



Documentation Requirements

*****In order to process your application, please bring the following documents as applicable to you and your household*****

Proof of Identification – Must provide *one* of the following:

- Driver's Licenses or State ID Card
- Government issued ID
- Passport
- Resident Card

Proof of Residence – must provide a *minimum of two* of the following:

- Property deed or tax statement
- Current utility bill with home address
- Voter registration card
- DL/ID with current address
- Lease agreement
- Landlord verification form

State benefits received – Must provide *all* award and/or denial letters for each household member:

- Medicare
- Medicaid
- SNAP
- TANF Assistance
- CHIP

Proof of assets and resources – Must provide resource documentation for *all* household members:

- Last 3 months of bank account statements (savings, checking, money markets, etc.)
- Title or Registration of vehicles, boats, RVs under household members
- Vehicle loan information showing current balance owed on vehicle
- Statements for CDs, IRAs, or other investment accounts
- Real Estate information for all property owned

Proof of all Household Income – Must provide income documentation for *all* household members

- 4 weeks of most recent, consecutive paystubs
- Self-employment (provide income tax returns or business records)
- Statement of Self-employment Income Form 3085
- Child Support – court orders or statement
- Unemployment award letter
- Current award letter for SSI, RSDI, VA, SSA, TANF
- Worker's Compensation
- Employer Verification Form 3084
- Pension/Retirement documents
- Proof of loans, gifts, or other contributions
- Any other income received by any household member

Social Security Number

- Provide for each household member

Application Materials

- Completed, signed, and dated Application
- Completed Supplemental Application
- Information Release Form
- Fraud Policy Form
- Behavioral Guidelines
- PHI Disclosure Form

Other Information (list here):

-
-
-
-
-

If any other information is required after your application and documentation is reviewed, you will be provided 14 days to submit the needed documentation. Failure to provide adequate documentation to prove program eligibility could result in denial of services. Anyone who knowingly misrepresents the truth in the completion of the program application will result in denial of services and /or criminal persecution.



County Indigent Health Care Program (CIHCP)
Application for Health Care Assistance

For Office Use Only

Status <input type="radio"/> Application <input type="radio"/> Review	Date Form 3064 Requested/Issued	Date Identifiable Form 3064 Received	Case Record No.	Appointment Date and Time, if applicable
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Name (Last, First, Middle)	Home Area Code and Phone No.	Other Area Code and Phone No.
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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
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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?
					<input type="radio"/> Yes <input type="radio"/> No
					<input type="radio"/> Yes <input type="radio"/> No
					<input type="radio"/> Yes <input type="radio"/> No
					<input type="radio"/> Yes <input type="radio"/> No
					<input type="radio"/> Yes <input type="radio"/> No
					<input type="radio"/> Yes <input type="radio"/> No
					<input type="radio"/> Yes <input type="radio"/> 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		-
2		-
3		-
4		-

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? _____

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.

Presidio-Brewster County Indigent Health Care Program Supplemental Application

Client Name:					County:	
Email address:			Phone number:		Citizenship:	
Marital Status:	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Separated	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed	<input type="checkbox"/> Common Law
Employment status:	<input type="checkbox"/> Employed	<input type="checkbox"/> Full Time	<input type="checkbox"/> Part Time	<input type="checkbox"/> Temporary	Primary Language:	
	<input type="checkbox"/> Unemployed					
Student Status:	<input type="checkbox"/> University/College, list name and place:					

How did you hear about the Presidio-Brewster County Indigent Health Program?

Provide details on any current medical conditions, list all on-going medical issues:

Is your medical condition a result of:	Yes	No
Workplace accident		
Motor vehicle accident		
Assault		

If yes, please explain:

Are you currently seeing a doctor? Do you have a primary care physician? If yes, please list doctor(s):

Are you currently taking any prescription medications? Please list all medications:

Do you have any immediate medical needs?

What benefits do you receive?

<input type="checkbox"/> Medicare Part A	<input type="checkbox"/> TANF
<input type="checkbox"/> Medicare Part B	<input type="checkbox"/> WIC
<input type="checkbox"/> Medicare Part D	<input type="checkbox"/> TX Medicaid Women's Health Program
<input type="checkbox"/> SNAP	<input type="checkbox"/> Housing assistance
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:

Do you have any of the following assets/resources?			
Asset/Resource	Yes	No	\$ Value
Cash on Hand			\$
Checking Account			\$
Savings Account			\$
Certificates of Deposit			\$
Stocks or Bonds			\$
Real Estate (excluding homestead)			\$
Retirement accounts			\$
Livestock			\$
Insurance or lawsuit settlements			\$
Boat/RV/ATV			\$
Vehicle(s):			\$
Other assets:			\$
Other assets:			\$

Do you have income from any of the following sources?				
Income source	Yes	No	\$ Amount	Frequency
Employment wages, salaries, commissions			\$	
Tip Income			\$	
Self-employment income			\$	
Unemployment benefits			\$	
Social Security benefits			\$	
Workers compensation benefits			\$	
Cash gifts			\$	
Child support			\$	
Dividends or royalties			\$	
Interest			\$	
Pensions			\$	
Alien sponsor income			\$	
Other income:			\$	
Other income:			\$	
Other income:			\$	

Social Security	Yes	No
Do you receive Social Security/SSI (Supplemental Security Income)		
Are you in the process of applying for Social Security/SSI benefits?		
What is the status of your application?		
<input type="checkbox"/> New Application <input type="checkbox"/> Appeal <input type="checkbox"/> Reconsideration <input type="checkbox"/> Hearing Request		

Do you need transportation assistance to medical appointments?	Yes	No
Is there anything else the Patient Advocate should know about you or your household? Do you have other needs?		

I verify that the information provided in this application is true and correct.

Applicant Signature

Date

P B C I H P



Presidio-Brewster County Indigent Healthcare Program
Big Bend Regional Hospital District

CONSENT TO OBTAIN AND RELEASE INFORMATION

Applicant: _____ SSN: _____

Spouse: _____ SSN: _____

I am a member of a household applying for health care assistance from the Presidio - Brewster County Indigent Health Care Program. I understand that in order to determine this household's eligibility or continued eligibility, it is necessary for the Presidio - Brewster County Indigent Health Care Program to verify all earnings and other information.

I authorize the Indigent Health Care Program to run a credit history and personal data search report for the purpose of making a preliminary determination of whether I meet the eligibility requirements for the Indigent Health Care Program. I also understand that any approval will be conditional based on the information reviewed in my report.

I authorize any relative, lawyer, employer, landlord, banker, postal savings official, insurance company, fraternal order, government agency, Texas Department of Health and Human Services, Social Security Administration, charitable organization, or other person or entity having information about me or my circumstances to furnish such information to a representative of the Presidio - Brewster County Indigent Health Care Program for the purpose of making a determination of whether I meet the eligibility requirements for the Indigent Health Care Program.

I agree to sign a written authorization permitting my physician(s) and other health care providers and health care entities to release my health information to the Presidio - Brewster County Indigent Health Care for the purpose of making a determination of whether I meet the eligibility requirements for the Indigent Health Care Program.

I authorize the Presidio - Brewster County Indigent Health Care Department to release information in my application to the persons and entities named above for the purpose of verifying all earnings and other information and to make a determination of my eligibility for the Indigent Health Care Program.

I understand that anyone who knowingly lies or misrepresents the truth or arranges for someone to knowingly lie or misrepresent the truth in the completion of this application and determination of eligibility is committing a crime, which can be punished under Federal law, State law, or both.

Signature of Applicant

Date

Signature of Applicant's Spouse

Date



AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

Last _____ First _____ Middle _____

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE (_____) _____ ALT. PHONE (_____) _____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____) _____ Fax (_____) _____

REASON FOR DISCLOSURE (Choose only one option below)

- Treatment/Continuing Medical Care
- Personal Use
- Billing or Claims
- Insurance
- Legal Purposes
- Disability Determination
- School
- Employment
- Other _____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name Big Bend Regional Hospital District
Address P.O. Box 1019
City Alpine State TX Zip Code 79831
Phone (432) 837-7051 Fax (432) 837-3261

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- | | | | |
|--|--|---|---|
| <input checked="" type="checkbox"/> All health information | <input type="checkbox"/> History/Physical Exam | <input type="checkbox"/> Past/Present Medications | <input type="checkbox"/> Lab Results |
| <input type="checkbox"/> Physician's Orders | <input type="checkbox"/> Patient Allergies | <input type="checkbox"/> Operation Reports | <input type="checkbox"/> Consultation Reports |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Diagnostic Test Reports | <input type="checkbox"/> EKG/Cardiology Reports |
| <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Billing Information | <input type="checkbox"/> Radiology Reports & Images | <input type="checkbox"/> Other _____ |

Your initials are required to release the following information:

_____ Mental Health Records (excluding psychotherapy notes) _____ Genetic Information (including Genetic Test Results)
_____ Drug, Alcohol, or Substance Abuse Records _____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X _____ **Signature of Individual or Individual's Legally Authorized Representative** _____ **DATE** _____

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: Parent of minor Guardian Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X _____ **Signature of Minor Individual** _____ **DATE** _____

PRESIDIO-BREWSTER COUNTY INDIGENT HEALTHCARE PROGRAM

BEHAVIORAL GUIDELINES

- ALL applicants and qualified clients are required to comply with all State and County policies and guidelines to receive services through the Presidio-Brewster County Indigent Healthcare Program.
- ALL applicants and qualified clients are required to comply with behavioral guidelines established by the State of Texas and apply to your Primary Care Physicians office and any specialist's offices they are referred to.
- ALL applicants and qualified clients who are rude and display disruptive or abusive languages and behavior will not be seen. Our personnel will be protected from dangerous situations; physical or combative confrontations are grounds for immediate termination from the Indigent Healthcare Program.
- ALL qualified clients are expected to comply with the medical regime proposed by the assigned Primary Care Physician's office or by the Specialist Office of whom they were referred. Referred additional testing, such as lab, radiology procedures or other specialist referrals, should be completed within one week of their last primary care physician's visit. We cannot properly treat without testing results. Qualified clients will be terminated from the program for repeated non-compliance.
- ALL qualified clients are expected to give all Physicians, Primary Care or Specialists, at least 24 hours advance notice to cancellation of an appointment, if the client is unable to keep the appointment. The client will be terminated from the Indigent Healthcare Program for repeated failure to keep scheduled appointments.
- No qualified clients shall receive any medications without periodic primary care physician evaluation (six months evaluation).
- Clients will be terminated from the Indigent Healthcare Program for illicit drug usage and continued alcohol abuse, if not currently and actively participating in a supervised rehab program.

I HAVE READ AND UNDERSTAND ALL OF THE ABOVE GUIDELINES:

PAUTAS DE COMPORTAMIENTO

- Todos los solicitantes y clientes calificados deben cumplir con todas las pólizas y pautas estatales del condado para recibir servicios a través del Programa de Cuidado de Salud Indigente del Condado de Presidio-Brewster
- Todos los solicitantes y clientes calificados están obligados a cumplir con las pautas de comportamiento establecidas por el Estado de Texas y aplicar a su oficina de Primary Care Physicians y a las oficinas de cualquier especialista a los que se les hace referencia.
- No se verán a los solicitantes y clientes calificados que sean groseros y muestren lenguajes y comportamientos disruptivos o abusivos. Nuestra voluntad personal estará protegida de situaciones peligrosas; las confrontaciones físicas o combativas son motivo para la terminación inmediata del Programa de atención Medica Indigente.
- Se espera que todos los clientes calificados cumplan con el régimen medico propuesto por la Oficina del Médico de Atención Primaria asignada o por la Oficina de Especialistas de quien fueron referidos. Las pruebas adicionales referidas, como el laboratorio, los procedimientos de radiología u otras derivaciones especializadas, deben completarse una semana después de la visita de su médico de atención primaria. No Podemos tartar adecuadamente sin los resultados de las pruebas. Los clientes calificados serán despedidos del programa por incumplimiento repetido.
- Ningún cliente calificado recibirá ningún medicamento sin evaluación periódica del médico de atención primaria (evaluación de seis meses).
- Los clientes serán despedidos del Programa de Cuidado de salud de Indigente por el uso ilícito de drogas y el abuso continuo de alcohol, si no participa actualmente y activamente en un programa de rehabilitación supervisado.
- Se espera que todos los clientes calificados notifiquen a todos los médicos, atención primaria o especialistas con lo menos 24 horas de anticipacion a la cancelación de una cita, si el cliente no puede cumplir la cita. El cliente será despedido del Programa de atención Medica de Indigente por fallas repetidas en a la realización de citas programadas.

HE LEIDO Y ENTIENDO TODAS LAS PAUTAS ANTERIORES:

Applicant's Signature/*Firme de Solicitante*

Date/*Fecha*

Printed Name of Applicant/*Nombre en molde del Solicitante*



Fraud Policy

I, _____ attest that the statements I have made in my application and interviews, including my answers to all questions, are true and correct to the best of my knowledge and belief.

I agree to give staff and the Big Bend Regional Hospital District any information necessary to prove statements about my eligibility.

I agree to report any of the following changes within 14 days:

- Address
- Household Members
- Property
- Income
- Application for/or receipt of SSI, TANF, or Medicaid/

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 criminal charges against me.

If a change occurs that makes you ineligible and you fail to report the change as required, you may be held responsible for payment of any health care services you receive after you become ineligible and/or you may be subject to prosecution under the Texas Penal Code.

Applicant Signature/*Firma de Solicitante*

Póliza de Fraude

Yo, _____ atestigo de que las declaraciones que hice en mi solicitud y entrevista, incluyendo mis respuestas a todas las preguntas, son ciertas y correctas al mayor de mi conocimiento y creencia.

Acepto dar información al personal de elegibilidad y al Big Bend Regional Hospital District cualquier información necesaria para probar declaraciones sobre mi elegibilidad.

Estoy de acuerdo en avisar cualquier de los siguientes cambios:

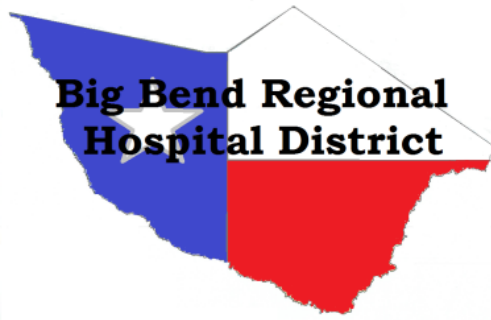
- Dirección
- Los miembros del hogar
- Propiedades
- Ingresos
- Solicitud de SSI, TANF o Medicaid

He sido informado/a y entiendo que al no cumplir con las obligaciones establecidas será considerado retención de información intencional y puede resultar en la recuperación de cualquier pérdida mediante pago o presentando cargos civiles y penales contra mi.

Si ocurre un cambio que lo haga inelegible y usted no reporta el cambio como es requerido, usted puede ser considerado/a responsable de cualquier atención medica resivida después de ser intelígible y puede ser sujeto/a a procesamiento bajo el Código Penal de Texas.

Date/Fecha

Alpine Office
 105 W. Holland Avenue
 P.O. Box 1019
 Alpine, Texas 79831
 (432) 837-7051
 (432) 837-3261-Fax



Presidio Office
 602 W. O'Reilly Street
 P.O. Box 3044
 Presidio, Texas 79845
 (432) 229-2151
 (432) 229-2161-Fax

Date/Fecha _____

I, _____,
Applicant's Name
 authorize

Yo, _____,
Nombre de Solicitante
 autorizo

Name of Bank or Credit Union
 to forward the requested bank statements to
Big Bend Regional Hospital District, for the
 purpose of the Presidio-Brewster County
 Indigent Healthcare Program.

Nombre del banco
 para enviar los extractos bancarios solicitados
 a **Big Bend Regional Hospital District**, a los
 fines del Programa de Indigent Healthcare del
 Condado de Presidio-Brewster.

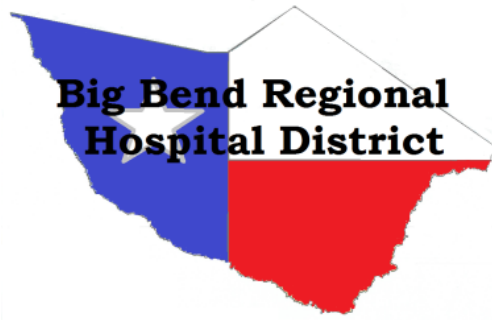
Bank statements for the following months are requested for the following bank accounts:

Account Number/Numero de Cuenta	Month/Year	Month/Year	Month/Year
Checking #			
Saving #			
Other #			

 Applicant Signature / Firma de Solicitantes

 Date / Fecha

Alpine Office
105 W. Holland Avenue
P.O. Box 1019
Alpine, Texas 79831
(432) 837-7051
(432) 837-3261-Fax



Presidio Office
602 W. O'Reilly Street
P.O. Box 3044
Presidio, Texas 79845
(432) 229-2151
(432) 229-2161-Fax

Banks

Alpine Community Credit Union
432-837-5156

WesTex Community Credit Union
432-837-9389

West Texas National Bank
432-837-3375

Trans Pecos Banks
432-837-0094

Ft. Davis State Bank (Alpine)
432-837-1888

Marfa National Bank
432-729-4344

Ft. Davis State Bank (Presidio)
432-229-5000

1st Presidio Bank
432-229-3724

Property Tax Offices

Brewster County Tax Office
432-837-2214

Presidio County Tax Office
432-729-3431

Utilities

City of Alpine
432-837-0047

City of Presidio
432-229-3517

City of Marfa
432-729-4315

Additional

Big Bend Community Action Committee
(Alpine)
432-729-4908

Big Bend Community Action Committee
(Presidio)
432-299-0480

Texas Workforce Commission (Local)
432-837-9800

Neighborhood Center of Alpine
432-837-2142