Jasper County Indigent Health Care Program

RETURN APPLICATION TO → ***PO Box 344***

Kirbyville, Texas 75956-0344

(409) 423-6935 Kirbyville (409) 994-5295 Buna (409)423-1070 Fax

Email – maggie.acord@co.jasper.tx.us **Maggie Acord, Case Worker**

tracie.simmons@co.jasper.tx.us **Tracie Simmons, Program Director**

IN ORDER TO PROCESS YOUR APPLICATION, YOU MUST PROVIDE THE FOLLOWING INFORMATION AT YOUR INTERVIEW: (IF it pertains to you or if not please bring something similar)

1. **Completed application-signed and dated. Spouse must sign also.**

2. **Proof of address and residing county**, such as:
   a. Driver's license or ID
   b. Mail addressed to you at your current address
   c. Voter's registration, or
   d. Utility bill(s)

PLEASE KEEP THIS PAGE FOR YOUR REFERENCE.

3. Social Security cards for all household members applying for services.

4. UTMB Patient Number (if you receive services there)

5. Proof of income for **all household members** such as:
   a. Check stubs for past 90 days or statement from employer. If self-employed, your records.
   b. Copy of SSI, Social Security, TANF, Child support, Workman's Comp, Unemployment or copy of award letter OR printout from Child Support, Workman's Comp, Unemployment
   c. If paid in cash, bring statement from employer
6. **Current bank statements - checking and/or savings.**

7. Current Medicaid/MQMB/QMB/Medicare cards or Insurance Coverage.
8. **If you are unemployed you must show proof of how you are living such as a statement from the person or persons supporting you, paying your bills, or giving you any cash money.**

9. If you have a lawsuit pending, we must have a statement from your attorney as to the status of the case and record of any money advance.

10. Status of any Lawsuits.

11. **Status of your Social Security Disability/SSI claim. Denial Notice and any current letters regarding your disability claim.**

12. Burial or Life Insurance Policy.

13. Proof of any lump sum payment such as: income tax refunds, lawsuits settlements, inheritance, etc.

NO EXCEPTIONS

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.

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? Si 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 vehículos 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; 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

Please answer all of these questions. Circle Yes or No.

1. Do you or anyone living with you receive any of the following:
   - Food Stamps: Yes No
     If Yes, give Case Number _____
   - Medicaid: Yes No
     If Yes, state Who? _____
   - Medicare: Yes No
     If Yes, state Who? _____
   - UTMB Services Yes No
     If Yes, What kind? _____
   - Health Dept Services Yes No
     If Yes, What kind? _____
   - Primary Health Care Services Program (Health Dept. Program)
     Yes No
     If Yes, What? _____
2. Have you or anyone who lives with you applied for disability? Yes No
   Who? _____ When? _____
   Where? _____ Is that person eligible? _____
3. If you have little or no income, briefly explain how you are able to support yourself and your family. Such as how you pay for housing, utilities, or buy food and any other expense you have.
   _____
   _____

			If Yes, give company name
4. Do you have insurance?	Health/Medical	Yes	No _____
	Life Insurance	Yes	No _____
	Burial Insurance	Yes	No _____

5. What is the value of each vehicle that you own or are paying for:
   Year _____ Make/Model _____ Body type _____ Value _____
   Year _____ Make/Model _____ Body type _____ Value _____
   Who pays for the insurance on your automobile? _____
6. Are you a veteran? Yes No Do you receive veteran's benefits? Yes No
7. Do you own property anywhere? Yes No
   If Yes, Where? _____
8. Do you own anything of value? (boat, livestock, trailer, computer, machinery, tools, equipment, etc)? Yes No
   If Yes, What? _____ Estimated Value _____
9. Please list the name, address and phone number of a friend or family member who we can contact if we are unable to reach you.

I have answered the above questions correctly and to the best of my ability.

_____ _____

Your Signature Date

JASPER COUNTY
INDIGENT HEALTH CARE PROGRAM
INFORMATION RELEASE FORM
ENTREGA DE INFORMACION

PLEASE READ:

I give the Jasper County Indigent Health Care Program permission to share Application Verifications and Eligibility status and/or Eligibility coverage dates: to medical providers, Hospitals, Doctors, Third party consultants (such as Cardon Healthcare Services in the Christus facilities), The Department of Human Resources, UTMB, and any other facility that can provide me with services or assistance. I authorize Jasper County to share this information with the Jasper Newton County Public Health District for services offered at the Health Department and with the Primary Health Care Program. (which provides transportation to UTMB and other medical offices)

I understand that I must fill out a separate application for any other assistance program such as the Primary Health Care Program, Food Stamps, Medicaid, etc.

_____ _____

Signature Date

TEXAS
Health and Human Services

Form/Formulario 108

COUNTY INDIGENT HEALTH CARE PROGRAM
CASE RECORD INFORMATION RELEASE
PROGRAMA DEL CONDADO DE ATENCIÓN MÉDICA AL INDIGENTE
REVELACIÓN DE INFORMACIÓN DE EXPEDIENTE DE CASO

Case Record Name/Nombre en el expediente de caso	**Case Record Number**/Número de expediente de caso

I do hereby authorize persons, organizations, or establishments having information or records concerning me/us (or) my/our circumstances, to furnish such information to a representative of the County Indigent Health Care Program.

I hereby grant permission for the County Indigent Health Care Program to obtain information which may have a bearing on my/our eligibility for assistance.

This release form is valid for six months after the date signed.

Yo, por este medio, autorizo a las personas, organizaciones o establecimientos que tengan información o documentos sobre mí/nosotros o sobre mis/nuestras circunstancias para que den dicha información a un representante del Programa del Condado de Atención Médica al Indigente.

Yo, por este medio, doy permiso al Programa del Condado de Atención Médica al Indigente para que obtenga la información que pudiera incidir en mi/nuestro derecho a recibir asistencia.

Este formulario de revelación es válido por seis meses a partir de la fecha en que se firma.

Person or Agency to Whom Information Will Be Released/Persona o agencia a quien se revelará la información

JASPER COUNTY INDIGENT HEALTH CARE PROGRAM

☐ **Specific Request (Specify in 1 and 2 below.)**
Petición específica (especifique en 1 y 2 a continuación).

1. **Information Requested**/Información pedida: _____

_____

2. **Period Covered (Dates)**/Periodo cubierto (fechas): _____

_____

☑ **General Request (Any information available may be released.)**
Petición general (puede revelarse toda la información disponible).

_____

_____

_____ _____
Signature- Applicant or Recipient/Firma – Solicitante o beneficiado — **Date**/Fecha

_____ _____
Signature – Spouse/ Firma - Cónyuge — **Date**/Fecha

_____ _____
Signature – Guardian, Power of Attorney, Parent of Minor Child/ Firma - Tutor, poder notarial o padre/madre del menor — **Date**/Fecha

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

You must complete all required fields. We will not honor your request unless all required fields are completed. *(*Signifies a required field. **Please complete these fields in case we need to contact you about the consent form).*

TO: Social Security Administration

*My Full Name	*My Date of Birth (MM/DD/YYYY)	*My Social Security Number

I authorize the Social Security Administration to release information or records about me to:

***NAME OF PERSON OR ORGANIZATION:**

Jasper County Indigent Health Care

***ADDRESS OF PERSON OR ORGANIZATION:**

P.O. Box 344

Kirbyville, Texas 75933

***I want this information released because:** status and progress of disability claim is a requirement of the eligibility for the Indigent Health Care Program.

We may charge a fee to release information for non-program purposes.

***Please release the following information selected from the list below:**
Check at least one box. We will not disclose records unless you include date ranges where applicable.

1. ☐ Verification of Social Security Number
2. ☐ Current monthly Social Security benefit amount
3. ☐ Current monthly Supplemental Security Income payment amount
4. ☐ My benefit or payment amounts from date _____ to date _____
5. ☐ My Medicare entitlement from date _____ to date _____
6. ☐ Medical records from my claims folder(s) from date _____ to date _____
   If you want us to release a minor child's medical records, do not use this form. Instead, contact your local Social Security office.
7. ☐ Complete medical records from my claims folder(s)
8. ☒ Other record(s) from my file (We will not honor a request for "any and all records" or "the entire file." You must specify other records; e.g., consultative exams, award/denial notices, benefit applications, appeals, questionnaires, doctor reports, determinations.)

   Status and progress of claim for disability.

I am the individual, to whom the requested information or record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury (28 CFR § 16.41(d)(2004) that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that I must pay all applicable fees for requesting information for a non-program-related purpose.

***Signature:** _____ ***Date:** _____

****Address:** _____ ****Daytime Phone:** _____

Relationship (if not the subject of the record): _____ ****Daytime Phone:** _____

Witnesses must sign this form ONLY if the above signature is by mark (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

1.Signature of witness	2.Signature of witness
Address(Number and street,City,State, and Zip Code)	Address(Number and street,City,State, and Zip Code)