601 N 13th Street Corsicana, Tx 75110

NAVARRO COUNTY INDIGENT HEALTH CARE PROGRAM

Please make sure to return this application.

You can drop it off by the office, mail or fax.

Phone: (903) 875-3349 & (903) 875-3348

Brianna Caldwell – Indigent Healthcare Coordinator

Julieta Herrera- Indigent Healthcare Assistant Coordinator

bcaldwell@navarrocounty.org

jherrera@navarrocounty.org

REQUIRED DOCUMENTS:

Photo ID

Proof of Residency

Proof of Income

If you have any questions don't hesitate to contact our office.

We are here to help you!

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

Please return the items checked above by the time you return your application..

A decision about your eligibility will be made no later than 14 days after your application is completed, including all requested information. If we do not receive the information and you do not contact me, I assume that you do not want assistance. Call me if you have any questions.

Brianna Caldwell
Staff Signature

903 875 3348
Area Code and Phone No.

Julieta Herrera

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.

NAVARRO COUNTY INDIGENT HEALTH CARE

(SUPPLEMENTAL APPLICATION)

1. MARITAL STATUS (choose one below):

   __Single __Married __Divorced __Separated __Widow(er)__Common Law

2. EMPLOYMENT
   - I currently work: YES___ NO___ My employer is:_____
   - The date of my last employment was:_____ My employer was:_____
   - I am self-employed/have my own business: YES____ NO____
   - I filed Federal Income Taxes: YES____ NO____

3. UNEMPLOYMENT BENEFITS
   - I RECEIVE Unemployment Insurance Benefits (UIB): YES___ NO___ if not, why?

     _____

4. WORKERS' COMPENSATION
   - . Have you filed for Workers' Compensation: YES____ NO____

5. SOCIAL SECURITY (SS) BENEFITS
   - I am receiving Social Security (SSI) benefits: YES____ NO____
   - I have applied for SS/Disability benefits: YES____ NO____
     - If denied, have you appealed the decision? YES___ NO___
     - Do you have a hearing date? YES___(what date_____) NO___

6. VETERAN BENEFITS
   - I am a Veteran of the US Armed Services: YES____ NO____
   - I am a Veteran and receive Veterans benefits: YES____ NO____

7. FINANCIAL ASSISTANCE
   - I receive money to help me: YES____ NO____
   - My bills are paid by individuals/organizations: YES____ NO____
   - I receive assistance of any kind: YES____ NO____

- I have applied for Food Stamps (SNAP): YES____ NO____
- I receive Food Stamps (SNAP): YES____ NO____
- I, or any household members, receive child support payments: YES___ NO___

Briefly explain your current medical problem(s). Be sure to include ***ALL*** diagnoses, (approximate) diagnosis dates, and plan of care.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

My responses to the above questions are true and correct. I understand that failure to provide true and correct statements will be considered fraudulent and will affect my ability to be approved for Navarro County Indigent Health Care.

Print Your Name:_____

Your Signature:_____

Date:__/__/__

Navarro County Indigent Health Care

Assistance Verification Statement

We need to verify the amount of assistance you provide to _____ and how that assistance is given.

I, _____ provide assistance by:

Please check all that apply:

___ **GIVE MONEY TO CLIENT**

DATE _____ AMOUNT _____ DATE _____ AMOUNT _____

DATE _____ AMOUNT _____ DATE _____ AMOUNT _____

DATE _____ AMOUNT _____ DATE _____ AMOUNT _____

___ **PAY BILLS DIRECTLY TO VENDORS**

NAME OF PERSON OR COMPANY	DATE	AMOUNT
_____	_____	_____
_____	_____	_____
_____	_____	_____

___ **HAVE BEEN PROVIDING FOOD, SHELTER, TRANSPORTATION, PERSONAL ITEMS AND/OR HOUSEHOLD NEEDS, ECT. IF CHECKED WHAT WAS PROVIDED AND WHICH MONTHS?**

_____ _____

_____ _____

_____ _____

Do you plan to continue this support? _____

If so, for how long? _____

I CERTIFY THE ABOVE INFORMATION IS CORRECT.

YOUR SIGNATURE: _____
PRINT YOUR NAME: _____
YOUR ADDRESS: _____
YOUR PHONE NUMBER: _____
YOUR RELATIONSHIP TO THE CLIENT: _____

Navarro County Indigent Healthcare Fraud Policy

Sec. 61.043 requires a county to adopt reasonable procedures for minimizing the opportunity for fraud. Navarro County adopts the following policy:

Providing false or misleading information will be considered fraud, if it is determined that fraud exists, the individual will be denied future eligibility and will be required to reimburse the county for all money paid out for claims.

Such cases will be reported to the Navarro County Auditor's and District attorney's office for further investigation and/or prosecution.

Acknowledgement of Policy:

I hereby understand that by signing this form, I acknowledge that I have received a copy of Navarro County Indigent Healthcare Policy.

Signature: _____

Date: _____

Release of Information

In order to eliminate fraud, it is Navarro County Indigent's policy to investigate and verify information *with regards to processing your application for Navarro County Indigent Healthcare.*

I authorize the release of any requested information by the following listed agencies, entities or individuals for the purpose of processing my application for Navarro County Indigent Healthcare. This release also authorizes Navarro County Healthcare representatives to request verification of information I have provided on my application for Indigent Healthcare.

- The State of Texas and any department or subdivision of The State of Texas, including but not limited to the following:
  - ✓ Texas Department of State Health Services
  - ✓ Texas Department of Health and Human Services
  - ✓ Texas Attorney General
  - ✓ Department of Family and Protective Services
  - ✓ Texas Workforce Commission
  - ✓ Texas Department of Insurance, Division of Worker's Compensation

- The County of Navarro and any department or subdivision of The County of Navarro, including but not limited to the following:
  - ✓ Navarro County Community Supervision and Corrections
  - ✓ Navarro County Sherriff's Office
  - ✓ Navarro County Clerk's Office
  - ✓ Navarro County District Clerk's Office
  - ✓ Navarro County Tax Office

- Veteran's Administration
- Social Security Administration
- Internal Revenue Services
- Any medical facility
- Any insurance carrier
- Any charity organization

Signature: _____

Date: _____

NAVARRO COUNTY INDIGENT HEALTH CARE PROGRAM

I UNDERSTAND THAT, AS A CLIENT OF IHC (INDIGENT HEALTH CARE PROGRAM)

- Report to IHC less than 14 days if my income changes, if I move, or if there are new members in my household. 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.
- Go only to my primary care physician unless he/she refers me to a specialist and the referral has been approved by the program. I understand that seeing a specialist on my own will result in my being responsible for those charges.
- See my primary care physician for non-emergency situations.
- I will use the emergency room only for true emergencies.
- 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, illegal drugs or alcohol.
- I understand the program will pay for only 3 prescriptions each calendar month, 30 days' supply only. Some drugs are restricted and generic drugs are recommended.
- Claims for medical services provided outside the State of Texas will not be paid by Navarro County Indigent Health.
- Navarro County 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.
- Navarro County IHC does NOT pay for: medicines that can be purchased without a prescription, restricted drugs (paid, psychiatric, lifestyle), ambulance services (unless it's a transfer from Navarro Regional), dental, vision, prenatal care and immunizations available at Texas Department of State Health Services.
- The program will cover up to $30,000 in medical bills OR up to 30 days in the hospital each fiscal year, whichever comes first.

I have read the above information and given the opportunity to ask questions. I understand and agree to what is stated above.

_____ _____

Signature Date Witness Date

Indigent Healthcare Behavioral Policy

- You are required to comply with all State, County and Medical provider policies and guidelines to receive services through the Navarro County Indigent Healthcare Program.
- You are required to comply with all behavioral guidelines established by the State of Texas, Navarro County, Your PCP office, and any other provider with which you are referred.
- If you display disruptive or abusive language or behavior you may NOT receive services. Our staff will be protected from dangerous situations. Physical or combative confrontations are grounds for immediate suspension from the Navarro County Indigent Healthcare Program.
- You are expected to comply with the medical recommendations as set forth by your PCP and by any other provider to whom you are referred. Non-compliance may be grounds for suspensions from the Navarro County Indigent Healthcare Program.
- You are expected to give any providers (example: Navarro County Indigent Healthcare Coordinators, PCP, Specialists, Hospitals, Clinics & etc.) **AT LEAST** 48 hours advance notice when cancelling an appointment or if you are unable to keep the appointment. You will **NOT** be rescheduled for appointments when you have failed to keep two or more scheduled appointments. *Their time and ours is valuable, as is yours!*

I have read, understand, and agree to the provisions of the foregoing policy:

_____ __/__/__

Client Signature Date

_____ __/__/__

Navarro County Indigent Healthcare Program Staff Date

Navarro County Indigent Health Care Program

Work Registration / Job Search

State policy section 1, page 3:

An entity that chooses to establish an optional work registration procedure may contact its local Texas Workforce Commission office to determine how to establish the county procedure and negotiate what type of information can be provided. If a nonexempt applicant fails without good cause to comply with the work registration requirements, disqualify him from the County Indigent Health Care Program benefits as follows:

- 1 month for the first non-compliance
- 3 consecutive months for the second non-compliance
- 6 consecutive months for the third or subsequent non-compliance

Navarro County adopts the following policy:

If a nonexempt applicant fails without good cause to comply with the work registration requirements, he/she will be disqualified from the County Indigent Health Care Program for a period of 3 months. After 3 months the applicant could reapply. There are no increases in disqualification.

_____ _____

Signature Date

Work Registration Requirements

Navarro County, Texas has adopted the following as the Work Registration Policy for the Indigent Health Care Program.

General Provisions:

1. Failure to register and actively seek employment through the Texas Workforce Commission constitutes a program violation of the Indigent Health Care Program.
2. Persons are exempt from having to register and seek employment if they meet one of the following criteria:
    - Receive unemployment insurance benefits or have applied but not yet been notified of eligibility.
    - Physically or mentally unfit for employment, a statement from your primary care physician (Dr. Kent E. Rogers Clinic) is required.
    - Undocumented alien
    - Age 60 or older
    - Participates in an outpatient substance abuse treatment and rehabilitation program who are not allowed to seek employment while in treatment.
    - Full time student participating in a work study program.
    - Employed or self-employed 20 hours per week or receive earrings at 20 hours per week at federal minimum wage (20hours x $7.25).
3. Job searches must be within your experience and qualifications. Searches not within your qualifications will not be counted.

Consequences:

1. If a non-exempt applicant or CIHCP eligible resident fails without good cause to comply with the work registration requirements he/she will be disqualified from the County Indigent Health Care Program for a period of 3 months.
2. Persons deemed not disabled by Social Security Administration guidelines at the hearing level will be required to seek employment.
3. Terminating employment solely for the purpose of becoming eligible for Indigent Health Care may cause disqualification from the program for a period of 6 months.

Job searches will be randomly checked to validate our programs participation. I hereby acknowledge that I have read and understand the above information stated in this document.

_____ _____

Signature Date