FREESTONE COUNTY TREASURER'S OFFICE
118 E. Commerce, Room 102
Fairfield, Texas 75840
Office: (903) 389-2180
Fax: (903) 389-5894

Mandy Chavers
County Treasurer

Kali Barco
Chief Deputy

To: County Indigent Health Care Applicants

PLEASE READ AND SIGN

FREESTONE COUNTY INDIGENT HEALTHCARE PROGRAM

The Freestone County Indigent Healthcare Program helps people get medical care on a short-term basis. Eligibility depends on your income, what you own, where you live, help you receive, and other items. Before you submit an application (Form 100) please be aware that Freestone County has two hospital districts, one in Teague and one in Fairfield, and if you live in either of these districts you must apply for assistance with them NOT Freestone County.

If approved, you will be required to have your status reviewed in 3 months and a new application in 6 mos. It is your responsibility to report any changes which could affect your eligibility within 14 business days. If you fail to notify me, you will be removed from the program.

Unemployed applicants are required to register with the local Texas Workforce Commission (TWC) located at 517 E Main St, Teague, TX. The printout you receive when you register with them must be date stamped and signed by them and included with your application.

Your application is not complete until all required forms and statements are received. Incomplete applications will NOT be processed. Some forms require a notarized signature.

You will be notified of an appointment for the interview once all documentation is received. If you do not come to the interview or contact me to reschedule, I will assume you are no longer requesting assistance.

APPLICANT: _____ DATE: _____
Signature

FREESTONE COUNTY INDIGENT HEALTH CARE PROGRAM

REQUIRED DOCUMENTATION CHECKLIST

Please note that you may be asked to provide more information during the application review process. Your application is not considered complete until all required documentation is received.

1. **Marital status (check one below)**
   - **Married**
   - **Single**
   - **Widowed**
   - **Separated**
   - **Divorced**

2. **Mail addressed to you at your physical address (no older than 30 days) and a valid Texas Driver's License or other official identification (must show current address). You must provide a verification of residence such as a lease agreement, mortgage information, and tax assessor information.**

3. **Automobile Registration (if the vehicle is in your name). You will be required to furnish a verification from a reputable dealer/website to determine the fair market value. A copy of a statement from the lender showing the current balance owed will be also be required.**

4. **Checking and Savings Accounts- a copy of the statements for the past 90 days on any account which your name is listed (joint/sole accounts). If you have a prepaid debit card, you must provide a current verified balance.**

5. **Income (check one below)**
   - **Pay check stubs for past 90 days**
   - **Employer Earnings Statement for past 90 days (must be notarized)**
   - **Federal Income Tax Return (current year)**

   Self-Employment Records (must be signed and notarized)
   Some types of self-employment include odd jobs, owning a private business, farm income, and income from property.

   NOTE: If any third party is contributing money to your support, you must provide a notarized statement of the amount they are contributing, what they are contributing for, and how it is paid.

APPLICANT: _____ **DATE:** _____
Signature

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 "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

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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Mandy Chavers
County Treasurer

Kali Barco
Chief Deputy

FREESTONE COUNTY INDIGENT HEALTH CARE

ACKNOWLEDGMENT OF LEGAL RESPONSIBILITY

Please read each section carefully and Initial beside each statement of acknowledgment. Please be sure you understand the section BEFORE you initial it. If you have an "Authorized Representative", he or she must ALSO initial beside each statement.

_____ I, _____, understand that I am legally responsible to provide the CIHCP with accurate and complete information about my income, resources, address, marital status, number of people living with me, and other public or private assistance I may be receiving or for which I have applied.

_____ I further acknowledge that if I do not give complete information at the time of application; or if I do not report changes in any of the information listed above within 14 days, I can expect one or all of the following things to happen:

- **I would be disqualified from CIHCP benefits for a specific time frame**
- **I would have to Re-pay the County**
- **I would have criminal charges filed against me for making false statements on a public record**
- **I would have civil charges filed against me**
- **I would go to jail for up to two (2) years**
- **I would pay additional fines of up to $4,000.**

_____ I understand that these things could happen to me because of State of Texas law. The law provides that:

- **If anyone makes a false statement on a governmental record, it is a criminal offense, punishable as ether a misdemeanor up to twelve (12) months in the county Jail (and up to $4,000 fine);**
- **OR as a State Jail Felony, punishable up to two years in a State Jail Facility.**

_____ I understand that false statements include the omission of all required information. I understand that if I make false statements on my CIHCP application, the CIHCP office may turn my case over to the County or District Attorney's Office as soon as there is indication that I have intentionally omitted certain information or have intentionally given incorrect information on my application.

_____ _____
Signature of Applicant Date

_____ _____
Signature of Spouse Date

_____ _____
Signature of Authorized Representative Date

For Agency Use Only

CIHCP Representative Signature: _____ _____
Jeannie Keeney, Freestone County Treasurer Date

TEXAS Department of State Health 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

Jeannie Keeney
Freestone County Treasurer
118 E. Commerce St. Suite 102
Fairfield, TX 75840

☐ **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

FREESTONE COUNTY INDIGENT HEALTH CARE PROGRAM

Mandy Chavers
Freestone County Treasurer
118 E Commerce St, Rm 102
Fairfield, TX 75840
903.389.2180
903.389.5894 fax
treasurer@co.freestone.tx.us

This is a required form.

APPLICANT-EMPLOYMENT VERIFICATION FORM

(If you are not currently employed, list the last place of your employment on this form.)

_____ _____

Company Name (Please Print) **Supervisor Name (Please Print)**

_____ _____

Address **Phone**

****

_____ _____

Employee / Applicant name (Please Print) Date of Birth

_____/_____/_____ to _____/_____/_____ or Currently Employed (no end date)
Hire Date End Date

- Full Time
- Part Time
- Hourly Wage $ _____
- Hours per week _____
- Other _____

_____
Employee Signature

_____
Supervisor Signature

Please check all that apply:

- Insurance offered by company
- Insurance not offered by company
- Insurance accepted by employee
- Insurance declined by employee

_____
Date

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This is a required form if you work any odd jobs such as mowing, babysitting, housesitting, or tending animals, etc.

You will be required to keep a record of your earnings and submit it to this office on a weekly basis.

SELF EMPLOYMENT VERIFICATION FORM

_____ _____
Applicant Name DOB

Day of the week	Description	Total Paid
Monday		$
Tuesday		$
Wednesday		$
Thursday		$
Friday		$
Saturday		$
Sunday		$
	TOTAL	$

Total Weekly Earnings for the week of

_____

date

_____ _____
Applicant Signature Date

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This is a required form.

Verification Statement

This form is to be completed by any person/persons who are providing any assistance to you.

Applicant Name: _____ DOB _____

If you have given cash to the above-named person within the past 95 days, please note the dates and amounts (however small) in the spaces below. You may use the back of this form if you need more space.

_____ Date	_____ Amount	_____ Date	_____ Amount
_____ Date	_____ Amount	_____ Date	_____ Amount
_____ Date	_____ Amount	_____ Date	_____ Amount
_____ Date	_____ Amount	_____ Date	_____ Amount

Have you paid any bills directly for the above-named person? If YES, name of person or company paid:

- o YES
- o NO _____

Is the above-named person currently living with you? OR are you currently providing room and board?

o YES	o YES _____ Amount
o NO	o NO

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

_____ *NAME and Signature* _____ *DATE*

_____ *ADDRESS* *CITY-STATE- ZIP* _____ *PHONE*

FREESTONE COUNTY TREASURER'S OFFICE
118 E. Commerce, Room 102
Fairfield, Texas 75840
Office: (903) 389-2180
Fax: (903) 389-5894

Mandy Chavers
County Treasurer

RE: Freestone County Indigent Health Care Program
Mandated Providers

The following list is a source of information which consist of ***PHARMACIES, PHYSICIANS AND HEALTH CARE FACILITIES*** (HEALTH CARE SERVICE PROVIDERS) selected by the county, who agrees to provide services to eligible county residents:

PHARMACIES
Hometown Pharmacy
201 East Commerce
Fairfield, TX 75840

Pharmacy Plus #1
600 Main Street
Teague, TX 75860

HOSPITAL
Freestone Medical Center
125 Newman Street
Fairfield, TX 75840

Limestone Medical Center

CLINICS
Freestone Health Clinic
734 W. Commerce
Fairfield, TX 75840

Parkview Medical Clinic of Teague
101 Anthony Drive
Teague, TX 75860

DENTAL
Dr. Brent Moore
670 W. Commerce Street
Fairfield, TX 75840

COUNTY OF FREESTONE
118 E. COMMERCE, ROOM 102
FAIRFIELD, TEXAS 75840
(903) 389-2180
FAX: (903) 389-5894

MANDY CHAVERS
County Treasurer

KALI BARCO
Chief Deputy Treasurer

INDIGENT HEALTH CARE CLAIM

CASE #	REFERENCE #	SERVICE DATE	BILLING DATE	TOTAL COST	ELIGIBLE EXPENSE

PROVIDER _____
_____
_____

APPROVED BY:

_____ **DATE** _____

MANDY CHAVERS
COUNTY TREASURER

The information attached to this claim form is confidential information and is intended only for the use of processing payment to the health care provider. By receiving this legally privileged information, the recipient is then assuming responsibility for properly protecting the information according to the law as outlined in the copy of the Freestone County Indigent Health Care Notice of Privacy Practices furnished to the Freestone County Auditor's Office.

TEXAS Health and Human Services

County Indigent Health Care Program (CIHCP)

WORKSHEET

Date Identifiable Form 100 Is Received in Office	Case Record Number	Type of Determination ☐ Application ☐ Review
Case Record Name (Last, First, Middle)	Case Record Action ☐ Approved ☐ Continued ☐ Denied	Eligibility Effective Date (MM-DD-YYYY)
		Prior Eligibility Effective Dates (MM-DD-YYYY)

Date _____ Signature – Eligibility Determiner _____

ELIGIBILITY ITEMS	DOCUMENTATION
1. Form 100	
A. Is the Form 100 appropriately signed and dated by the applicant? ☐ Yes ☐ No	
B. Is the Form 100 appropriately signed and dated by the spouse, if the applicant is married and the spouse lives in the house? ☐ Yes ☐ No ☐ N/A	
C. Is information complete and consistent? ☐ Yes ☐ No	
2. Household	
A. Who is applying for CIHCP? _____	
B. Does legal responsibility for support exist between the applicant(s) listed in 2A and any other person living in the house? ☐ Yes ☐ No	
If Yes, between whom? _____	
C. Does any individual listed in 2A or 2B receive Medicaid? ☐ Yes ☐ No If Yes, who? _____	
Disqualify the Medicaid recipient(s) listed in 2C and use Step 2 of the Budget Calculation on Page 3, if applicable.	
D. Is any individual listed in 2A or 2B potentially eligible to receive Medicaid? ☐ Yes ☐ No	
If yes, who? _____	
Use the Medicaid screening tool: www.yourtexasbenefits.com and refer to the CIHCP Handbook for application processing.	
E. Who are the members of the CIHCP household?	
[Verify household if questionable.]	
In the following questions 3 - 10, "CIHCP household member " refers to each individual listed in 2E above.	

ELIGIBILITY ITEMS | **DOCUMENTATION**

3. Residence

A. Is each CIHCP household member a county resident?..... ☐ **Yes** ☐ **No**

B. Does each CIHCP household member plan to remain in the county? ..... ☐ **Yes** ☐ **No**

[Verify residence if questionable.]

4. Resources *[Exempt all resources of the Medicaid recipients listed in 2C.]*

A. Does any CIHCP household member own the following?

Resource	Yes	No	Countable Value
1. Cash on Hand			
2. Certificates of Deposit			
3. Checking Accounts			
4. Insurance Settlements			
5. Lawsuit Settlements			
6. Livestock			
7. Lump Sum Payments			
8. Notes, Bonds, Stocks			
9. Prepaid Burial Insurance			
10. Real Estate (excluding homestead)			
11. Retirement (including IRAs)			
12. Savings Accounts			
13. Vehicles			
14. Alien Sponsor's Resources			
15. Other Resources			
16. **TOTAL COUNTABLE RESOURCES** *[This amount is not rounded.]*			**$**

B. Has any CIHCP household member transferred a countable resource within 3 months before application? . ☐ **Yes** ☐ **No**

[Document regarding countable resources for the application month and the 3 months prior. Verify resources if questionable or if the countable value is close to the resource limit.]

5. Income *[Exempt all income of the Medicaid recipients listed in 2C.]*

A. Does any CIHCP household member have terminated income in the application month or the 3 months prior? .... ☐ **Yes** ☐ **No**

B. Does any CIHCP household member have any other countable income in the application month or the 3 months prior?..... ☐ **Yes** ☐ **No**

[Document and verify all countable income, including terminated income, for the application month and the 3 months prior.]

ELIGIBILITY ITEMS	DOCUMENTATION

6. Budget Calculation

A. Determine the household's monthly total countable income.

Type of Income	Name of Member(s) w/ Income		
Earned Income (#1 through #7)			
1. Monthly Gross Earned Income			
2. Standard Work-Related Expense	–	–	
3. Subtotal (Line 1 minus Line 2)	=		
4. Calculate 1/3 of Line 3	–	–	
5. Subtotal (Line 3 minus Line 4)	=		
6. Child / Incapacitated Adult Care	–	–	
7. Countable Earned Income	=		
Unearned Income (#8 through #17)			
8. Alien Sponsor's Income			
9. Cash Gifts, Contributions, Prizes			
10. Child Support Payments			
11. Interest and Dividend Payments			
12. Retirement Benefit Payments			
13. Social Security Benefit Payments			
14. Unemployment Benefit Payments			
15. V. A. Benefit Payments			
16. Worker's Compensation Payments			
17. Other Unearned Income			
(Add Line 7 plus Lines 8 through 17.) 18. TOTAL COUNTABLE INCOME	+	+	= $

B. Complete 6B if anyone in the CIHCP household is making child support payments, alimony payments, other payments to persons they can claim as tax dependents or are legally obligated to support and who reside outside the CIHCP home, or if a household member was disqualified due to receiving Medicaid (refer to section 2C page1). If none of these exist, then proceed to 6C.

1. Total countable Income from 6A, Line 18	$
2. Deduction for the support of the Medicaid recipients listed in 2C **(See Handbook,Section2, Page 29.)**	–
3. Deduction for the actual amount of household member's payments made to dependents outside the household group including child support, alimony, and other payments made to persons they can claim as tax dependents or are legally obligated to support.	–
4. Net Countable Income **(Line 1 minus Lines 2 and 3)**	= $

C. Compare the CIHCP Household's Net Countable Income to the CIHCP Monthly Income Standard.

1. NET COUNTABLE INCOME **(from 6A, Line 18 or from 6B, Line 4)** with cents rounded down.	$
2. CIHCP Monthly Income Standard for the CIHCP household **(See Handbook, Section 2, Page 30.)**	$

If the Line 1 amount is equal to or less than the Line 2 amount, the CIHCP household is income eligible.

If the Line 1 amount is greater than the Line 2 amount, the CIHCP household is not income eligible.

ELIGIBILITY ITEMS	DOCUMENTATION

7. Eligibility

A. Is the household eligible for CIHCP?..... ☐ **Yes** ☐ **No**

B. *[Question 7B is for applications. Mark N/A if this is a review.]*

Is any CIHCP household member eligible in any of the three month(s) before the month in which the identifiable application was filed?..... ☐ **Yes** ☐ **No** ☐ **N/A**

If Yes, list the name(s) and the eligible prior month(s).

_____

_____

_____

_____

[If the household is eligible for CIHCP, complete Items 8, 9, and 10.]

8. Other Sources of Health Care Coverage

Does any CIHCP household member have private health insurance, Veterans' Administration (V. A.) health care coverage, Worker's Compensation health care coverage, Texas Rehabilitation Commission (TRC) health care coverage, or any other source of health care coverage? ..... ☐ **Yes** ☐ **No**

If Yes, document regarding other source(s).

[Receipt of any other source of non-Medicaid health care coverage does not deny an applicant or recipient from CIHCP. It may indicate another payment source.]

9. SSI Status

A. Has any CIHCP household member applied for SSI or RSDI with the Social Security Administration?.....

☐ **Yes** ☐ **No** ☐ **N/A** If yes, who? _____

_____

B. Is any CIHCP household member an SSI or RSDI appellant with the Social Security Administration?.....

☐ **Yes** ☐ **No** ☐ **N/A** If yes, who? _____

_____

The Benefit Eligibility Screening Tool (BEST) screens for potential eligibility for benefits from any of the programs that Social Security administers. BEST may be accessed at http://best.ssa.gov

10. Case Review

This case is due for its next 6-month review in .....

MM-YYYY

Freestone County Indigent Health Care Information & Contacts

An individual applying for County Indigent must apply with the hospital district they reside in. Only if the individual does not reside in a hospital district, will they contact the Freestone County Treasurer Office to apply.

Freestone County has two hospital districts:

- Fairfield Memorial Hospital District
- Teague Hospital District

Application Contact Information:

Teague Hospital District	**Fairfield Hospital District**	**Freestone County Treasurer Office**
254-739-5322	903-389-1628	903-389-2180

TWS-VRS serves people with a variety of disabilities including, but not limited to:

- Blindness and visual impairments
- Hearing impairments, including deafness and hearing loss
- Mental and behavioral health conditions
- Physical disabilities, such as birth defects, back injuries or spinal cord injuries
- Traumatic brain injuries and seizure disorders
- Intellectual and developmental disabilities
- Other physical or mental conditions that impact a person's ability to obtain, retain or advance in competitive integrated employment

Freestone County Treasurer is unable to assist individuals with psychotropic medications. There is no contact with the mental health authority for individuals living in Freestone County. The purpose of Vocational Rehabilitation services is to help people with disabilities to prepare, find, keep and advance in employment opportunities. Eligibility for services does not depend on income. We hope that you will consider referring individuals to our agency that we may be able to help. Please feel free to reach out to Rhonda or Giovanne with any additional questions.

Limestone County Transit	**Klaras Center for Families**	**Freestone County Heart of Texas MHMR**
510 W State St Groesbeck, TX 76642 254-729-2625	1105 Jefferson Ave Waco, TX 76701 254-752-7889	622 W. Main St Fairfield, TX 75840 903-389-4521

Rhonda Corell
Counselor of Freestone County
Texas Workforce Solutions
Vocational Rehabilitation Services
1416 S. New Road
Waco, TX 76711
Phone: 254-296-5306
Fax: 254-756-1728
Email: rhonda.corell@twc.state.tx.us
Website: twc.texas.gov
Board website: wfscapitalarea.com

Giovanne M. Turincio, MRC, CRC
Community Outreach & Awareness Specialist
Vocational Rehabilitation Services
6400 E. Highway 290, Suite 201
Austin, Texas 78723
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A Delores Griggs-Myles
Email: a.deloresgriggsmyles@twc.state.tx.us