TRINITY COUNTY

Phone: 936-642-1736
Fax: 936-642-2733
Email: kathy.brown@co.trinity.tx.us

MUST READ BEFORE FILLING OUT APPLICATION

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.

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.

RESIDENCE VERIFICATION:
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

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, 223, West First Street, P. O. Box 312, Groveton, Texas 75845 .

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Groveton, Texas 75845
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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**

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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

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: _______

☐ 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

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EMPLOYMENT VERIFICATION FORM

<u>If you are currently employed fill out the following:</u>

___________________________ ______________________________
Company Name (Please Print) Phone #

□ Full Time □ Part time □ Currently Employed

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

Number of hours worked_______ Hourly wages: $_______

<u>If you are NOT currently employed fill out the following:</u>

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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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 ____________________________,

has lived at ____, on a permanent

basis (seven days a week) since ________________________________.

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

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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, ____ make the following voluntary statement concerning assistance I have given to: ____________________________________.

I certify that the information listed below is true and correct.

1. Have you given cash to the above person? Yes____ No.____ If yes how much and how often: $ _____ every _____________.
2. Have you paid any bills for the applicant such as cell phone bills (minutes) or any other bills? Yes____ No____. If yes who have you paid and in what amounts:______________
3. Is the person currently living with you and are you providing room and board? Yes____ No____. If yes, how long has applicant been living with you __________.

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

____
Signature

____
Date

____
Address

____
Relationship to Applicant

____
Phone number

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?
				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 "Si," ¿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; manutención de niños, 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 must 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, se require 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

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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 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. ____________________ ____________________ __________

____________________________ ____________________

Applicant Signature Date