MID COAST HEALTH SYSTEM
POLICY / PROCEDURE

SUBJECT: CHARITY CARE PROGRAM	DATE: 4/1/2018
APPLICABLE: EL CAMPO MEMORIAL HOSPITAL PALACIOS COMMUNITY MEDICAL CENTER MID COAST MEDICAL CENTER – CENTRAL MID COAST MEDICAL CENTER - BELLVILLE MID COAST MEDICAL CENTER – TRINITY MID COAST MEDICAL CENTER - CROCKETT	
APPROVAL: David H. Mak, CFO	REVISED: 1/1/2025

POLICY

All patients who cannot provide major medical insurance, Medicare, Medicaid, or other third party payment services and who request assistance through the Mid Coast Health System and its affiliated hospitals (Hospital); Charity Care Program (CCP) will be screened for their ability to pay charges. Also, those patients with insurance whose co-insurance amount is excessively high may apply under the same CCP guidelines as those with no insurance. Hospital reserves the right to refuse assistance for debts incurred due to drug and/or alcohol related diagnosis. The amount of charity applied to an account will be determined by the guidelines established through this policy. Charity care does not include private physician charges, tests performed by other facilities, or care provided in other hospitals. Charity care will always be a payer of last resort. A program will be established to monitor and verify all charity applications.

STATEMENT OF PURPOSE

As part of the Hospital's mission to serve the health care needs of our County, and as required to be a Medicare provider, Hospital will provide financial assistance to patients without financial means to pay for Hospital services.

Financial assistance will be provided to all qualifying patients who present themselves for care at Hospital without regard to race, religion, sexual orientation or national origin and who are classified as financially indigent or medically indigent according to this policy.

Hospital shall determine the ability of patients and/or legally responsible individuals to make payments for Hospital services taking into consideration the rights and human dignity of the individual. Every effort shall be made to stimulate an attitude of independence through encouraging the person to develop his or her own resources; however, prompt determination of need and supplying care and treatment is in the best interest of the patient's welfare.

The individual's right of self-determination dictates the retention of choice of whether or not he or she seeks financial assistance. Therefore, in all cases the request for aid and the proof of eligibility is the responsibility of the patient. Hospital will maintain the confidentiality of patient's financial and medical information.

This policy is intended as a guideline for determining eligibility of the individual and the charity responsibility of the Hospital. Because the policy addresses individuals in a healthcare environment, it may become necessary for the Hospital to make an exception or to override this policy. With appropriate documentation, the Hospital Administrator along with approval from the Chief Financial Officer may make exceptions in catastrophic cases.

DOCUMENTATION

1. Each patient applicant will be required to complete and sign the Charity Care Questionnaire and Application in forms similar to that attached as Exhibit A.

2. Data requiring verification to determine eligibility for Charity Care Program are in the areas of patient identification, income and patient or responsible party, debt and financial responsibilities, and the number of dependents in the family.

3. Identity may be established by producing any two (2) of the following:

   a. Social Security Card
   b. Driver's License
   c. Voter Registration
   d. Credit Card
   e. Employee Identification
   f. Birth Certificate
   g. Baptismal Record
   h. School Transcript
   i. Marriage License
   j. Medicaid or Medicare Card

4. The following sources must be included as income verification. Verification of these sources of income and amounts requires last year's IRS 1040 Form or W-2 or a statement from an employer. Check stubs may also be used to determine current income status.

   a. Wages and Salaries before deduction
   b. Self-Employment Income
   c. Farm Income
   d. Public Assistance
   e. Social Security
   f. Unemployment Benefits
   g. Worker's Compensation
   h. Strike Benefits
   i. Veteran's Benefits
   j. Child Support
   k. Pensions
   l. Annuities
   m. Income from Dividends
   n. Income from Interest
   o. Rents
   p. Royalties
   q. Income from Estates and Trusts

5. Proof of dependency is the responsibility of the applicant. Any person dependent on the family income for over 50% of his or her support may be considered a dependent. Dependency may be evidenced by any of the following:

    a. Current Income Tax 1040 and 1040A, listing dependents
    b. School Records
    c. Birth Records
    d. Hospital Records
    e. Baptismal Records
    f. Proof of Guardianship
    g. AFDC Records

6. Copies of all documents used for certification of identity, income and dependency will be attached to the Charity Care Questionnaire, and retained in Hospital's records.

7. When proof of identity, income and dependency have been established, the patient's financial qualifications will be established from the Charity Care formula, as attached at Exhibit C.

8. When it is established that the patient is to be either Charity or Partial Pay, the following processes will take place:

    a. Patient or guarantor will be required to either pay or sign a note and make arrangements to pay the obligations, if any.
    b. The balance of the account will be reduced if patient qualifies.
    c. If the patient qualifies under the CCP, then that determination will be effective for the next six (6) months from the date of determination.

ELIGIBILITY

1. Financially Indigent.

    a. A financially indigent patient is defined as a person who is uninsured or underinsured and is accepted for care with no obligation or a discounted obligation to pay for the services rendered based on the Hospital's eligibility criteria set forth in the policy.

    b. To be eligible for complete financial assistance as a financially indigent patient, a person's income shall be: (i) at or below 400 percent of the federal poverty guidelines; (ii) between 400 and 700 percent a sliding scale benefit is available; and (iii) for patients with income exceeds 700 percent of the poverty guidelines may be eligible to receive discounted rates or adjustments based on charity care provisions, based on a case by case basis on their specific circumstances the final determination of such shall be solely within the Hospital's discretion. The Hospital may consider other financial assets and liabilities of the person when determining eligibility.

c. The Hospital will use the most current poverty income guidelines issued by the U.S. Department of Health and Human Services to determine an individual's eligibility for charity care as a financially indigent patient. The poverty income guidelines are usually published in the *Federal Register* in February of each year and for purposes of this policy will become effective the first day of the month following the month of publication.

d. Other than as stated in Paragraph (b)(iii) in no event will the Hospital establish eligibility criteria for financially indigent patients which base the income level for financial assistance lower than that required for counties under the Texas Indigent Health Care and Treatment Act, or higher than 400 percent of the federal poverty guidelines. The Hospital may, however, adjust the eligibility criteria from time to time based on financial resources of the Hospital and as necessary to meet the financial assistance needs of the community.

2. Medically Indigent.

a. A medically indigent patient is defined as a person who's medical or hospital bills after payment by third-party payers exceed a specified percentage of the person's annual gross income as established in this policy and who is unable to pay the remaining bill.

b. To be eligible for financial assistance as a medically indigent patient, the amount due and owing by the patient on the Hospital bill after payment by third party payers must exceed 30 percent of the patient's annual gross income and the patient must be unable to pay the remaining bill. The Hospital may consider other financial assets and liabilities of the person when determining ability to pay. Hospital bills greater than 30 percent of annual income may be eligible for discount, subject to Hospital approval.

c. A determination of a patient's ability to pay the remainder of the bill will be based on whether the patient can reasonably be expected to pay the account in full over a three (3) year period.

d. If a determination is made that a patient has the ability to pay the remainder of the bill, such a determination does not prevent a reassessment of the patient's ability to pay at a later date.

3. Presumptive Financial Assistance Eligibility.

There are instances when a patient may appear eligible for charity care discounts, but there is no financial assistance form on file due to a lack of supporting documentation. Often there is adequate information provided by the patient or through other sources, which could provide sufficient evidence to provide the patient with charity care assistance. In the event there is no evidence to support a patient's eligibility for charity care, the Hospital could use outside agencies in determining estimate income amounts for the basis of determining charity care eligibility and potential discount amounts. Once determined, due to the inherent nature of the presumptive circumstances, the only discount that can be granted is a 100%

write off of the account balance. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:

1. State-funded prescription programs;

2. Homeless or received care from a homeless clinic;

3. Participation in Women, Infants and Children programs (WIC);

4. Food stamp eligibility;

5. Subsidized school lunch program eligibility;

6. Eligibility for other state or local assistance programs that are unfunded (e.g., Medicaid spend-down);

7. Low income/subsidized housing is provided as a valid address; and

8. Patient is deceased with no known estate.

9. Historical significance of non-payment that establishes a justification of future non-payment and lack of ability to pay.

4. Amount Generally Billed (AGB)

For those uninsured patients/individuals eligible for a discount, they will be responsible for paying no more than thirty (30%) of the total gross charges owed on their hospital bills. The AGB for Hospital is calculated by taking the average reimbursement as a percentage of the total claims allowed by Medicare and all private health insurers over the past fiscal year (Oct-Sept) that pay claims to the hospital.

Patients whose family exceeds 400% of the PFL may be eligible to receive discounted rates on a case-by-case basis based on their specific circumstances, such as catastrophic illness or medical indigence, at the discretion of Hospital; however the discounted rate shall not be greater that the amounts generally billed to commercially insured patients.

5. Relationship to Collection Polices.

Hospital management shall develop policies and procedures for internal and external collection practices. These collection practices include actions the hospital may take in the event of non-payment, including collections action and reporting to credit agencies. Additionally, these collection practices shall also take into account the extent to which the

patient qualifies for charity, patient's good faith effort to apply for a governmental program or for charity from Hospital, and a patient's good faith to comply with this or her payment agreements with Hospital. For patients who qualify for charity and who are cooperating good faith to resolve their discounted hospital bills, Hospital may offer extended payment plans, shall not send unpaid bills to outside collection agencies, and may cease all collection efforts. Hospital will not impose extraordinary collections actions such as wage garnishments; liens on primary residences, or other legal actions for any patient without first making reasonable efforts to determine whether that patient is eligible for charity care under this financial assistance policy. Reasonable efforts shall include.

1. Validating that the patient owes the unpaid bills and that all sources of third-party payment have been identified and billed by the hospital;
2. Documentation that Hospital has or has attempted to offer the patient the opportunity to apply for charity care pursuant to this policy and the at the patients has not complied with the hospital's application requirements;
3. Documentation that the patient does not quality for financial assistance on a presumptive basis;
4. Documentation that the patient has been offered a payment plan but has not honored the terms of that plan.

PROCEDURE

1. Identification of Financial Assistance Cases.

   a. The Hospital will post notice of its financial assistance program and how a patient may apply for financial assistance.

   b. The Hospital's Chief Financial Officer or a designee will attempt to identify all cases that will qualify as financially indigent cases at the time of Hospital admission. Patients identified as possible financial assistance cases will be offered to complete a financial assistance form (Exhibit A).

   c. The Hospital's Chief Financial Officer or designee will refer those patients who may qualify for financial assistance from a government program to the appropriate program (e.g. Medicaid). Patients who are eligible for Medicaid and other indigent health care programs do not qualify as financial indigent, but the unreimbursed costs of providing services to recipients of these programs shall be reported as government-sponsored indigent health care, by the Hospital.

   d. As soon sufficient information is available concerning the patient's financial resources and eligibility for government assistance, a determination will be made concerning the

patient's eligibility for financial assistance. No collection efforts will be pursued on a financial assistance account after such determination.

e. The current federal poverty income guidelines are included in this policy as Attachment C. This guideline is to be updated annually based on federal data. The definition of "family income" and "exclusions from income" are included in the poverty guidelines and will be used in all financial assistance eligibility determinations.

2. Failure to Provide Appropriate Information.

Failure to provide information necessary to complete a financial assessment may result in a negative determination; however, the account may be reconsidered upon Hospital receipt of the required information. A determination of eligibility for financial assistance may be made without a completed assessment form if the patient or information is not reasonably available and eligibility is warranted under the circumstances, subject to prior Hospital administrative approval.

3. Time Frame for Eligibility Determination.

A determination of eligibility will be made by the Hospital's Chief Financial Officer or his/her designee within ten (10) working days after receipt of information necessary to make a determination.

4. Approval of Financial Assistance.

Either the Hospital's Chief Financial Officer or designee shall approve or disapprove the financial assistance application. The patient will be notified in writing of the approval or denial. As a practical consideration, approval shall be valid for six (6) months from the date of determination. However, should information indicate the patient's financial resources have materially improved, the Chief Financial Officer or designee may require a new financial assistance application prior to the expiration of the normal six (6) month coverage.

5. Exclusions.

The Financial Assistance Policy does NOT COVER: cosmetic procedures, services provided by providers who are not employed by Mid Coast Health System and its affiliated hospitals, or providers who bill separately from the Hospital for their services (including Radiology; Pathology; Hospitalists; Emergency Room Physicians and Anesthesiologist).

EXHIBIT A

ELIGIBILITY ON OUR PROGRAMS DO NOT QUALIFY AS HAVING A QUALIFIED HEALTH INSURANCE PLAN

INSTRUCTIONS FOR INDIGENT / CHARITY HEALTH CARE APPLICATION

BEFORE YOUR APPLICATION WILL BE CONSIDERED, YOU WILL NEED TO PROVIDE THE FOLLOWING INFORMATION:

(1) Copy of last 6 (six) paycheck stubs for ALL household members.

(2) Copy of Current Income Tax Return (forms 1040) and All W-2's

(3) Copy of Current Utility Bill to verify your home address

(4) Current (West Wharton County) Driver's License or I.D. Card

(5) Social Security Card

(6) Birth Certificate

(7) Unemployment Award Letter

(8) Workman's Comp Award Letter

(9) Social Security Award Letters

(10) Food Stamp / TANF / Medicaid Award Letters and Copy of Medicaid/CHIPS Cards

(11) Copy of Current Checking / Savings Accounts Bank Statements (including IRA's, CD's, etc.) for ALL household members.

(12) Copy of all Vehicle Titles or Copy of Vehicle Loan contracts.

(13) Proof of All other household Income (Spouses' Income, Child Support, Odd Jobs, etc)

(14) Copies of all Current Health Insurance Cards

If you have any questions, please call . at (979) 578-5194.

ALL INFORMATION MUST BE CURRENT and SUBMITTED WITH THE APPLICATION

EXHIBIT B

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.: _____

EXHIBIT C

Medical Financial Assistance Discount (for 2025) Income Ranges)

	Sliding Scale Discount based on FPL					
	100%	80%	60%	40%	20%	0%
Family Size	Base Income Guidelines					
1	$ 62,600	$ 71,990	$ 81,380	$ 90,770	$ 100,160	$ 109,550
2	$ 84,600	$ 97,290	$ 109,980	$ 122,670	$ 135,360	$ 148,050
3	$ 106,600	$ 122,590	$ 138,580	$ 154,570	$ 170,560	$ 186,550
4	$ 128,600	$ 147,890	$ 167,180	$ 186,470	$ 205,760	$ 225,050
5	$ 150,600	$ 173,190	$ 195,780	$ 218,370	$ 240,960	$ 263,550
6	$ 172,600	$ 198,490	$ 224,380	$ 250,270	$ 276,160	$ 302,050
7	$ 194,600	$ 223,790	$ 252,980	$ 282,170	$ 311,360	$ 340,550
8	$ 216,600	$ 249,090	$ 281,580	$ 314,070	$ 346,560	$ 379,050
9	$ 238,600	$ 274,390	$ 310,180	$ 345,970	$ 381,760	$ 417,550

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.