FANNIN COUNTY INDIGENT HEALTH CARE PROGRAM

Physical: 200 E 1st Street, Bonham, TX 75418
Mailing: 101 E Sam Rayburn Drive, Bonham, TX 75418

The Fannin County Indigent Health Care Program assists qualified applicants in paying for basic healthcare on a short-term basis. Eligibility is based on Residency, Household, Income and Resources. Below you will find a list of documents that you will be required to provide, if applicable, for you and your household. Call 903-583-2915 if you have questions and to request an appointment. Bring your application and the following documents with you to your appointment.

CALL 903-583-2915 FOR AN APPOINTMENT

- TX DL or TX ID and Social Security Card for all members of the household.
- Final Divorce Decree.
- A current Medicaid Denial Notice for you, if you share custody or are responsible for a minor child and Medicaid Card for all Medicaid eligible members of the household. Custody Order if someone else has custody of your child.
- Envelope addressed to you at your current physical address postmarked within the last 30 days, or a lease agreement, or current utility bill that shows your physical address, this may be in another household member's name. Post Office Box addresses are not acceptable.
- Proof of your household income for the current month and three months prior: Form 128 completed by employer/former employer, or if self employed Form 149 Statement of Self Employment for current month and 11 months prior complete with supporting documentation, if not working Unemployment Award/Denial of benefits. Proof of any other money received by any member of the household and proof of child support received.
- Auto registration for all vehicles listed on the application with statement from lien holder stating amount still owed, or copy of the title.
- Proof of value of any property owned.
- Last 3 months Checking/Savings/Retirement account statements.
- Notice of Application, Denials and Appeals if you have applied for or you are appealing SSI/RSDI. If age 62 or older Notice of Award of Benefits from Social Security Administration.
- Notice of Award or Denial for any assistance you receive or have applied for from Social Services or Charity Organizations i.e., County Indigent Health Care Program, Crime Victims Compensation, Food Stamps, Salvation Army, Texas Dept of Rehabilitative Services, Veterans Benefits, Women's Medicaid Program or Worker's Compensation Program.

FAILURE TO PROVIDE ALL REQUESTED
DOCUMENTATION WILL DELAY THE DETERMINATION PROCESS

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.

TEXAS
Health and Human Services

Form 3076
January 2020-E

County Indigent Health Care Program (CIHCP)

Case Record Information Release

Case Record Name:	Case Record No.

I do hereby authorize persons, organizations or establishments having information or records concerning me/us or my/our circumstances, to furnish such information to a representative of the County Indigent Health Care Program. I hereby grant permission for the CIHCP to obtain information which may have a bearing on my/our eligibility for assistance. This release form is valid for six months after the date signed.

Person or Agency to Whom Information will be Released:

☐ 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

FCIHC ASSISTANCE VERIFICATION STATEMENT

This form should be completed by any person providing support to the applicant.

APPLICANTS NAME: _____

Have you given money to the applicant? (Please Circle) YES NO

If yes, however small, please note the dates and amounts below.

Date	Amount	Date	Amount	Date	Amount	Date	Amount
Date	Amount	Date	Amount	Date	Amount	Date	Amount

Have you loaned money to the applicant? (Please Circle) YES NO

If yes, please note the dates and amounts, however small below.

Date	Amount	Date	Amount	Date	Amount

Have you paid any bills directly for the applicant? (Please Circle) YES NO

If yes, please list below:

Amount Paid	Company Paid	Date Paid
Amount Paid	Company Paid	Date Paid

Are you currently providing food for the applicant? (Please Circle) YES NO

Is the applicant currently living with you? (Please Circle) YES NO

If Yes, Name and address of person applicant lives with _____

_____

Does the applicant pay you rent? (Please Circle) YES NO

Do you provide the applicant a place to live other than in your home? (Please Circle) YES NO

If Yes, What are the living arrangements? _____

_____

Does the applicant have children staying with them? (Please Circle) YES NO

I help support the above named applicant and I certify that the above information is correct to the best of my knowledge and that the above named applicant (please check one)

☐ Does not have any income or ☐ Does have income.

I understand that providing false information can result in a fine or possible imprisonment.

_____ _____

Signature of person providing support Date

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.

TEXAS
Health and Human Services

Form 3085
January 2020-E

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.