



## TRINITY COUNTY

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

Email: [kathy.brown@co.trinity.tx.us](mailto:kathy.brown@co.trinity.tx.us)

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The Trinity County Indigent Health Care Program is designed to assist eligible Trinity County residents who are living at the poverty level and who are unable to secure health care services. The income guidelines are established by the Texas Department of State Health Services and are not negotiable. This is not a need-based program but, an income based program. In short, your resources and not your health determine eligibility. An applicant is expected to exhaust every resource possible in order to obtain health care service for themselves. The County provides this program for those residents of the County that have tried diligently to attain health insurance but, have been unable to do so. In order for a decision on your eligibility to be made, you will need to return this packet with all forms completely filled out and a copy of each item from the list I have enclosed. **If you have any questions, you may contact me at 936-642-1736.**

Once you have completed the packet and have all copies of the required information, you will need to return this information to our office. You may mail the information or you may drop it off in person.

If all the required information is submitted correctly, a decision regarding your eligibility will be made within 14 business days. The IHC office will notify you by mail on the decision that was determined.

You may be asked to apply for assistance from other programs before our department can determine your eligibility status. If you are asked to apply for other programs or you have applied but are awaiting an answer, your completed TCIHCP application may be held until you are determined to be ineligible for the other assistance programs.

After turning in a completed packet, you must report any household changes including address, income, resources, number of people living in home and any information from other assistance programs. If your packet is submitted incomplete, it will be returned to you by mail for completion.



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### Authorization for Release of Information

**Applicants Name:** \_\_\_\_\_

I hereby give permission to the Trinity County Indigent Health Care Office to contact any source to prove the statements I have made in applying for the Trinity County Indigent Health Care Program. I will cooperate fully with Trinity County personnel to obtain any information necessary to prove statements about my eligibility. I have been told and understand that my failure to meet the obligations set forth, can result in the recovery of any loss by repayment, or by filing criminal or civil charges against me.

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.

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**Applicant Signature Date**

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**Spouse Signature Date**

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



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**Verification Statement**

**This form is to be completed by the person or persons whom are providing any assistance to you.**

Applicants Name: \_\_\_\_\_

- Have you given cash to the above named person? (Please circle) Yes or No
- If so, please note the amounts, however small, in the space below. Please provide if amounts are given daily, weekly or monthly. Please use the back of this form if you need additional space.

\_\_\_\_\_

- Have you paid any bills directly to others for the benefit of the above named person? (Please circle) Yes or No

If so, please list below:

\_\_\_\_\_

\_\_\_\_\_

- Is the person listed above currently living with you? (Please circle) Yes or No
- Are you currently providing room and board for the above listed person? (Please circle) Yes or No

I understand that providing any false information can result in a fine or imprisonment. I certify that the above information is correct to the best of my knowledge.

**Print Name** \_\_\_\_\_

Address: \_\_\_\_\_

Phone # \_\_\_\_\_ Relationship to Applicant: \_\_\_\_\_



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### 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.

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**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 have access to:**

- Ownership of any property in the U.S. located at: \_\_\_\_\_
- Vehicles: (Make \_\_\_\_\_ Model \_\_\_\_\_ Year \_\_\_\_\_ Amount owed: \_\_\_\_\_)
- 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

Subscribed and Sworn to before me the undersigned authority on the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Notary Public



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**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: \$ \_\_\_\_\_

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**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 \$ \_\_\_\_\_.