TRINITY COUNTY

INDIGENT HEALTH CARE
P. O. Box 312
Groveton, Texas 75845
Phone: 936-642-1736
Fax: 936-642-2733
Email: indigenthealthcare@co.trinity.tx.us

TRINITY COUNTY INDIGENT HEALTH CARE PROGRAM

"PAYOR OF LAST RESORT"

Trinity County Indigent Health Care serves only those eligible county residents who are not eligible for health care services from Federal or State assistance programs.

Have you, or could you, apply for Medicaid or Healthy Texas Women?
Have you applied for Supplemental Security (SSI)?
Would you qualify for Social Security Disability (SSDI)?
Would you qualify for TANF (Temporary Assistance for Needy Families)?

All of the above mentioned services that *would, or could*, pertain to you must have been exhausted before you are considered an applicant for Trinity County's Indigent Health Care Program.

If you are asked to apply, or have applied and have not received a decision, your application with be **pended** until a decision has been made.

If you have been denied services from the above list you must provide the denial letters.

If none of the above mentioned services pertain to you, then you will need to request an application. Once the completed application is received in our office, we will start the application process. If you qualify for the program, only **medically necessary** services are provided.

If you need assistance with determining if you would be eligible for any of the above programs, please go to www.yourtexasbenefits.com to fill out a short questionnaire to see if you might qualify.

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APPLICATION PROCESS

How to apply:

- Make sure that you meet all the requirements and that you do not reside in the Hospital District. (Trinity, TX)
- Next, you will need to fill out an application. You can find the application on the county website or pick one up at the office. *(Courthouse, 1st floor, Judge's Office)*

Submitting an Application:

To submit an application, fill out all forms and submit them along with all documentation requested. In order for the application to be considered, it **must** have a correct name and address, as well as a signature and date on page three (3).

Please return the application by mail or deliver it in person.

WHAT HAPPENS NEXT?

Once received, the application will be reviewed. If there is any additional information needed, you will be notified by mail and asked to submit the additional documentation. The applicant may also be asked to come to the office for an interview.

When the application is complete and **all** necessary documentation is turned in, we will begin processing the application. A determination will be made within 14 days. The office will let you know by mail if you have been accepted or denied.

If the applicant fails to provide all requested information, we will assume the applicant is no longer interested and they will be denied.

After turning in an application, you **must** notify this office within 14 days of any changes such as address, income, employment, etc.

Payor of Last Resort:

You may be asked to apply for assistance through other program(s) before our office will determine eligibility. If you are asked to apply, or have applied but have not received a decision, your application will be pended until a decision has been made.

If you need assistance with your application please call Lisa at (936) 642-1736.

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INDIGENT OVERVIEW

The Trinity County Indigent Health Care Program is designed to benefit those citizens within our county who are not eligible for health care coverage through private health insurance or by way of the Trinity Hospital District. The CIHCP is overseen by the CIHCP Director and the Commissioners Court of Trinity County. This CIHCP office is responsible for carrying out the program in its entirety.

Eligibility:

- Must reside in Trinity County
    - The County Indigent Program provides assistance to non-hospital district residents in Trinity County. If you have a Trinity, Texas address, contact Healthpoint Trinity at 936-744-1400 for assistance.
- Must meet Income and Resource Guidelines
- Must be at least 18 years old
- Must have no private health insurance

Trinity County is the "*Payor of Last Resort*" and serves only those who are **not** eligible for Federal or State Assistance Programs (Medicaid, SSI, Healthy Texas Women, etc.)

Services Provided:
A county shall provide the basic health care services such as;

- Physician Services
- Annual Physical Examinations
- Immunizations
- Medical Screening Services (blood sugar, blood pressure, cholesterol screening)
- Labs/X-rays
- Family Planning Services
- Rural Health Clinic
- Prescription Drugs (3 per month)
- Inpatient/Outpatient Services

(*Dental, vision and physical therapy* are some services that are **not** covered.)

Limits to our program are $30,000 per client per fiscal year or 30 days stay in a hospital.

Approvals:
Applicants who are approved are sent a Form 109 which explains the program, coverage, and eligibility. All applicants are covered for a period of 6 months before a renewal application is issued, unless there are changes in residency or income within the 6 month period. Applicants are required to submit new applications and/or income/household verifications any time the coordinator/staff have the reason to suspect fraudulent activity within the indigent household.

Once approved, clients must come to the IHC office on the first of each month to pick up their monthly voucher. The voucher must be brought with you to every appointment. The voucher is marked with the client's name, address, expiration date and signed by the Administrator.

The client must notify this office within 14 days of any changes in your situation, such as changes in:

- Address
- Household Members
- Property
- Income
- Application for or receipt of SSI, TANF, Medicaid, or Texas Healthy Women

If any change occurs that makes you ineligible and you fail to report the change as required, you may be held responsible for payment of any health care services you receive after you become ineligible and/or you may be subject to prosecution under the Texas Penal Code.

Requisitions:
If the client has an appointment with any other facility other than their local clinic, then a separate voucher is required, i.e. xrays, mri, ct scans, etc. Anything that is preformed at a hospital must have a separate voucher in order for it to be approved and the voucher must have the date of the procedure on the voucher.

Prescriptions:
As stated above, approved applicants are eligible to receive **3** prescriptions a month. If a prescription is expensive, i.e. hundreds of dollars, we help the applicant apply for coverage of the medication through Needymeds.com or another similar program.

If you have any questions please contact the County Indigent Office at (936) 642-1736

INFORMATION NEEDED TO PROCESS APPLICATION

APPLICANT NAME: ________________________________

APPLICANT PHONE #: ________________________________

PROOF OF IDENTIFICATION:
a) Social Security Card
b) Texas Driver's License with Trinity County address AND/OR identification card.

IF YOUR ADDRESS IS DIFFERENT THEN WHAT IS ON YOUR ID YOU WILL NEED PROOF OF AT LEAST ONE OF THE FOLLOWING:
a) Utility bill in your name showing your address; AND/OR
b) completed address verification form; AND/OR
c) copy of rental agreement

INCOME VERIFICATION:
a) Last three (3) check stubs or a written statement from your employer (if applicable)
b) Written verification of Unearned Income: Retirement payments, donations, rental property, etc.
c) Copy of the prior year's W-2 statements for Income Tax Return

IF YOU ARE SELF-EMPLOYED YOU WILL NEED TO SHOW PROOF OF INCOME FROM MONEY YOU RECEIVE.

OTHER:

Yes	No	
___	___	1. Have you applied for any kind of unemployment?
___	___	2. Do you have a pending Worker's Compensation claim?
___	___	3. Are you receiving Worker's Compensation Benefits?
___	___	4. Do you have a Social Security Claim or SSI Claim pending? If yes, bring in proof of denial. *IF DENIED, APPEALING OR REAPPLYING?*
___	___	5. Do you have a lawsuit pending concerning a prior medical condition, illness or accident? If yes, bring proof of the lawsuit.

RESOURCE VERIFICATION
a) Last 3 months checking, savings, & debit card statements

MARITAL STATUS:

Married ___, please provide spouse's name as well as place and date of marriage;
Divorced ___, please provide date and place of divorce or a copy of decree;
Separated ___, please provide spouse's name and date of separation;
Single ___

All individuals completing an application for the Trinity County Indigent Health Care Program must provide a current physical address to qualify. If you receive your mail at a Post Office Box, you must provide this office with a physical location or directions to your home. Complete all paperwork to the best of your ability, and sign where indicated. Failure to complete the paperwork completely can result in a delay of benefits or a denial. Return all forms and verifications to The Indigent Health Care Office, located at 162 West 1st Street, in the Courthouse on the 1st floor, Groveton, Texas 75845 .

TEXAS
Health and Human Services

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.

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MEDICAL QUESTIONNAIRE

______________________________ ______________________
Applicant Name Date of Birth

What is your primary health concern at this time? ______________________
____.

Please list all other ongoing health issues or diagnoses: ____________________
____
____.

Were you referred to our office by another facility? ____yes ____no
If yes, what facility? ______________________________________

Do you have any unpaid medical bills within the past 95 days? ____yes ____no
If yes, please complete the following information:

______________________ ____________ ____________
Facility (hospital) Admit date Discharge date

____.
Reason for visit

Were you taken by ambulance to the hospital? ______ yes ______no

Are you currently on any type of assistance for medical coverage through any other form of insurance? _________yes ______no

Please list all medication you are currently taking.

Medication	Reason for medication	Daily Dosage
1.__________________	__________________	__________
2. __________________	__________________	__________
3. __________________	__________________	__________
4. __________________	__________________	__________

______________________________ ______________________
Applicant Signature Date

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Authorization for Release of Information

Applicants Name: ______________________________

I, ____________________ (print name), grant the Trinity County Indigent Health Care Program in Trinity County, Texas permission to view my personal tax, financial and employment documents at their discretion; hence, I release all my personal tax, financial, and employment documents to the Trinity County Indigent Health Care Program at any time which they deem it necessary to view.

I understand that I can, at any time, request and be provided a copy of the retrieved information. I also understand that if any changes or discrepancies are detected, my application can and will be reviewed by the Trinity County Indigent Health Care Program accordingly. Furthermore, I understand that I will be provided with a copy of this release form.

I give permission for my legal counsel or the Social Security office to release information regarding my application of appeal for SSI Disability benefits.

I also give permission for providers treating me to release my medical records to Trinity County Indigent Health Care Office for the purpose of determining proper referrals and/or determining whether or not the services provided meet the criteria for payment by the Trinity County Indigent Health Care Program.

____
Applicant Signature **Date**

____
Spouse Signature **Date**

____
Witness Signature (if signed with "X") **Date**

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Contact List

Give the name and address of a relative or friend to contact in case of an emergency.

Name Relationship to Client

Address Email Address

City State Zip Code

Phone Number

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Trinity County Indigent Health Care Fraud Policy

Definition
Fraud is the deliberate misrepresentation of some 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:

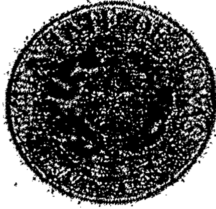
1. The IHC staff shall investigate all cases of suspected fraud and shall collect and document evidence.
2. Upon a finding of fraud, the client shall be administratively ineligible from IHC as follows:
   First offense 12 months from the date fraud was discovered
   Second offense 24 months from the date fraud was discovered
   Third offense 36 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 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 by confronting any adverse witness and by presenting his own argument and evidence. The IHC staff must disclose any evidence used to prove its case to the client so he has an opportunity to dispute it. The administrative hearing will be conducted by the Coordinator of the Trinity County IHC Program. If the client does not appear at the administrative hearing, the IHC Coordinator or designee may proceed with presentation of her case only if proof of notice is present. The Coordinator of the Trinity County IHC Program must make a decision within ninety days of the hearing.
5. The client shall have the right to appeal any unfavorable decision to the Trinity County IHC Appeal Authority.

Consequence of Fraud

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

- shall reimburse Trinity County for the cost of benefits they were ineligible to receive;
- shall be administratively ineligible for Trinity County IHC benefits in accordance with Trinity County IHC Policies and Procedures; and• may be subject to prosecution under Texas Penal Code.

Signature____________________ **Date** ____________________



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AFFIDAVIT OF ASSETS, INCOME AND RESOURCES

This affidavit is made by me ______________________________ (APPLICANT) for the purpose of assuring Trinity County Indigent Healthcare Program of what assets, income or resources that I have access to:

Please check the items you own or have access to:

☐ Ownership of any property in the U.S. located at: ____________________________

☐ Vehicles: (Make_____ Model_____ Year______ Amount owed: _______
Miles_____

☐ U.S. Banking accounts including checking, savings, IRA, etc.: (provide copies of most current statements)

☐ Retirement plans in the U.S. or foreign countries: (provide copies of statements)

I understand that if I fail to report any of the above information, I will be held responsible for payment of any medical services that I may have received under the Trinity County Indigent Health Care Program, and I will be subject to prosecution under the Texas Penal Code.

I swear (affirm) that the contents of this affidavit signed by me are true and correct.

____
Print Name Date

____
Signature Date

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EMPLOYMENT VERIFICATION FORM

If you are currently employed fill out the following:

______________________________ ______________________________
Company Name (Please Print) Phone #

□ Full Time □ Part time □ Currently Employed

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

Number of hours worked________ Hourly wages: $________

If you are NOT currently employed fill out the following:

When was the last time that you were employed: ______________

Who was your last employer: ________________________________

Date of your last paycheck:___________ in the amount of $____________.

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This form is to be filled out by the person who helps you with your bills or who gives you any assistance.

ASSISTANCE DISCLOSURE FORM

I, ______________________, living at ______________________________ make the following voluntary statement concerning assistance I have given to______________________________, Applicant.

I have helped or am helping the applicant in the following manner:

☐ Providing Cash Money: Approximately how much and how often? $ ______ every ________________

☐ Other : I pay the following bills for Applicant: (cell phone bill, transportation costs, groceries, miscellaneous expenses)
Total per month (approximately): $ ____________________

☐ I pay Rent/Mortgage for applicant: Yes____ No ____

☐ Is the Applicant currently living with you? Yes ____ No____

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

____   ____________________
Signature   Date

____   ____________________
Phone Number   Relationship to Applicant

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If you live at a different address than is on your DL or ID card, please furnish this office with a copy of any mail addressed to you at your new address. If you live with someone else and they provide you with a place to live then have that person fill out the following form.

ADDRESS VERIFICATION FORM

I, ______________________________, certify that __________________________,

lives at my residence located at ___________________________________ and

that I am currently providing room and board for applicant.

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

______________________________	______________________________
Signature of home owner	Printed name of home owner
______________________________	______________________________
Date	City, State, Zip Code

FOR THE PARTICIPANT: (person applying for coverage)

I understand that giving incorrect information to the Trinity County Indigent Health Care Program is sufficient cause for termination from the program, recoupment of benefits and prosecution for fraud.

______________________________	______________________________
Signature of Applicant	Date