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 – iva.samuel@co.jasper.tx.us **Iva Samuel, Eligibility & Billing Specialist**
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

The County Indigent Health Care Program (CIHCP) helps people pay for needed health care. Whether you can get this help depends on your income, what you own, where you live, other help you receive or could receive and other items. Be sure to:

1. Complete your name and address;
2. Sign and date Page 3 of the application; and
3. Answer as many questions as you can on this application.

Turn in or mail back your application today even if you cannot answer all the questions.

Your Responsibilities

You may be asked to bring proof of what you write on your application or what you tell the person interviewing you. If you need help getting proof, the person interviewing you will help. Examples of some of the items you may be asked to prove and documents you can use for proof are listed below.

Where You Live and Plan to Continue Living – Mail that you received at your address; school records; voting records; property taxes, rent or mortgage receipts; Texas driver license; and other official identification.

What You Own and What it is Worth – Property tax appraisals; estimates from car dealers; ads selling similar items; statements from real estate agents; and bank statements.

Your Income – Paycheck stubs; paychecks; W-2 tax forms or income tax returns; sales records; statements from employers; award letters; legal documents; and statements from persons giving you money.

Other Health Care Coverage – Award or claim letters; insurance policies; court documents; and other legal papers.
Information regarding Social Security numbers should be given if this information is available. Information regarding sex (male/female) is voluntary. This information will not affect your eligibility.

You must give information about health care insurance and any other third party financially liable for health care services paid by the county for yourself and members of your household. By signing and submitting this application, you are agreeing to give the county the right to recover the cost of health care services provided by the county from any third party.

You may be asked to apply for Medicaid, Temporary Assistance for Needy Families (TANF) or Supplemental Security Income (SSI) benefits. If you are asked to apply for one of these programs, or have applied but are waiting for an answer, your CIHCP application may be pended until you are determined ineligible for the other program. If you are not eligible for these other programs and if you have answered all the questions on the application and have given all the proof asked for, your application can be processed. Then, the CIHCP must determine if you are eligible within 14 days.

After turning in your application, you must report within 14 days any changes in your address, income, resources, people living with you, or application for or receipt of Medicaid, TANF or SSI.

TEXAS
Health and Human Services

Form 3064
January 2020-E

County Indigent Health Care Program (CIHCP)

Application for Health Care Assistance

For Office Use Only				
Status ○ Application ○ Review	Date Form 3064 Requested/Issued	Date Identifiable Form 3064 Received	Case Record No.	Appointment Date and Time, if applicable

Name (Last, First, Middle)	Home Area Code and Phone No.	Other Area Code and Phone No.

Have you ever used another name? If so, list other names you have used.
○ Yes ○ No

Mailing Address (Street or P.O. Box)	Apt. No.	City	State	ZIP Code

Home Address, if different from above. If it is rural, give directions.

1. On the chart below, fill in the first line with information about yourself. Fill in the remaining lines for everyone who lives in the house with you, whether or not you consider them household members.

Name (Last, First, Middle)	**Social Security No.** (if available)	**Sex** (Male/ Female)	**Date of Birth**	**Relation to You**	**Are you a sponsored alien?**
					○ Yes ○ No
					○ Yes ○ No
					○ Yes ○ No
					○ Yes ○ No
					○ Yes ○ No
					○ Yes ○ No
					○ Yes ○ No

Note: The word "household" in Questions 2 through 16 refers to you, your spouse and anyone else who lives with you and with whom you have a legal relationship. You do not need to include information on people who live with you but are not part of your "household."

2. What is your household's county and state of residence (where you make your permanent home)?

County: ____________ State: ________ Do you plan to remain in this county and state? ○ Yes ○ No

3. Living Arrangements – Check all boxes that apply to your household.

☐ Own or paying for home ☐ Live in a house provided by someone else ☐ No permanent residence

☐ Live with someone else ☐ Rent house or apartment ☐ Jail

4. List your average monthly household expenses.

Rent/Mortgage	$
Utilities (gas, water, electric)	$
Phone	$
Transportation (such as gas, car payments, bus)	$
Tax and Insurance on Home Per Year	$
Other:	$
Other:	$
Other:	$

Does anyone pay these household expenses for you? ◯ Yes ◯ No If Yes, who pays? ____________

5. Are you or is anyone in your household receiving any of the following? ◯ Yes ◯ No

☐ Temporary Assistance for Needy Families (TANF) ☐ Food Stamps ☐ Medicaid Benefits

If Yes, who? ____________

6. Are you or is anyone in your household pregnant? ◯ Yes ◯ No If Yes, who? ____________

7. Are you or is anyone in your household disabled? ◯ Yes ◯ No If Yes, who? ____________

8. Have you or has anyone in your household applied for Supplemental Security Income (SSI) or Social Security Disability Income (SSDI)?
◯ Yes ◯ No If Yes, who applied and when? ____________

9. Do you or does anyone in your household have unpaid health care bills from the last three months? ◯ Yes ◯ No
If Yes, which months? ____________

10. Do you or does anyone in your household have health care coverage (Medicare, health insurance, Veterans Affairs, Tricare, etc.)?
◯ Yes ◯ No If Yes, who? ____________

11. How much money do you have in your wallet, in your home, in bank accounts or other locations? ☐

12. How many cars, trucks or other vehicles do you and anyone in your household have? List the year, make and model below. ☐

	Year	Make and Model	+
1			−

13. Do you or does anyone in your household own or pay for a home, lot, land or other things? ◯ Yes ◯ No

14. Did you or did anyone in your household sell, trade, or give away any cash or property during the last three months? ◯ Yes ◯ No

15. Have you or has anyone in your household worked in the last three months? ◯ Yes ◯ No If Yes, who? ____________

16. List all of your household's income below. Include the following: government checks; money from training or work; money you collect from charging room and board; cash gifts, loans or contributions from parents, relatives, friends and others; sponsor's income; school grants or loans; child support; and unemployment.

Name of Person Receiving Money	Name of Agency, Person or Employer Providing Money	Amount Received	How Often Received?

The statements I have made, including my answers to all questions, are true and correct to the best of my knowledge and belief. I agree to give eligibility staff and the county any information necessary to prove statements about my eligibility. I agree to report any of the following changes within 14 days:

- Income
- Resources
- Number of people who live with me
- Address
- Application for or receipt of SSI, TANF or Medicaid

I have been told and understand that this application will be considered without regard to race, color, religion, creed, national origin, age, sex, disability or political belief; that I may request a review of the decision made on my application or recertification for assistance; and that I may request, orally or in writing, a fair hearing about actions affecting receipt or termination of health care assistance.

I understand that by signing this application, I am giving the county the right to recover the cost of health care services provided by the county from any third party.

I agree to give the county any information it needs to identify and locate all other sources of payment for health care services.

I have been told and understand that my failure to meet the obligations set forth may be considered intentional withholding of information and can result in the recovery of any loss by repayment or by filing civil or criminal charges against me.

Before you sign, be sure each answer is complete and correct. If the applicant is married and the spouse is a household member, the spouse may also sign and date this form, even if the spouse is a disqualified household member.

Signature — Applicant ____ Date ____ Signature — Spouse ____ Date ____

Signature — Person Helping Complete Form 3604 ____ Signature — Applicant's Representative ____ Signature — Witness (if applicant signed with "X") ____

Address of Person Helping Complete Form 3064 (Street, City, State, ZIP Code): ____ Area Code and Phone No.: ____

Please answer all 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 can support yourself and your family. Such as how you pay for housing, utilities, or buy food and any other expense you have.
   ____
   ____
4. Do you have insurance?

			If Yes, give company name
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

TEXAS
Health and Human Services

Form 3076
January 2020-E

County Indigent Health Care Program (CIHCP)

Case Record Information Release

Case Record Name:	Case Record No.

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 CIHCP 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.

Person or Agency to Whom Information will be Released:
JASPER COUNTY INDIGENT HEALTH CARE PROGRAM

☐ Specific Request (Specify in 1 and 2 below.)

1. Information Requested ____________________

2. Period covered (Dates) ____________________

☑ General Request (Any information available may be released.)

Signature – Applicant or Recipient — Date

Signature – Spouse — Date

Signature – Guardian, Power of Attorney, Parent of Minor Child — 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 Verification and Eligibility status and/or Eligibility coverage dates: to Medical Providers, Hospitals, Doctors, Third Party Consultants (such as: Meddata 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 limited 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, SNAP Food Stamps, TANF or Medicaid, etc.

______________________________ ______________

Signature **Date**

Social Security Administration

Form Approved
OMB No. 0960-0566

Consent for Release of Information

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)