _____ Work _____

Physician: _____ Allergies: _____

US Citizen _____ Legal Resident _____

Household Members

Adults _____ Children _____ Total in Household _____

Please Circle One

Separated Single Married Divorced Widowed Common Law

Vehicles

Year	Make and Model	Year	Make and Model
1. _____	_____	3. _____	_____
2. _____	_____	4. _____	_____

All Household Income

Salary / Wages _____ Pension _____

RSDI _____ Bonds / CD / Savings _____

SSI _____ Annuities / Stocks _____

Workers Comp _____ Interest / Dividends _____

Unemployment _____ Alimony /Child Support _____

Other _____ Food Stamps _____

Total Monthly Household Income _____ Last Year Income Tax Filed _____

_____ _____ _____ _____

Patient Signature Date Spouse Signature Date

Rev: 10/2013

CONTACT PERSON

Name: _____ Phone #: _____

Relationship: _____

Medications Currently Taking

Medications	*Strength*	*Directions*	*MFG*	*Pt. Mfg ID#*