TRINITY COUNTY

INDIGENT HEALTH CARE
P. O. Box 312
Groveton, Texas 75845
Phone: 936-642-1736
Fax: 936-642-2733
Email: indigenthealthcare@co.trinity.tx.us

TRINITY COUNTY INDIGENT HEALTH CARE PROGRAM

"PAYOR OF LAST RESORT"

Trinity County Indigent Health Care serves only those eligible county residents who are not eligible for health care services from Federal or State assistance programs.

Have you, or could you, apply for Medicaid?
Have you applied for Supplemental Security (SSI)?
Would you qualify for Social Security Disability (SSDI)?
Would you qualify for TANF (Temporary Assistance for Needy Families)?

All of the above mentioned services that *would, or could*, pertain to you must have been exhausted before you are considered an applicant for Trinity County's Indigent Health Care Program.

If you are asked to apply, or have applied and have not received a decision, your application with be **pended** until a decision has been made.

If you have been denied services from the above list you must provide the denial letters.

If none of the above mentioned services pertain to you, then you will need to request an application. Once the completed application is received in our office, we will start the application process. If you qualify for the program, only **medically necessary** services are provided.

If you need assistance with determining if you would be eligible for any of the above programs, please go to www.yourtexasbenefits.com to fill out a short questionnaire to see if you might qualify.

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APPLICATION PROCESS

How to apply:

- Make sure that you meet all the requirements and that you do not reside in the Hospital District. (Trinity, TX)
- Next, you will need to fill out an application. You can find the application on the county website or pick one up at the office. *(Courthouse, 1st floor, Judge's Office)*

Submitting an Application:

To submit an application, fill out all forms and submit them along with all documentation requested. In order for the application to be considered, it **must** have a correct name and address, as well as a signature and date on page three (3).

Please return the application by mail or deliver it in person.

WHAT HAPPENS NEXT?

Once received, the application will be reviewed. If there is any additional information needed, you will be notified by mail and asked to submit the additional documentation. The applicant may also be asked to come to the office for an interview.

When the application is complete and **all** necessary documentation is turned in, we will begin processing the application. A determination will be made within 14 days. The office will let you know by mail if you have been accepted or denied.

If the applicant fails to provide all requested information, we will assume the applicant is no longer interested and they will be denied.

After turning in an application, you **must** notify this office within 14 days of any changes such as address, income, employment, etc.

Payor of Last Resort:

You may be asked to apply for assistance through other program(s) before our office will determine eligibility. If you are asked to apply, or have applied but have not received a decision, your application will be pended until a decision has been made.

If you need assistance with your application please call Lisa at (936) 642-1736.

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INDIGENT OVERVIEW

The Trinity County Indigent Health Care Program is designed to benefit those citizens within our county who are not eligible for health care coverage through private health insurance or by way of the Trinity Hospital District. The CIHCP is overseen by the CIHCP Director and the Commissioners Court of Trinity County. This CIHCP office is responsible for carrying out the program in its entirety.

Eligibility:

- Must reside in Trinity County
    - The County Indigent Program provides assistance to non-hospital district residents in Trinity County. If you have a Trinity, Texas address, contact ETMC Hospital in Trinity at 936-594-3541 for assistance.
- Must meet Income and Resource Guidelines
- Must be at least 18 years old
- Must have no private health insurance

Trinity County is the "*Payor of Last Resort*" and serves only those who are **not** eligible for Federal or State Assistance Programs (Medicaid, SSI, etc.)

Services Provided:

A county shall provide the basic health care services such as;

- Physician Services
- Annual Physical Examinations
- Immunizations
- Medical Screening Services (blood sugar, blood pressure, cholesterol screening)
- Labs/X-rays
- Family Planning Services
- Rural Health Clinic
- Prescription Drugs (3 per month)
- Inpatient/Outpatient Services

(*Dental, vision and physical therapy* are some services that are **not** covered.)

We currently have a contract with UTMB in Galveston. Clients are sent to them when there is no local Doctor that will take our program. Usually, the only clients that are sent to Galveston are those with back pain or orthopedic type issues.

Limits to our program are $30,000 per client per fiscal year or 30 days stay in a hospital.

Approvals:

Applicants who are approved are sent a Form 109 which explains the program, coverage, and eligibility. All applicants are covered for a period of 6 months before a renewal application is issued, unless there are changes in residency or income within the 6 month

period. Applicants are required to submit new applications and/or income/household verifications any time the coordinator/staff have the reason to suspect fraudulent activity within the indigent household.

Once approved, clients must come to the IHC office on the first of each month to pick up their monthly voucher. The voucher must be brought with you to every appointment. The voucher is marked with the client's name, address, expiration date and signed by the Administrator.

The client must notify this office within 14 days of any changes in your situation, such as changes in:

- Address
- Household Members
- Property
- Income
- Application for or receipt of SSI, TANF, or Medicaid

If any change occurs that makes you ineligible and you fail to report the change as required, you may be held responsible for payment of any health care services you receive after you become ineligible and/or you may be subject to prosecution under the Texas Penal Code.

Requisitions:
If the client has an appointment with any other facility other than their local clinic, then a separate voucher is required, i.e. xrays, mri, ct scans, etc. Anything that is preformed at a hospital must have a separate voucher in order for it to be approved and the voucher must have the date of the procedure on the voucher.

Prescriptions:
As stated above, approved applicants are eligible to receive **3** prescriptions a month. If a prescription is expensive, i.e. hundreds of dollars, we help the applicant apply for coverage of the medication through Needymeds.com or another similar program.

If you have any questions please contact the County Indigent Office at (936) 642-1736

INFORMATION NEEDED TO PROCESS APPLICATION

APPLICANT NAME: ____

APPLICANT PHONE #: ____

PROOF OF IDENTIFICATION:
a) Social Security Card
b) Texas Driver's License with Trinity County address AND/OR identification card.

IF YOUR ADDRESS IS DIFFERENT THEN WHAT IS ON YOUR ID YOU WILL NEED PROOF OF AT LEAST ONE OF THE FOLLOWING:
a) Utility bill in your name showing your address; AND/OR
b) completed address verification form; AND/OR
c) copy of rental agreement

INCOME VERIFICATION:
a) Last three (3) check stubs or a written statement from your employer (if applicable)
b) Written verification of Unearned Income: Retirement payments, donations, rental property, etc.
c) Copy of the prior year's W-2 statements for Income Tax Return

IF YOU ARE SELF-EMPLOYED YOU WILL NEED TO SHOW PROOF OF INCOME FROM MONEY YOU RECEIVE.

OTHER:

Yes	No	
___	___	1. Have you applied for any kind of unemployment?
___	___	2. Do you have a pending Worker's Compensation claim?
___	___	3. Are you receiving Worker's Compensation Benefits?
___	___	4. Do you have a Social Security Claim or SSI Claim pending? If yes, bring in proof of denial. *IF DENIED, APPEALING OR REAPPLYING?*
___	___	5. Do you have a lawsuit pending concerning a prior medical condition, illness or accident? If yes, bring proof of the lawsuit.

MARITAL STATUS:

Married ___, please provide spouse's name as well as place and date of marriage;
Divorced ___, please provide date and place of divorce or a copy of decree;
Separated ___, please provide spouse's name and date of separation;
Single ___

All individuals completing an application for the Trinity County Indigent Health Care Program must provide a current physical address to qualify. If you receive your mail at a Post Office Box, you must provide this office with a physical location or directions to your home. complete all paperwork to the best of your ability, and sign where indicated. Failure to complete the paperwork completely can result in a delay of benefits or a denial. Return all forms and verifications to The Indigent Health Care Office, located at 162 West 1st Street, in the Courthouse on the 1st floor, Groveton, Texas 75845 .

FOR OFFICE USE ONLY / PARA USO DE LA OFICINA				
Status ☐ Application ☐ Review	Date Form 100 is Requested/Issued	Date Identifiable Form100 is Received	Case Record Number	Appointment Date and Time, if applicable

APPLICATION FOR HEALTH CARE ASSISTANCE / SOLICITUD DE ASISTENCIA DE ATENCIÓN MÉDICA

Name (Last, First, Middle)/Nombre (Apellido, primer, segundo)	Home Telephone No./Teléfono de la casa	Other Telephone No./Otro número de teléfono

Have you ever used another name? If so, list other names you have used./¿Ha usado alguna vez otro nombre? Sí es el caso, enumere los nombres que ha usado.

☐**Yes**/Sí ☐**No**

Mailing Address (Street or P.O. Box)/Dirección Postal (Calle o Apdo.)	Apt.# /Apto.#	City/Ciudad	State/Estado	ZIP

Home Address, if different from above. If it is rural, give directions. / Domicilio particular, si es diferente a la dirección de arriba. Si es rural, explique cómo llegar.

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.** / En la tabla a continuación, llene la primera línea con información acerca de usted mismo. Llene las líneas restantes acerca de todos que viven en la casa con usted, los considere miembros de la unidad familiar o no.

Name (Last, First, Middle) Nombre (Apellido, primero, segundo)	**Social Security Number (if available)** Número de Seguro Social (si lo tiene a su disposición)	**Sex** Sexo **Male/ Female** Hombre/ Mujer	**Date of Birth** Fecha de nacimiento	**What Relation to you?** ¿Parentesco con usted?	**Are you a sponsored alien?** ¿Es usted un extranjero patrocinado?
				MYSELF Yo mismo	

The word "household" in Questions #2 - #16 refers to: you, your spouse, and anyone else that 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."
Las palabras "unidad familiar" en las preguntas #2- #16 se refiere a: usted, su esposo o esposa, y cualquier otra persona que vive con usted y con quien tiene una relación legal. No necesita incluir información de las personas quienes viven con usted que no son parte de su "unidad familiar."

2. **What is your household's county and state of residence (where you make your permanent home)?**
¿En qué condado y en qué estado viven (tienen su hogar permanente) usted y las personas de la unidad familiar?

   County/Condado ____________________ **State**/Estado ____________

   Do you plan to remain in this county and state?
   ¿Piensa quedarse en este condado y este estado? ..... ☐**Yes**/Sí ☐**No**

3. **Living Arrangements**/Vivienda
Check all boxes that apply to your household./Marque todas las cajitas que se apliquen a su caso.

   ☐ **Own or paying for home** Soy dueño de mi casa o la estoy comprando
   ☐ **Live in a house provided by someone else** Vivo en una casa ajena
   ☐ **No permanent residence** No tengo residencia permanente
   ☐ **Live with someone else** Vivo con otra persona
   ☐ **Rent House/Apartment** Rento una casa o apartamento
   ☐ **Jail** Cárcel

4. **List your average monthly household expenses.**/Enumere los gastos mensuales de la unidad familiar.

Rent/Mortgage/Renta/hipoteca .... $ ________

Utilities (gas, water, electric)/Servicios públicos (gas, agua, luz) .... $ ________

Telephone/Teléfono .... $ ________

Transportation, such as gas, car payments, bus/Transportación, tal como gasolina, pagos del carro, autobús ..... $ ________

Tax and Insurance on home per year/Impuesto y seguro anual de la casa .... $ ________

Other/Otro .... $ ________

Other/Otro .... $ ________

Other/Otro .... $ ________

Does anyone pay these household expenses for you?
¿Hay otra persona que paga estos gastos de la unidad familiar por usted? .... ☐ **Yes**/Sí ☐ **No**

If Yes, who?/Si contesta "Sí," ¿ quién? ________

5. **Are you – or is anyone in your household – receiving ☐ TANF ☐ Food Stamp ☐ Medicaid benefits?**
¿Está usted o alguien de la unidad familiar recibiendo beneficios de TANF, estampillas para comida, y/o Medicaid? .... ☐ **Yes**/Sí ☐ **No**

If Yes, who?/Si contesta "Sí," ¿ quién? ________

6. **Are you – or is anyone in your household – pregnant?**
¿Está usted o alguien de la unidad familiar embarazada? .... ☐ **Yes**/Sí ☐ **No** **If Yes, who?** Si contesta "Sí," ¿ quién? ________

7. **Are you – or is anyone in your household – disabled?**
¿Está usted o alguien de la unidad familiar incapacitada? .... ☐ **Yes**/Sí ☐ **No** **If Yes, who?** Si contesta "Sí," ¿ quién? ________

8. **Have you – or has anyone in your household – applied for SSI or SSDI?**
¿Alguna vez usted o alguien de la unidad familiar solicitó beneficios de SSI o SSDI? .... ☐ **Yes**/Sí ☐ **No**

If Yes, who applied and when?
Si contesta "Sí," quién los solicitó y cuando? ________

9. **Do you – or does anyone in your household – have unpaid health care bills from the last three months?**
¿Tiene usted o alguien de la unidad familiar cuentas médicas sin pagar de los últimos tres meses? .... ☐ **Yes**/Sí ☐ **No**

If Yes, which months?
Si contesta "Sí," ¿Cuáles meses? ________

10. **Do you – or does anyone in your household – have health care coverage (Medicare, health insurance, V. A., Tricare, etc.)?**
¿Tiene usted o alguien de la unidad familiar la cobertura médica (Medicare, seguro médico, V. A., Tricare, etc.)? .... ☐ **Yes**/Sí ☐ **No**

If Yes, who?/Si contesta "Sí," ¿ quién? ________

11. **How much money do you have? For example, on your person, in your home, in bank accounts, or other locations?**
¿Cuánto dinero tiene usted; por ejemplo, en el bolsillo, en la casa, en las cuentas bancarias, o en otros lugares? .... **$** ________

12. **How many cars, trucks, or other vehicles do you – and anyone in your household -- have? List the year, make, and model in the chart below.**/¿Cuántos carros, camionetas u otros vehiculos tienen usted y las personas de la unidad familiar? Anote el año, la marca, y el modelo en la tabla a continuación. .... ________

	Year/Año	**Make and Model**/Marca y Modelo
1.		
2.		

	Year/Año	**Make and Model**/Marca y Modelo
3.		
4.		

13. **Do you – or does anyone in your household – own or pay for a home, lot, land, or other things?**
¿Tiene o paga usted o alguien de la unidad familiar una casa, un lote, un terreno, u otros bienes? .... ☐ **Yes**/Sí ☐ **No**

14. **Did you – or did anyone in your household – sell, trade, or give away any cash or property during the last three months?**
Durante los últimos tres meses, ¿traspasó, vendió o regaló usted o alguien de la unidad familiar dinero o alguna propiedad? .... ☐ **Yes**/Sí ☐ **No**

15. **Have you – or has anyone in your household – worked in the last three months?**
¿Ha trabajado usted o alguien de la unidad familiar en los últimos tres meses? .... ☐ **Yes**/Sí ☐ **No** **If Yes, who?** Si contesta "Sí," ¿quien? ________

16. **List all of your household's income below. Be sure to 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.**/Haga una lista de los ingresos de la unidad familiar a continuación. Asegúrese de anotar: Cheques del gobierno; ingresos de trabajo o de capacitación; dinero que recibe de cobros de cuarto y comida; regalos en efectivo, préstamos, o aportaciones de sus padres, familiares, amigos, y otras personas; los ingresos del patrocinador; becas o préstamos de la escuela; o pagos por desempleo.

Name of person receiving money Nombre de la persona que recibe el dinero	**Name of agency, person, or employer who provides the money** Nombre del patrón, la persona o la agencia que paga el dinero	**Amount received** Cantidad recibida	**How often received? (daily, weekly, every two weeks, twice a month, monthly?)** ¿Con qué frecuencia lo recibe? (¿diariamente, por semana, cada quincena, dos veces al mes, una vez al mes?)

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 re-certification for assistance; and that I may request, orally or in writing, a fair hearing about actions affecting receipt or termination of health care assistance.

A mi leal saber y entender, las declaraciones que he hecho, y mis respuestas a todas las preguntas, son verdaderas y correctas.

Me comprometo a dar al personal que verifica la elegibilidad y al condado toda la información necesaria para comprobar mis declaraciones sobre la elegibilidad.

Me comprometo a avisar, dentro de los 14 días, de cualquier cambio de:

- Ingresos
- Recursos
- Número de personas que viven conmigo
- Dirección
- Solicitud de SSI, TANF, o Medicaid o la entrega de cualquiera de estas.

Me han dicho y comprendo que esta solicitud será considerada sin discriminación por raza, color, religión, credo, origen nacional, edad, sexo, discapacidad, ni afiliación política; que puedo pedir una revisión de la decisión que se haga acerca de mi solicitud de asistencia o recertificación para asistencia; y que puedo pedir, oralmente o por escrito, una audiencia imparcial sobre cualquier acción que afecte la entrega o la terminación de asistencia de atención médica.

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.

Comprendo que al firmar esta solicitud, doy al condado el derecho a recuperar de cualquier tercero el costo de los servicios médicos proporcionados por el condado. Me comprometo a dar al condado la información necesaria para identificar y localizar cualquier otro fuente de pagos por mis servicios médicos.

Me han dícho y comprendo que si dejo de cumplir con las obligaciones especificadas en ésta podría considerarse como una retención intencional de información y podría dar lugar a la recuperación de pérdidas por medio de la devolución de pagos o por medio de la presentación de cargos criminales en mi contra.

BEFORE YOU SIGN, BE SURE EACH ANSWER IS COMPLETE AND CORRECT.
ANTES DE FIRMAR, ASEGÚRESE DE QUE CADA RESPUESTA SEA COMPLETA Y CORRECTA.

Signature – Applicant / Firma – Solicitante	**Date** / Fecha	**Signature – Spouse** / Firma – Esposo o Esposa	**Date** / Fecha

If the applicant is married and his/her spouse is a household member, the spouse may also sign and date this Form 100 even if the spouse is a disqualified household member. Si el/la solicitante está casado/a y su esposo o esposa vive en la misma casa, el cónyuge también puede firmar que su esposo o esposa también firme esta Forma 100, aunque no tenga derecho de recibir asistencia.

Signature - Person Who Helped Complete This Application / Date Firma - Persona que ayudó a llenar esta solicitud / Fecha	**Signature - Applicant's Representative / Date** Firma – Representante del solicitante / Fecha	**Signature – Witness (if signed with "X") / Date** Firma – Testigo (si firma con "X") / Fecha

Address (Street, City, State, ZIP) and telephone number of anyone who helped complete this Form 100/Dirección (Calle, Ciudad, Estado, ZIP) y teléfono de la persona que ayudó a llenar esta Forma 100

APPLICATION FOR HEALTH CARE ASSISTANCE

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:

Where You Live and Plan To Continue Living
Possible Proof: Mail that you received at your address; school records; voting records; property tax, rent or mortgage receipts; Texas driver's license; other official identification.

What You Own and What It Is Worth
Possible Proof: Property tax appraisals, estimates from car dealers, ads selling similar items, statements from real estate agents, bank statements.

Your Income
Possible Proof: Pay check stubs, pay checks, W-2 tax forms or income tax returns, sales records, statements from employers, award letters, legal documents, statements from persons giving you money.

Other Health Care Coverage
Possible Proof: Award or claim letters, insurance policies, court documents, other legal papers.

Information on social security numbers should be given if this information is available. Information on sex (Male/Female) is voluntary. These types of 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, if you have answered all the questions on the application, and if you 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.

SOLICITUD DE ASISTENCIA DE ATENCIÓN MÉDICA

El Programa de Atención Médica para Indigentes del Condado (CIHCP) ayuda a la gente a pagar los servicios médicos que necesita. La elegibilidad para esta ayuda depende de los ingresos del solicitante, sus posesiones, el lugar donde vive, otra ayuda que recibe o que podría recibir, y otras consideraciones. Asegúrese de:

1.) Poner su nombre y dirección;
2.) Firmar y fechar la tercera página de la solicitud; y
3.) Conteste tantas preguntas que pueda sobre esta solicitud.

Entregue su solicitud, o échela al correo, hoy mismo aun si no ha podido contestar todas las preguntas.

SUS RESPONSABILIDADES

Puede que le pidan pruebas de lo que escriba en su solicitud o de lo que diga en su entrevista. Si necesita ayuda para obtener las pruebas, la persona que le haga la entrevista le puede ayudar. Estos son algunos ejemplos de información que puede que tenga que probar y de documentos que le puede servir de prueba:

El Lugar Donde Vive O Donde Tiene Su Hogar Permanente
Posibles Pruebas: Correo que recibió en esa dirección; expedientes de de la escuela; registros de votante; recibos de impuestos, renta o hipoteca; la licencia para manejar de Tejas; otra identificación oficial.

Las Posesiones Que Tiene Y Cuanto Vale Cada Una
Posibles Pruebas: El avalúo para impuestos sobre la propiedad, avalúos hechos por vendedores de carros, anuncios de la venta de articulos parecidos, declaraciones de agentes que venden propiedades, estado de cuentas del banco.

Los Ingresos Que Tiene
Posibles Pruebas: Talones del cheque de paga, cheque de paga, comprobante de salaries e impuestos (Forma W-2), declaración de impuesto federal, el historial de ventas, declaraciones de empleadores, carta de concesión, documentos legales, declaraciones de personas que le dan dinero.

Otra Cobertura Para Gastos Médicos
Posibles Pruebas: Cartas de reclamación o de concesión, pólizas de seguros, papeles de la corte u otros documentos legales.

Si tiene a su disposición los números de seguro social, debe darlos. La información sobre el sexo (Hombre/Mujer) es voluntaria. Esta información no afectará su elegibilidad.

Debe dar información sobre seguros médicos y de cualquier tercero que tenga la responsabilidad de pagar los servicios médicos pagados por el condado en beneficio de usted y miembros de la unidad familiar. Al firmar y presentar esta solicitud, usted se compromete a darle al condado el derecho de recuperar el costo de servicios de un tercero.

Pueden pedirle que solicite Medicaid, Asistencia Temporal a Familias Necesitadad (TANF), o Seguridad de Ingreso Suplemental (SSI). Si le han pedido que solicite beneficios de alguno de estos programas o si usted ya los solicitó y está esperando la respuesta, su solicitud de CIHCP puede ser detenida hasta que decidan que no es elegible para los programas mencionados. Si no es elegible para estos programas, si ha contestado todas las preguntas de la solicitud, y si ha dado todos los comprobantes que piden, ya pueden procesar su solicitud. Entonces, el CIHCP tiene un plazo de 14 dias para determinar su elegibilidad.

Después de entregar su solicitud, usted debe reportar dentro de un plazo de 14 dias cualquier cambio de dirección, ingreso, recursos, el número de personas que viven con usted, o si solicita o recibe Medicaid, TANF, o SSI.

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MEDICAL QUESTIONNAIRE

______________________________ ______________________

Applicant Name Date of Birth

What is your primary health concern at this time? ______________________________
____.

Please list all other ongoing health issues or diagnoses: ______________________
____
____.

Were you referred to our office by another facility? ____yes ____no
If yes, what facility? ______________________________________

Do you have any unpaid medical bills within the past 95 days? ____yes ____no
If yes, please complete the following information:

______________________________ ___________ ______________

Facility (hospital) Admit date Discharge date

____.

Reason for visit

Were you taken by ambulance to the hospital? ______ yes _____no

Are you currently on any type of assistance for medical coverage through any other form of insurance? _________yes ______no

Please list all medication you are currently taking.

Medication	Reason for medication	Daily Dosage
1.__________________	____________________	__________
2. __________________	____________________	__________
3. __________________	____________________	__________
4. __________________	____________________	__________

______________________________ __________________

Applicant Signature Date

TRINITY COUNTY

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Email:

Authorization for Release of Information

Applicants Name: ______________________________________

I, __________________________ (print name), grant the Trinity County Indigent Health Care Program in Trinity County, Texas permission to view my personal tax, financial and employment documents at their discretion; hence, I release all my personal tax, financial, and employment documents to the Trinity County Indigent Health Care Program at any time which they deem it necessary to view.

I understand that I can, at any time, request and be provided a copy of the retrieved information. I also understand that if any changes or discrepancies are detected, my application can and will be reviewed by the Trinity County Indigent Health Care Program accordingly. Furthermore, I understand that I will be provided with a copy of this release form.

I give permission for my legal counsel or the Social Security office to release information regarding my application of appeal for SSI Disability benefits.

I also give permission for providers treating me to release my medical records to Trinity County Indigent Health Care Office for the purpose of determining proper referrals and/or determining whether or not the services provided meet the criteria for payment by the Trinity County Indigent Health Care Program.

____

Applicant Signature **Date**

____

Spouse Signature **Date**

____

Witness Signature (if signed with "X") **Date**

TRINITY COUNTY

Indigent Health Care
P. O. Box 312
Groveton, Texas 75845
Phone: 936-642-1736
Fax: 936-642-2733

Contact List

Give the name and address of a relative or friend to contact in case of an emergency.

________________________ ________________________

Name Relationship to Client

________________________ ________________________

Address Email Address

____

City State Zip Code

____

Phone Number

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Trinity County Indigent Health Care Fraud Policy

Definition
Fraud is the deliberate misrepresentation of some material fact for the purpose of acquiring benefits.

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

1. The IHC staff shall investigate all cases of suspected fraud and shall collect and document evidence.
2. Upon a finding of fraud, the client shall be administratively ineligible from IHC as follows:
   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
3. The IHC staff shall contact the client who is suspected of fraud by sending a certified letter informing him of the withdrawal of eligibility and explaining the allegations. If the client disputes the allegations, the client will be allowed to submit applicable supporting documents/verifications for further consideration.
4. If the dispute remains unresolved, the IHC staff shall schedule an administrative hearing to allow the client to defend himself by confronting any adverse witness and by presenting his own argument and evidence. The IHC staff must disclose any evidence used to prove its case to the client so he has an opportunity to dispute it. The administrative hearing will be conducted by the Coordinator of the Trinity County IHC Program. If the client does not appear at the administrative hearing, the IHC Coordinator or designee may proceed with presentation of her case only if proof of notice is present. The Coordinator of the Trinity County IHC Program must make a decision within ninety days of the hearing.
5. The client shall have the right to appeal any unfavorable decision to the Trinity County IHC Appeal Authority.

Consequence of Fraud

If, after due process, a person is found to have intentionally misrepresented information in order to receive benefits, that person:

- shall reimburse Trinity County for the cost of benefits they were ineligible to receive;
- shall be administratively ineligible for Trinity County IHC benefits in accordance with Trinity County IHC Policies and Procedures; and• may be subject to prosecution under Texas Penal Code.

Signature ______________________ **Date** ______________________

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AFFIDAVIT OF ASSETS, INCOME AND RESOURCES

This affidavit is made by me ______________________________ (APPLICANT) for the purpose of assuring Trinity County Indigent Healthcare Program of what assets, income or resources that I have access to:

Please check the items you own or have access to:

☐ Ownership of any property in the U.S. located at: ___________________________

☐ Vehicles: (Make_____ Model_____ Year______ Amount owed: _______
Miles______

☐ U.S. Banking accounts including checking, savings, IRA, etc.: (provide copies of most current statements)

☐ Retirement plans in the U.S. or foreign countries: (provide copies of statements)

I understand that if I fail to report any of the above information, I will be held responsible for payment of any medical services that I may have received under the Trinity County Indigent Health Care Program, and I will be subject to prosecution under the Texas Penal Code.

I swear (affirm) that the contents of this affidavit signed by me are true and correct.

____
Print Name Date

____
Signature Date

TRINITY COUNTY

Indigent Health Care
P. O. Box 312
Groveton, Texas 75845
Phone: 936-642-1736
Fax: 936-642-2733
Email:

EMPLOYMENT VERIFICATION FORM

If you are currently employed fill out the following:

______________________ ______________________
Company Name (Please Print) Phone #

☐ Full Time ☐ Part time ☐ Currently Employed

___/___ Hire Date ___/___ End Date ___/___ No end Date

Number of hours worked_______ Hourly wages: $_______

If you are NOT currently employed fill out the following:

When was the last time that you were employed: ____________

Who was your last employer: ____________________________

Date of your last paycheck:__________ in the amount of $__________.

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This form is to be filled out by the person who helps you with your bills or who gives you any assistance.

ASSISTANCE DISCLOSURE FORM

I, ________________________, living at _____________________________ make the following voluntary statement concerning assistance I have given to____________________________________, Applicant.

I have helped or am helping the applicant in the following manner:

☐ Providing Cash Money: Approximately how much and how often? $ ______ every ________________

☐ Other : I pay the following bills for Applicant: (cell phone bill, transportation costs, groceries, miscellaneous expenses)
Total per month (approximately): $ ____________________

☐ I pay Rent/Mortgage for applicant: Yes___ No ___

☐ Is the Applicant currently living with you? Yes ___ No___

I understand that giving false information to the Trinity County Indigent Health Care Program is sufficient cause for prosecution for fraud.

____ Signature

____________________ Date

____ Phone Number

____________________ Relationship to Applicant

TRINITY COUNTY

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Groveton, Texas 75845
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If you live at a different address than is on your DL or ID card, please furnish this office with a copy of any mail addressed to you at your new address. If you live with someone else and they provide you with a place to live then have that person fill out the following form.

ADDRESS VERIFICATION FORM

I, ______________________________, certify that __________________________,

lives at my residence located at ____________________________________ and

that I am currently providing room and board for applicant.

I understand that giving false information to the Trinity County Indigent Health Care Program is sufficient cause for prosecution for fraud.

______________________________ ______________________________
Signature of home owner Printed name of home owner

______________________________ ______________________________
Date City, State, Zip Code

FOR THE PARTICIPANT: (person applying for coverage)

I understand that giving incorrect information to the Trinity County Indigent Health Care Program is sufficient cause for termination from the program, recoupment of benefits and prosecution for fraud.

______________________________ ______________________________
Signature of Applicant Date