Dickens County Indigent Health Care Program
P.O. Box 179
Dickens, TX 79229

Dear Applicant:

Attached you will find the Dickens County Indigent Care Program application. Completion of this application will enable us to present your account for consideration of financial assistance for your health care bill(s).

We understand your desire for privacy. Accordingly, except for verification purposes, the information included in your application will be treated as confidential information and will only be shared on a need to know basis.

Please complete each item on the application and provide the copies of the following:

1. Proof of income and/or 3 prior pay stubs for ALL adults in the home
2. Copy of Driver's License for ALL adults in the home
3. Copy of Social Security cards for All adults in the home
4. Copy of insurance card, Medicaid/Medicare cards of anyone in the home
5. 2 prior months bank statements (checking, savings, cd's, Ira's)
6. Copy of denial letter from Medicaid from the past six months
7. Copy of denial letter from Social Security from the past six months
8. Copy of last 3 payments from Social Security...SSI or SSDI or SS
9. Federal Income Tax Return for the previous year
10. Household Letter*

After processing your application you will be notified in writing as to the status of your request for assistance.

Thank you for your cooperation in this matter.

Stephanie Beaty
Indigent Care Coordinator
806-623-5532

*If someone assists you with your household bills, please have them complete the Third Party Financial Help Letter regarding what they pay, how much they pay, how often they pay the bills for you and to whom they give the money to. You will find this letter in your application packet.

DICKENS COUNTY INDIGENT HEALTH

RIGHTS AND RESPONSIBILITIES

After reading, please initial each item.

1. _____I have been informed that the Dickens County Indigent Health Care Program does not discriminate. I can apply for services regardless of sex, race creed, national origin, religious beliefs, sexual orientation or disability.
2. _____As an Indigent Health Care recipient, if I need specialized care, my Primary Care Physician (PCP) will need to provide Dickens County Indigent Health Care with written referral to a specialist for medical treatment in order for the bill to be paid.
3. _____I have been informed that Indigent Health Care covers only medically necessary services.
4. _____I have been informed that Indigent Health Care covers only three prescriptions per month.
5. _____I have been informed that Dickens County Indigent Health Care requires that I ask my medical care providers for generic prescriptions if available.
6. _____I have been informed that I am responsible for notifying my medical care providers of my eligibility and instructing those providers to submit eligible unpaid medical bills to Dickens County Indigent Health Care Office within 95 days from date of service.
7. _____I have been informed that failure to notify my providers will result in non-payment of my medical bills.
8. _____I have been informed that I must present my eligibility card or letter when I attend a medical appointment, go to the hospital, or present or pickup a prescription at the pharmacy.
9. _____I have been informed that I must notify the office within fourteen (14) days of any changes in my situation, (such as changes in income, property, household members, address, vehicles, or applying for or receiving SSI, TANF, Medicaid, Lawsuit, Unemployment Benefits, Worker's Compensation Benefits, or any type of correspondence or approval of Social Security benefits).

10._____I have been informed that if I fail to report changes that make me ineligible, I will be held responsible for payment or reimbursement of any medical services rendered to me or paid on behalf that I received after becoming ineligible. I understand I may be subject to prosecution under the Texas Penal Code.

(Print Your Name)_____ (Date) _____

(Signature)_____

Dickens County Indigent Health Care Program
Fraud Policy

Definition:

Fraud is the deliberate misrepresentation of a material fact for the purpose of acquiring benefits.

Procedure:

When the Indigent Health Care (IHC) staff has reason to believe that fraud may have occurred, the following procedures shall be followed:

1. The IHC staff shall investigate all cases of suspected fraud and shall collect and document evidence.

2. Upon a finding of fraud, the client shall be administratively ineligible from IHC as follows:
   - First Offense — 24 months from the date fraud was discovered
   - Second Offense — 36 months from the date fraud was discovered
   - Third Offense — 24 months + 12 months per subsequent offense

3. The IHC staff shall contact the client who is suspected of fraud by sending a certified letter informing him/her of the withdrawal of eligibility and explaining the allegations. If the client disputes the allegations, the client will be allowed to submit applicable supporting documents/verifications for further consideration.

4. If the dispute remains unresolved, the IHC staff shall schedule an administrative hearing to allow the client to defend himself/herself by confronting any adverse witness and by presenting his/her own argument and evidence. The IHC staff must disclose any evidence used to prove its case to the client so he/she has an opportunity to dispute it. The client shall be given 30 days written notice of the date of the administrative hearing. The burden of proof lies with the IHC program. If the client does not appear at the administrative hearing, the IHC program coordinator may proceed with presentation of her case only if proof of notice is present.

Consequences of Fraud

If, after due process, a person is found to have intentionally misrepresented information in order to receive benefits, that person:

1. Shall reimburse Dickens County for the cost of benefits they were ineligible to receive

2. Shall be administratively ineligible for Dickens County IHC benefits in accordance with the IHC handbook

3. May be subject to prosecution under the Texas Penal Code

_____ _____

Signature Date

Dickens County Indigent Health Care Program

I understand that the Indigent Health Care program will not pay for the following treatments:

- Ambulatory surgical center (freestanding) services
- Colostomy medical supplies and equipment
- Social and educational counseling services
- Dental care
- Diabetic medical supplies and equipment
- Durable medical equipment
- Emergency medical services **clients going to the emergency room with non-emergency conditions will be held financially responsible for treatment without regard to indigent eligibility status**
- Home and community health care services
- Physician assistant service
- Vision care or eyeglasses
- Federally qualified health center services
- Occupational therapy services
- Physical therapy services
- Elective surgeries
- Prosthetic and orthopedic devices
- Diet consults
- Hearing aids
- Chiropractors
- Home oxygen
- Mental disorder or related services
- Alcohol or drug related services

_____ _____

Signature Date

DICKENS COUNTY INDIGENT HEALTH

VEHICLE OWNERSHIP

If you do not own a vehicle, please write "N/A" on first line and initial the bottom right corner.

If you own a vehicle, you must provide the following information:

Make:_____

Model:_____

Year:_____

License Plate Number:_____

Owner's Name:_____

(Please Initial)_____

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 Insurance (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.: _____

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.