Callahan County Indigent Health Care

Ivy Byram, IHC Director

Mailing Address 100 W. 4th St. Ste. 200 Baird, TX 79504
Physical Address: 1257 FM 2047 Baird, TX 79504
Phone: 325.854.5805, Fax: 325.854.5806
Email: ivy.byram@callahancounty.org

Enclosed is the application requested for assistance with medical expenses. The mission of the program is to assist those who qualify return to good health and self-sufficiency whenever possible and to the greatest extent possible. Eligibility is based on income, resources, residency, and household composition. It is the responsibility of the applicant to obtain and submit all necessary information to be used in determining eligibility.

Applicant's Printed Name:

_____

Date:

_____

If at any time after you submit your application any changes occur in your income (earned or unearned), resources, people who live with you, residency, or eligibility to any other programs, you *must* notify us within 14 days. Applications that are faxed, copied, without applicant's signature (including spouse) not dated, altered (including correction fluid) or signature older than 30 days will not be accepted.

Once you have completed the application, please return it to the Indigent Healthcare office in the enclosed return envelope. You may also send any documents via email to the email address listed above if that is more convenient.

While completing this application, try not to leave anything blank. If a question does not apply to you, please write "N/A", and sign the bottom of the page if asked. Along with the enclosed application (completed and signed within the last 30 days) **please provide the following documentation:**

Identification (at least one picture): Identification required for the applicant and all adults with whom there is a legal responsibility between such as spouses, adults with minor children. Submit drivers' license or birth certification or student identification. If you possess a US visa, permanent residency card, border crossing card submit a copy as well. Birth certificate required on all minor children (under age 18) at the domicile.

Residency/Household Composition: Household is the applicant and spouse and or minor children for which the applicant is legally responsible for, if any. Submit lease agreements, utility or land line telephone bills, property tax statements for physical address, mortgage statements. If the applicant's name does not appear on these, they will be asked to submit additional independent verification of residency to the address. Letters from homeless shelters if you are living in shelter Documents with a P.O Box will not be accepted as proof of residency.

Resources: Things owned by the household and worth: **Checking accounts, savings accounts,** campers, boasts, bonds, stock, prepaid burial insurance, certificates of deposit, livestock, real estate (homestead exempt), retirement accounts, trailers, titles to all automobiles that are in your name and at the residents where the household is residing. Include documents to show loan balances on your vehicles.

Continued on next page →

Income: Income is money in the form of cash, money orders, checks or direct deposits received or anticipated to be received by the household. Examples are cash gifts, contributions, cash loans, wages, salary, commission, tips, unemployment compensation, pensions, credit card cash advances, child support payments, disability payments, self-employment. Submit documentation for last 4 months. Self-employed persons required to submit business accounts, receipts, invoice, business ledgers for all income received and business expenses, income tax filing for previous year.

Persons with permanent residency cards issued whose entry to US was based on sponsorship must include a copy of Affidavit of Support completed by their sponsor and co-sponsors, if any. Include sponsor household income and resources for last 3 months along with copy of most recent IRS filing for sponsor.

Other healthcare coverage public or private: Applicant must reveal and provide documentation if they or any member of their household possess: health insurance policies, automobile insurance policy if you have a claim pending for monetary or medical coverage, Medicaid, Medicare, Unemployment Compensation, Workman's Compensation, Veterans Administration, application for Crime Victims Compensation, etc.

Other assistance: Provide documentation if any household member is a recipient of any of the following: Food stamps, Callahan Housing Authority, Texas Department of Rehabilitative Services, SSI/Medicaid.

The information you submit will be reviewed for potential eligibility. If further information is required, you will be notified by our office by mail. Information will be reviewed and investigated for accuracy. Once all the information required is obtained, the office may contact you to be scheduled for an in- person interview to finalize your application.

"I have read this entire document and understand it completely."

_____

Applicant's Signature

If you have any questions, feel free to contact our office at the number and/or email listed above.

Our office hours are:
Monday – Thursday, 8:00 AM – 5:00 PM
Friday, 8:00 AM – 2:00 PM

Thank you,

Ivy Byram
Indigent Healthcare Director
County Judge Administrator
Callahan County, Texas

Callahan County Indigent Health Care

Ivy Byram, IHC Director

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Callahan County Indigent Health Care Application Packet & Index

Please find attached the following forms to be completed and submitted to the address above.

1. **CCIHC Policy** – Must be signed and dated. *Page 4*
2. **Application** (Form 3064) – Must be completed, signed, and dated. *Page 5*
3. **Resources** – Must be completed, signed, and dated. *Page 9*
4. **Vehicle Information** – Must be completed, signed, and dated. *Page 10*
5. **Employment Verification** (Form 3084) – This form gives your employer permission to disclose your employment status and pay. Must be signed and dated by both parties. *Page 11*
6. **Self-Employment** (Form 3085) – Complete this form if you have any self-employment income. *Page 13*
7. **Zero Income Declaration** – Complete, sign, & date if you have NO income. *Page 15*
8. **Assistance Verification** – Must be completed by anyone who is providing financial assistance to you. *Page 16*
9. **Social Security Information** – Must be completed, signed, and dated. *Page 17*
10. **Case Record Information Release** (Form 3076) – Must be completed, signed, and dated. *Page 18*
11. **Notice of Privacy Practices** – Must be completed, signed, and dated. Copies will be made available upon request. *Page 19*
12. **Fraud Policy** – Must be signed and dated. Copies will be made available upon request. *Page 26*
13. **Client Responsibilities** – Read through these. Upon understanding, sign in front of a witness and have them sign. Make sure you both sign and date. You can obtain a paper copy of this notice from us upon request. *Page 27*

Your application will not be processed until it is complete.

It can take up to 2 weeks to fully process after ALL requested information has been received. Once everything has been gathered and reviewed, you will be notified of your approval or denial to the CCIHC program either by mail, phone, or email.

Callahan County Indigent Healthcare Program (CCIHCP) Policy

All clients must be reviewed, and a renewal application completed *every six months*. To get this process completed, you must complete your application, schedule an interview, and provide ALL required supporting documents. If you do not call to reschedule your interview, you will be automatically rescheduled. Callahan County will send a notice of upcoming expired benefits with a renewal application but will *not* be responsible for reminding you of your application submission. You are responsible for keeping up with your term dates and submitting an application to reapply.

Abusive or threatening behavior, whether verbally or physically, by client or client's family or friends to any County staff, Physicians, Pharmacists, or their staff WILL NOT BE TOLERATED, and the client will be subject to immediate termination or denial of benefits.

Continual use of the ER for medical treatment of non-emergency conditions is considered ER abuse. This will not be tolerated and could be grounds for suspension from CCIHCP. All non-emergency conditions should be treated by your PCP in their office.

I, _____, understand that:

Applicant's Printed Name

CCIHCP does NOT pay for: medicine that is not prescribed, some restricted medications, ANY diabetic supplies, colostomy supplies, ambulance services, immunizations, vision, dental, prenatal care, cancer treatments (chemotherapy, radiation, or extensive treatment plans), physical therapy or occupational therapy, or any other services outside of what we are contractually obligated to do referenced in Chapter 61, *Health and Safety Code.*

CCIHCP is a program, NOT insurance coverage. Certain criteria must be met before claims/bills for medical services can be paid. We cannot guarantee all your claims/bills for medical services will be paid. If you receive any medical bills by mail, contact the provider or bring the bill into the CCIHCP Office.

CCIHCP can cover up to $30,000.00 in medical bills, OR up to 30 DAYS in the hospital each fiscal year – whichever comes first. CCIHCP retains the discretion to modify coverage dependent on funding or other unusual circumstances. These policies may be amended as needed by action of the Callahan County Indigent Healthcare Director. Chapter 61, *Health and Safety Code* may be found online at:
https://statutes.capitol.texas.gov/Docs/HS/htm/HS.61.htm

I must report any changes to my situation in less than 14 days to the CCIHCP Office.

_____ _____

Client/Applicant Signature Witness

_____

Date

Form 3064
January 2020-E

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)	Area Code and Phone No.	Marital Status

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? **$** ⇦ **TOTAL**

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			−
2			−

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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Resources

1. Do you have a bank account? (Check all that apply)
   ☐ Checking account ☐ Savings Account ☐ Multiple accounts
   ☐ I do not have any bank accounts

2. Do you have any of the following applications designed to transfer payments from one user to another through connected bank accounts? (Check all that apply)
   ☐ Venmo ☐ Cash App ☐ PayPal ☐ Wise ☐ Zelle ☐ Other: _____
   ☐ I do not have any of these

3. Identify any resources you may have along with its estimated value: (Check all that apply)
   ☐ Certificates of Deposit: _____
   ☐ Insurance Settlements: _____
   ☐ Lawsuit Settlements: _____
   ☐ Livestock: _____
   ☐ Lump Sum Payments: _____
   ☐ Notes, Bonds, or Stocks: _____
   ☐ Prepaid Burial Insurance: _____
   ☐ Real Estate: _____
   ☐ Retirement: _____
   ☐ Alien Sponsor's Resources: _____
   ☐ Other: _____
   ☐ ***NONE*** of these

4. Does any member of your household have any terminated income in the month this application is being submitted or in the 3 months prior? ☐ Yes ☐ No Explain: _____
   _____

_____ _____
Applicant's Signature Date

Callahan County Indigent Health Care

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Vehicle Information

Do you own a vehicle (title is in your name)? ☐ YES ☐ NO

If **YES**, you must provide the following information:

Make: _____ Model:_____

Year:_____ License Plate Number: _____

Mileage:_____

Primary Use: _____

Estimated Value:_____

Owner's Name: _____

If **NO**, what is your main source of transportation?

☐ I have a vehicle, but it's in someone else's name: _____

☐ Someone drives me where I need to go: _____

☐ Other: _____

_____ _____
Applicant's Signature Date

_____
Applicant's Printed Name

TEXAS
Health and Human Services

Date	Case Record No.
Address (Street, City, State, County and ZIP Code)	
Area Code and Phone No.	

County Indigent Health Care Program (CIHCP)

Employment Verification

Employee or Individual	Social Security No.

This employee or individual named above is a member of a household applying for health care assistance from the County Indigent Health Care Program. To determine this household's eligibility, it is necessary to verify all earnings. Since this individual is, was, or will be your employee, your help is needed.

This individual has given permission below for you to completely and accurately provide the information requested on Page 2 of this form. If a question does not apply, mark it N/A. After you complete this form, give it to your employee or mail it in the envelope provided, or fax it to the number listed above.

This information is appreciated and needed by [date]. If you have questions, call the office phone number listed above. Thank you for your help.

_____
Staff Signature

Enclosed: Envelope

I give my permission to release the information requested on this form.

_____ _____
Employee or Individual Signature Date

Comments:

Employment Verification

Employee Name (as shown on your records)	
Employee Address – Street, City, State, ZIP Code (as shown on your records)	
Is, was, or will this person be employed by you? ◯ Yes ◯ No If yes: ◯ Permanent ◯ Temporary	Is FICA or FIT withheld? ◯ Yes ◯ No

Rate of Pay ◯ Per Hour ◯ Per Day ◯ Per Week ◯ Per Month ◯ Per Job	Average Hours per Pay Period	How Often Employee Paid

On the chart below, list all wages received by this employee during the months of:

Date Pay Period Ended	Date Employee Received Paycheck	Actual Hours	Gross Pay	Other Pay* (Bonuses, Commissions, Overtime, Pension Plan, Profit Sharing, Tips)

*In Comments below, explain when and how other pay is received.

Date Hired	Date First Paycheck Received	If Employee is or was on Leave Without Pay Start Date: End Date:

If this person is no longer in your employ

Date Final Paycheck Received: Gross Amount of Final Paycheck:

Is health insurance available? ◯ Yes ◯ No

If Yes, employee is: ◯ Not Enrolled ◯ Enrolled for Self Only ◯ Enrolled with Family Members

Comments:

Signature of Person Verifying Information | Title of Person Verifying Information | Date

Company or Employer	Address (Street, City, State, ZIP Code)	Area Code and Phone No.

Form 3085
January 2020-E

TEXAS Health and Human Services

County Indigent Health Care Program (CIHCP)

Statement of Self-Employment Income

Case Record Name	Case Record No.

See Page 2 for instructions and additional information.

1. Name of the person who has self-employment income: _____

2. Give the number of months covered by this income statement: _____

3. Describe what you did to earn this money:

4. List your business expenses and income. **Important: Attach receipts, invoices or other verifying papers.**

Date	Expenses	Amount
	Total Expenses	

Date	Income	Amount
	Total Income	
	Subtract Expenses –	
	Net Self-Employment Income	

The above information is true, correct and complete to the best of my knowledge. I understand that giving false information to the county could result in my being disqualified for fraud.

_____ _____
Signature Date

_____ _____
Signature of Person Helping Complete Form, if Applicable Date

If you or any member of your household has any kind of self-employment income, fill out this form and attach it to your application. You may attach a copy of the latest income tax forms in place of this form. If your accounting system is not the same as this form, you may substitute a copy of your accounting statement. You must answer all questions and sign and date the bottom of Page 1. **Use additional sheets of paper if you need to.** Sign and date each additional sheet. This is your sworn statement. When you have your interview, you will need to bring bills, receipts, checks or stubs, and any other business records you have as your worker will need to see them. **Your records will be returned to you.**

Self-employment income is any money you earn working for yourself. It is not money you earn working for someone else. If you are in doubt, ask your caseworker.

Questions 1, 2 and 3. These questions are self-explanatory.

Question 4. List your business income and expenses. In the boxes on the left side of Page 1, list your business **expenses** (see the information below). Enter the dates you paid the expenses and the amount of each expense. Add the amounts and enter your total in the box "Total Expenses." In the boxes on the right side of Page 1, list your income (see the information below). List the dates you received the income, your sources of income, and the amounts. Add the amounts and enter your total in the box "Subtotal." Under the “Subtotal” box, enter your total expenses. Subtract your total expenses from the Subtotal and enter your "Net Self-Employment Income."

Expenses are your costs of doing business. Examples are supplies, repairs, rent, utilities, seed, feed, business insurance, licenses, fees, payments on principal of loans for income-producing property, capital asset purchases (such as real property, equipment, machinery, and other durable goods and capital asset improvements), your Social Security contribution for people who worked for you, and labor (not salaries you pay yourself). If you claim labor costs, list each person and the amount you paid them. If you have any other kinds of business expenses, list them and the date they were paid.

You may not claim:

- Rent, mortgage, taxes or utilities on your business if it operates out of your home (unless these costs are separate from the costs of your home);
- Cost of goods you buy for the business but use yourself;
- Net business loss from a prior period; and
- Depreciation.

If you are in doubt, bring proof of the expense and ask your caseworker.

Income includes money from sales, cash receipts, crops, commissions, leases, fees, or whatever you do or sell for money. If you have any other kind of income from your business, list that income and the dates that income was received.

Who must sign. The form must be signed by the applicant, spouse or authorized representative. Any person may help you complete the form, but that person must also sign and date the form. Ask your caseworker if anyone else needs to sign the form.

With a few exceptions, you have the right to request and be informed about the information that the county obtains about you. You are entitled to receive and review the information upon request. You also have the right to ask the county to correct information that is determined to be incorrect (Government Code, Sections 552.021, 552.023, 559.004). To find out about your information and your right to request correction, please contact your local county office.

ZERO INCOME DECLARATION

I, _____, have had no source of income since _____.
(Applicant's Printed Name) (Date)

1. **Date of Last Employment**: _____
2. **Place of Last Employment**: _____
3. **Reason for Leaving**: _____

4. **Have you received public assistance within the last year**? ☐ Yes ☐ No

   If YES, from whom? _____

5. **Explain how your basic necessities have been provided**:

   A. Food: _____

   B. Non-food items (clothing, personal items, etc.):

   _____

   _____

   _____

   C. Shelter (rent / house payment):

   _____

   _____

   D. Electricity: _____

   E. Heating: _____

   F. Transportation: _____

I certify that the information contained in this declaration is accurate and true to the best of my knowledge.

_____ _____
Applicant's Signature Date

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Assistance Verification Statement

We need to verify the amount of assistance you provide to _____.
(Applicant's Printed Name)

I, _____ provide assistance to the applicant listed above.
(Printed name of person helping)

Please Check:

☐ Giving money to the client:

Date: _____ Amount: _____ Date: _____ Amount:_____

Date: _____ Amount:_____ Date: _____ Amount:_____

☐ Paying bills directly to: _____

_____

_____
(Name of person or company money goes)

☐ Providing: _____

_____

_____

What do you plan to provide for this person in the future? _____

_____

I understand that providing false information can result in a fine or jail term for tampering with Government records. I certify that the above is correct.

Your Signature: _____ Date: _____

Your Address: _____

Phone Number: _____ Email Address: _____

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Social Security / Medicaid Information

1. Have you applied for any type of Social Security benefits at the Social Security office?

   ☐ **YES** ☐ **NO**

2. If yes, approximately when did you apply? _____ / _____ / _____
   a. What type of benefits do you want from Social Security?

   _____

3. Have you received a letter from Social Security since you applied?

   ☐ **YES** ☐ **NO**

4. If YES, were you:

   ☐ **APPROVED** ☐ **DENIED**

5. If you were denied, did you submit an appeal or reapply within sixty (60) days?

   ☐ **YES** ☐ **NO**

6. What is the approximate date that you appealed or reapplied? _____ / _____ / _____

_____ _____
Applicant's Signature Date

_____
Applicant's Printed Name

Form 3076
January 2020-E

TEXAS Health and Human Services

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:

☐ 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

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice, please contact: Ivy Byram by calling 325-854-5805.

EFFECTIVE DATE

This Notice of Privacy Practices becomes effective on April 14, 2004.

OUR RESPONSIBILITIES

We are required by law to maintain the privacy of protected health information and to provide participants in the Callahan County Indigent Health Care Program (CCIHCP) with notice of our legal duties and privacy practices with respect to protected health information. This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. If we make a material change to our Notice, we will mail a revised Notice to the address that we have on record for you.

Primary Uses and Disclosures of Protected Health Information

The following is a description of how we are most likely to use and/or disclose your PHI.

- *Treatment, Payment, and Health Care Operations*
  We have the right to use and disclose your PHI for all activities that are included within the definitions of "treatment," "payment" and "health care operations" as set out in the HIPAA Privacy Rule (45 CFR parts 160 and 164).

- *Treatment*
  We may use and disclose your PHI for treatment purposes, such as coordinating or managing health care and related services by one or more of your health care providers.

- *Payment*
  We will use or disclose your PHI to pay claims for services provided to you or to otherwise fulfill our responsibilities for coverage and providing benefits. For example, we may disclose your PHI when a provider requests information regarding your eligibility for coverage under the CCIHCP, or we may use your information to determine if a treatment that you received was medically necessary. Other payment purposes include, but are not limited to, pre-authorizations, utilization review activities, coordination of benefits, and subrogation.

- *Health Care Operations*
  We will use or disclose your PHI to support our business functions. These functions include but are not limited to: quality assessment and improvement, reviewing provider and vendor performance, licensing, and business planning. For example, we may use or disclose your PHI: (1) to respond to a customer service inquiry from you; or (3) in connection with fraud and abuse detection and compliance programs. Health care operations may also include, but are not limited to, case management, legal reviews, handling appeals and grievances, plan or claims audits, and other general administrative activities.

- *Business Associates*
  We may contract with individuals and entities (Business Associates) to perform various functions on our behalf or to provide certain types of services. To perform these functions or to provide the services, our Business Associates may receive, create, maintain, use, or disclose PHI, but only after we require the Business Associates to agree in writing to contract terms designed to appropriately safeguard your information. For example, we may disclose your PHI to a Business Associate to administer claims or to provide service support, utilization management, subrogation, or pharmacy benefit management.

  In the event a Business Associate is a "health care component" as designated by our governing body, no written agreement regarding the safeguarding of your information is required by law, and we will not enter into such an agreement with those health care components.

- *Other Covered Entities*
  We may use or disclose your PHI to assist health care providers in connection with their treatment or payment activities, or to assist other covered entities in connection with payment activities and certain health care operations. For example, we may disclose your PHI to a health care provider when needed by the provider to render treatment to you, and we may disclose PHI to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities, or accreditation, certification, licensing, or credentialing. This also means that we may disclose or share your PHI with other insurance carriers or governmental programs providing or paying for health care in order to coordinate benefits if you or your family members have coverage through such other carrier or governmental program.

- *Plan Sponsor*
  We may disclose your PHI to the County for purposes of plan administration or pursuant to an authorization request signed by you.

Other Possible Uses and Disclosures of Protected Health Information

The following is a description of other possible ways in which we may, and are permitted to, use and/or disclose your PHI.

- *Required by Law*
  We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. If required by law, you will be notified of any such uses or disclosures.

- *Public Health Activities*
  We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury, or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

- *Health Oversight Activities*
  We may disclose your PHI to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee: (1) the health care system; (2) government benefit programs; (3) other government regulatory programs; and (4) compliance with civil rights laws.

- *Abuse or Neglect*
  We may disclose your protected health information to a public health authority or other government authority that is authorized by law to receive reports of child abuse or neglect. In addition, if we believe that you have been a victim of abuse, neglect, or domestic violence we may disclose your protected health information to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

- *Legal Proceedings*
  We may disclose your PHI: (1) in the course of any judicial or administrative proceeding; (2) in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized); and (3) in response to a subpoena, a discovery request, or other lawful process, once we have met all administrative requirements of the HIPAA Privacy Rule. For example, we may disclose your PHI in response to a subpoena for such information, but only after we first meet certain conditions required by the HIPAA Privacy Rule.

- *Law Enforcement*
  Under certain conditions, we also may disclose your PHI to law enforcement officials. For example, some of the reasons for such a disclosure may include, but not be limited to: (1) it is required by law or some other legal process; (2) it is necessary to locate or identify a suspect, fugitive, material witness, or missing person; and (3) it is necessary to provide evidence of a crime that occurred on our premises.

- *Coroners, Medical Examiners, Funeral Directors, and Organ Donation*
  We may disclose PHI to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We also may disclose, as authorized by law, information to funeral directors so that they may carry out their duties. Further, we may disclose PHI to organizations that handle organ, eye, or tissue donation and transplantation.

- *Research*
  We may disclose your PHI to researchers when an institutional review board or privacy board has: (1) reviewed the research proposal and established protocols to ensure the privacy of the information; and (2) approved the research.

- *To Prevent a Serious Threat to Health or Safety*
  Consistent with applicable federal and state laws, we may disclose your PHI if we believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We also may disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

- *Military Activity and National Security, Protective Services*
  Under certain conditions, we may disclose your PHI if you are, or were, Armed Forces personnel for activities deemed necessary by appropriate military command authorities. If you are a member of a foreign military service, we may disclose, in certain circumstances, your information to the foreign military authority. We also may disclose your PHI to authorized federal officials for conducting national security and intelligence activities, and for the protection of the President, other authorized persons, or heads of state.

- *Inmates*
  If you are an inmate of a correctional institution, we may disclose your PHI to the correctional institution or to a law enforcement official for: (1) the institution to provide health care to you; (2) your health and safety and the health and safety of others; or (3) the safety and security of the correctional institution.

- *Workers' Compensation*
  We may disclose your PHI to comply with Workers' Compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

- *Others Involved in Your Health Care*
  Using our best judgment, we may make your PHI known to a family member, other relative, close personal friend or other personal representative that you identify. Such a use will be based on how involved the person is in your care, or payment that relates to your care. We may release information to parents or guardians, if allowed by law.

We also may disclose your information to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.

If you are not present or able to agree to these disclosures of your PHI, then, using our professional judgment, we may determine whether the disclosure is in your best interest.

Required Disclosures of Your Protected Health Information

The following is a description of disclosures that we are required by law to make.

- *Disclosures to the Secretary of the U.S. Department of Health and Human Services*
  We are required to disclose your PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA Privacy Rule.

- *Disclosures to You*
  We are required to disclose to you most of your PHI in a "designated record set" when you request access to this information. Generally, a "designated record set" contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. We also are required to provide, upon your request, an accounting of most disclosures of your PHI that are for reasons other than treatment, payment, and health care operations and are not disclosed through a signed authorization.

  We will disclose your PHI to an individual who has been designated by you as your personal representative and who has qualified for such designation in accordance with relevant Texas law. However, before we disclose PHI to such a person, you must submit a written notice of his/her designation, along with the documentation that supports his/her qualification (such as a power of attorney).

  Even if you designate a personal representative, the HIPAA Privacy Rule permits us to elect not to treat the person as your personal representative if we have a reasonable belief that: (1) you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; (2) treating such person as your personal representative could endanger you; or (3) we determine, in the exercise of our professional judgment, that it is not in your best interest to treat the person as your personal representative.

Other Uses and Disclosures of Your Protected Health Information

Other uses and disclosures of your PHI that are not described above will be made only with your written authorization. If you provide us with such an authorization, you may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of PHI. However, the revocation will not be effective for information that we already have used or disclosed, relying on the authorization.

YOUR RIGHTS

The following is a description of your rights with respect to your PHI and a brief description of how you may exercise these rights.

- *You have the right to request a restriction of your protected health information.*
  This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

  We are not required to agree to a restriction that you may request. If we believe it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If we agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your health care provider. You may request a restriction by completing a "Restriction of use and Disclosures Request Form," which you may obtain from our Contact Person designated in this Notice.

- *You have the right to request to receive confidential communications from us by alternative means or at an alternative location*.
  We will accommodate reasonable requests, but only if you state that disclosure of all or part of the communications in a manner inconsistent with your instructions would put you in danger. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Contact Person designated in this Notice.

- *You have the right to inspect and copy your protected health information.*
  This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that we use for making decisions about you.

  Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to any law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. Please contact our Contact Person designated in this Notice if you have questions about access to your medical record.

- *You may have the right to have us amend your protected health information.*
  This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. Requests for amendment must be in writing and must provide a reason to support each requested amendment. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Contact Person designated in this Notice if you have questions about amending your protected health information.

- *You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.*

This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, for notification purposes, and for other purposes, as permitted by law. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2004, and during the six years prior to your request. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions, and limitations.

- *You have the right to obtain a paper copy of this notice from us upon request*,
  Even if you have agreed to accept this notice electronically.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying the person named below of your complaint. We will not retaliate against you for filing a complaint.

For further information about the complaint process, or to file a complaint, contact:

Nicki Harle, County Judge
100 West 4th Street, Suite 200
Baird, Texas 79504
Phone: 325-854-5805
Fax: 325-854-5806

For further information about filing a complaint with the Secretary of Health and Human Servers, or to file a complaint, contact:

U.S. Department of Health and Human Services, Office for Civil Rights
Medical Privacy, Complaint Division
200 Independence Avenue, SW
HHH Building, Room 509H
Washington, D.C. 20201
Phone: 866-627-7748
TTY: 886-788-4989

"I have hereby read the Notice of Privacy Practices for the Callahan County Indigent Health Program."

_____
Applicant's Printed Name

_____ _____
Applicant's Signature **Date**

Callahan County Indigent Health Care

Ivy Byram, IHC Director

Mailing Address 100 W. 4th St. Ste. 200 Baird, TX 79504
Physical Address: 1257 FM 2047 Baird, TX 79504
Phone: 325.854.5805, Fax: 325.854.5806
Email: ivy.byram@callahancounty.org

Fraud Policy

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

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

1. All cases of suspected fraud shall be investigated. Evidence shall be collected and documented.
2. The client shall be notified of the allegation of fraud and of a scheduled administrative hearing via certified mail. The IHC staff must disclose any evidence used to prove its' allegation, so that the client has an opportunity to dispute it.
3. Members of the Administrative Hearing Committee shall conduct the hearing. If the client does not appear at the administrative hearing, they may proceed if proof of notice is present. The committee must make a decision within ninety days of the hearing.
4. Upon a finding of fraud, the client shall be administratively ineligible from IHC as follows:

    - First offense: 12 months ineligibility from the date of the administrative decision.
    - Second offense: Permanently Ineligible for IHC

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

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

_____ _____

Applicant's Signature Date

Callahan County Indigent Health Care

Ivy Byram, IHC Director

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Physical Address: 1257 FM 2047 Baird, TX 79504
Phone: 325.854.5805, Fax: 325.854.5806
Email: ivy.byram@callahancounty.org

Client Responsibilities

I understand that, as a client of IHC (the Indigent Health Care Program), I must:

- Report to the IHC Coordinator in less than 14 days if my income changes, if I move, or if there are new members in my household (such as getting married, a child or spouse moving back with me). Any new job, new income, or money received must be reported. If I don't report a change that disqualifies me for services, I will have to pay for those services or I could face legal charges.
- Report if I apply for Social Security Disability, or if there are any changes in my SSI or SSDI case.
- See my regular doctor for non-emergency situations.
- I will use the emergency room only for true emergencies, otherwise I will pay a $20.00 co-pay for non-emergency visits to the emergency room.
- Always call ahead to make an appointment with my doctor and follow the doctor's orders.
- I will take my medicine as instructed.
- I will follow recommended diets and restrictions (i.e., no smoking, tobacco products, or alcohol).
- Carry my orange eligibility card when I go to the doctor, hospital, or pharmacy. I may not get services if I don't show my card.
- Call the IHC Coordinator to arrange for a replacement if I lose my eligibility card.
- I must call the IHC Coordinator and request to reapply 2 weeks prior to the end of my eligibility.
- Get my prescriptions at United pharmacy in Clyde. I understand that the program will pay for only 3 prescriptions each calendar month, 30-day supply only. Some drugs are restricted. Generics will be given if available.
- If I receive any bills, I will tell the doctor, hospital, or pharmacy to send the claims to Callahan County IHC immediately. All charges must be billed on an approved medical claim form.

I also understand that:

- Claims for medical services provided outside of the State of Texas will not be paid by Callahan County IHC, unless prior arrangements have been made and services pre-approved by the program administrators
- Callahan County IHC does not pay for treatment of, or hospital confinements for, drug or alcohol abuse or overdose. Self-inflicted injuries or abuse are also not covered.
- Callahan County IHC program does **NOT** pay for: medicines you can buy without a prescription, restricted drugs (pain, psychiatric, lifestyle), ambulance services, major dental, vision, prenatal care, and immunizations available at the State Health clinics.
- The program will cover up to $30,000 in medical bills, or up to 30 days in the hospital each fiscal year (September 1 through August 31)—whichever comes first.

I have read (or the above information has been read to me) and my questions have been answered.
I understand and agree to what is stated here.

Applicant' Signature Date Witness' Signature Date