Falls County Indigent Health

Name: _____ Date: _____

Marital Status:

- Married
- Single
- Widowed
- Separated
- Divorced (Provide a copy of Final Decree of Divorce – all pages)

Supporting Documents

- All checking account statements (*Applicant/Spouse: Individual/Joint: for the past 90 days*)
- All savings account statements (*Applicant/Spouse: Individual/Joint: for the past 90 days*)
- Paycheck stubs or Employer Earnings Statements (*90 days*)
- Unemployment Compensation award or Denial letter (*Applicant / Spouse*)
- Proof of Registration from The Texas Workforce Commission (*if unemployed/ under 60yrs*)
- Worker's Compensation award letter or Denial letter (*Applicant / Spouse*)
- Social Security award letter or Denial letter (*Applicant / Spouse*)
- Verification of Benefits: ○ *Adult Medicaid* ○ *TANF* ○ *Food Stamps/SNAP* ○ *Children's Medicaid*
- Verification of Veterans Benefits (*Applicant / Spouse*)
- Automobile Registration/ Title (*if vehicle(s) are in Applicant/Spouse's name*)
- Current Balance owed on vehicle(s) and current mileage _____
- Verification of any retirement plans, payments or funds
- Verification of Residence: ○ *Lease Agreement* ○ *Mortgage Info* ○ *Tax Statement*
- Current Mail (*Addressed to you at your physical address, no older than 30 days of app*)
- Social Security Card (*copies for anyone listed on question 1 of application*)

- Texas Driver's License or Texas Identification Card (*must show current address*)
- Certificate of Deposit
- Insurance Settlement
- Lawsuit Settlements
- Livestock
- Lump Sum Payments
- Prepaid Burial Insurance

**Please review and bring any information that pertains to you. Such as if you are married all information for you and your spouse must be included. If you are separated there must be a legal separation agreement to prove you are separated. Current paperwork must be submitted if you have filed for disability.

The last page of the application is an affidavit of income and support and must be notarized by the person supporting you. Applications will no longer be processed until all paperwork is complete. After completing, please call for an appointment.

Thank you,

Falls County Indigent Healthcare Coordinator

Falls County Indigent Health Care
P.O. Box 60
Marlin, Texas 76661
Phone #: (254) 803-3561 ext. 2374

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.

VERIFICATION OF INCOME

NAME: _____ DATE: _____

PLEASE CHECK YES OR NO TO EACH TYPE OF INCOME

DO YOU RECEIVE ANY OF THE FOLLOWING?

UNEMPLOYMENT BENEFITS ○ YES ○ NO

RSDI ○ YES ○ NO

(SOCIAL SECURITY CHECK)

SSI ○ YES ○ NO

(SUPPLIMENTAL SOCIAL SECURITY CHECKS)

PENSIONS ○ YES ○ NO

VA/MILITARY ○ YES ○ NO

CASH CONTRIBUTIONS ○ YES ○ NO

(MONEY FROM FAMILY OR FRIENDS)

WORKMAN'S COMPENSATION ○ YES ○ NO

CHILD SUPPORT ○ YES ○ NO

WAGES ○ YES ○ NO

(MONEY EARNED FROM WORKING)

SELF – EMPLOYMENT ○ YES ○ NO

(WORKING FOR YOURSELF)

ODD JOBS ○ YES ○ NO

(LAWN MOWING, HOUSEKEEPING, BABY SITTING, PICKING UP CANS FOR MONEY)

MEDICAL QUESTIONNAIRE

_____ _____
Applicant Name Date of Birth

1.) What is your primary health concern at this time? _____

_____

2.) Please list all other ongoing health issues of diagnosis: _____

_____

3.) Were you referred to our office by another facility? ○ YES ○ NO

If yes, what facility? _____

4.) Do you have any unpaid medical bills within the past 90 days? ○ YES ○ NO

If yes, please complete the following information:

_____ _____ _____
Facility (Hospital) Admit Date Discharge Date

a) Were you taken by ambulance to the hospital
b) Are you currently a Lifepath Systems (MHMR) client?
c) Are you currently on the Northstar Program?
d) Are you currently receiving assistance through DARS?
e) Do you have a primary physician?

If yes, complete the following information:

_____ _____
Office Name Physician's Name

Please list all medications you are currently taking: (If you need extra space, please use the back of this form)

_____

_____

_____

_____

_____

_____ _____
Applicant Signature Date

CONTACT LIST

Applicant Name _____

I give the persons listed below permission to speak to CCIHP staff to verify the information I have provided on my application (please list at least two (2) persons.)

1.) _____ _____
NAME RELATIONSHIP TO APPLICANT

_____ _____
ADDRESS EMAIL ADDRESS

_____ _____
CITY STATE ZIP CODE TELPHONE #

2.) _____ _____
NAME RELATIONSHIP TO APPLICANT

_____ _____
ADDRESS EMAIL ADDRESS

_____ _____
CITY STATE ZIP CODE TELPHONE #

EMERGENCY CONTACT

PLEASE PROVIDE THE NAME AND ADDRESS OF A RELATIVE OR FRIEND WE MAY CONTACT IN CASE OF AN EMERGENCY

_____ _____
NAME RELATIONSHIP TO APPLICANT

_____ _____
ADDRESS EMAIL ADDRESS

_____ _____
CITY STATE ZIP CODE TELPHONE #

_____ _____
Applicant Signature Date

This form is required to be completed and notarized even if you are supporting yourself

AFFIDAVIT OF INCOME AND SUPPORT/AFFIDAVIT OF SELF SUPPORT

○ ***Check this box if you are supporting yourself.***

This affidavit is made by me, _____ for the purpose of assuring The Falls County Indigent Healthcare Program that _____
(Applicant name)

- ○ *Lives with me at* _____
- ○ *Does not live with me at*_____

1.) I help support this person and affirm that he/she:

○ ***Does not have an income*** ○ ***Does have an Income***

2.) I affirm that I currently support the applicant ***financially and/or provide the applicant with a place to live***. I affirm that Falls County Indigent Healthcare Program representative has explained this affidavit of income and support to either the applicant or myself and that I have been/will be given the opportunity to ask questions about this form. I understand that if a change occurs that makes the applicant ineligible for FCIHCP services and I fail to report changes as required, I may be held responsible for payment of any medical services that the applicant received after becoming ineligible and/or I may be subject to prosecution under the Texas Penal Code.

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

_____

Signature of Person providing support Date Relationship to applicant

_____

Witness Signature Date

Subscribed and sworn to (affirmed) before me this _____day of _____, _____
Day Month Year

at _____ Notary Public in and for the State of Texas.
Place of Notary

My Commission expires on _____.
MM/DD/YYYY

_____
Notary Signature

(NOTARY MUST SIGN AND STAMP THIS PAGE)