ELLIS COUNTY INDIGENT HEALTH CARE PROGRAM

September 1, 2015 through August 31, 2016

Ellis County administers an Indigent Health Care Program for eligible residents. This Program, known as the *Ellis County Indigent Health Care Program*, complies with the provisions of the Texas Health and Safety Code, Indigent Health Care and Treatment Act, Sections 61.001 – 61.044.

The Ellis County Indigent Health Care Program offices are located in the historic County Court House, Suite B-105 located at 101 W Main Street, Waxahachie, TX 75165 and in the Ennis Sub-Court House located at 207 S. Sonoma Trail, Ennis, TX, 75119 .

The following Basic Health Care Services are available to those County residents who have applied for the Program, met and maintained the eligibility criteria, and who do not qualify for other state or federal health care assistance programs:

1. immunizations—given when appropriate
2. annual physical examination—examinations provided once per calendar year by a physician or physician assistant; associated testing, such as mammograms, can be covered with a physician referral.
3. medical screening services—include blood pressure, blood sugar, and cholesterol screening
4. inpatient hospital services—must be medically necessary and provided in an acute care hospital to hospital inpatients, by or under the direction of a physician and for the care and treatment of patients
5. outpatient hospital services—must be medically necessary and provided in an acute care hospital to hospital outpatients, by or under the direction of a physician.
6. laboratory and X-ray services—professional and technical services ordered and provided under the personal supervision of a physician in a setting other than a hospital (inpatient or outpatient)
7. physician services—include services ordered and performed by a physician that are within the scope of practice of their profession as defined by State law
8. prescription—up to 3 prescription drugs per calendar month; new and refilled prescriptions count equally toward this 3 prescription drugs per month total; drugs must be prescribed by a physician or other practitioner within the scope of practice under law

In addition, Ellis County has elected to make available the following optional health care services:

a. advanced practice nurse(APN) services—must be provided within the scope of practice of the APN and covered in the Texas Medicaid Program; an APN must be licensed as a registered nurse (RN) within the categories of practice , specifically a nurse practitioner, a clinical nurse specialist, a certified nurse midwife (CNM), and a certified registered nurse anesthetist (CRNA) as determined by the Board of Nurse Examiners
b. physician assistant (PA) services—must be provided by a PA under the supervision of a physician and billed by and paid to the supervising physician
c. diabetic and colostomy – medical supplies and equipment

Ellis County Indigent Health Care Program procedures will follow those standards established by the Texas Department of State Health Services (DSHS) for:

- eligibility, including application, documentation and verification
- processing and payment of health care services
- establishing procedures for applicants and eligible residents to register for work with the Texas Employment Commission detection and identification of fraud

Ellis County Indigent Health Care
101 W. Main St., Suite B105
Waxahachie, TX 75165
972-825-5085 (Fax: 972-825-5003)

APPLICATION FOR HEALTH CARE ASSISTANCE

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:

Where You Live and Plan To Continue Living
Possible Proof: Mail that you received at your address; school records; voting records; property tax, rent or mortgage receipts; Texas driver's license; other official identification.

What You Own and What It Is Worth
Possible Proof: Property tax appraisals, estimates from car dealers, ads selling similar items, statements from real estate agents, bank statements.

Your Income
Possible Proof: Pay check stubs, pay checks, W-2 tax forms or income tax returns, sales records, statements from employers, award letters, legal documents, statements from persons giving you money.

Other Health Care Coverage
Possible Proof: Award or claim letters, insurance policies, court documents, other legal papers.

Information on social security numbers should be given if this information is available. Information on sex (Male/Female) is voluntary. These types of 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, if you have answered all the questions on the application, and if you 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.

SOLICITUD DE ASISTENCIA DE ATENCIÓN MÉDICA

El Programa de Atención Médica para Indigentes del Condado (CIHCP) ayuda a la gente a pagar los servicios médicos que necesita. La elegibilidad para esta ayuda depende de los ingresos del solicitante, sus posesiones, el lugar donde vive, otra ayuda que recibe o que podría recibir, y otras consideraciones. Asegúrese de:

1.) Poner su nombre y dirección;
2.) Firmar y fechar la tercera página de la solicitud; y
3.) Conteste tantas preguntas que pueda sobre esta solicitud.

Entregue su solicitud, o échela al correo, hoy mismo aun si no ha podido contestar todas las preguntas.

SUS RESPONSABILIDADES

Puede que le pidan pruebas de lo que escriba en su solicitud o de lo que diga en su entrevista. Si necesita ayuda para obtener las pruebas, la persona que le haga la entrevista le puede ayudar. Estos son algunos ejemplos de información que puede que tenga que probar y de documentos que le puede servir de prueba:

El Lugar Donde Vive O Donde Tiene Su Hogar Permanente
Posibles Pruebas: Correo que recibió en esa dirección; expedientes de de la escuela; registros de votante; recibos de impuestos, renta o hipoteca; la licencia para manejar de Tejas; otra identificación oficial.

Las Posesiones Que Tiene Y Cuanto Vale Cada Una
Posibles Pruebas: El avalúo para impuestos sobre la propiedad, avalúos hechos por vendedores de carros, anuncios de la venta de articulos parecidos, declaraciones de agentes que venden propiedades, estado de cuentas del banco.

Los Ingresos Que Tiene
Posibles Pruebas: Talones del cheque de paga, cheque de paga, comprobante de salaries e impuestos (Forma W-2), declaración de impuesto federal, el historial de ventas, declaraciones de empleadores, carta de concesión, documentos legales, declaraciones de personas que le dan dinero.

Otra Cobertura Para Gastos Médicos
Posibles Pruebas: Cartas de reclamación o de concesión, pólizas de seguros, papeles de la corte u otros documentos legales.

Si tiene a su disposición los números de seguro social, debe darlos. La información sobre el sexo (Hombre/Mujer) es voluntaria. Esta información no afectará su elegibilidad.

Debe dar información sobre seguros médicos y de cualquier tercero que tenga la responsabilidad de pagar los servicios médicos pagados por el condado en beneficio de usted y miembros de la unidad familiar. Al firmar y presentar esta solicitud, usted se compromete a darle al condado el derecho de recuperar el costo de servicios de un tercero.

Pueden pedirle que solicite Medicaid, Asistencia Temporal a Familias Necesitadad (TANF), o Seguridad de Ingreso Suplemental (SSI). Si le han pedido que solicite beneficios de alguno de estos programas o si usted ya los solicitó y está esperando la respuesta, su solicitud de CIHCP puede ser detenida hasta que decidan que no es elegible para los programas mencionados. Si no es elegible para estos programas, si ha contestado todas las preguntas de la solicitud, y si ha dado todos los comprobantes que piden, ya pueden procesar su solicitud. Entonces, el CIHCP tiene un plazo de 14 dias para determinar su elegibilidad.

Después de entregar su solicitud, usted debe reportar dentro de un plazo de 14 dias cualquier cambio de dirección, ingreso, recursos, el número de personas que viven con usted, o si solicita o recibe Medicaid, TANF, o SSI.

Ellis County Indigent Health Care
101 W. Main St., Suite B105
Waxahachie, TX 75165
972-825-5085 (Fax: 972-825-5003)

FOR OFFICE USE ONLY / PARA USO DE LA OFICINA				
Status ☐ Application ☐ Review	Date Form 100 is Requested/Issued	Date Identifiable Form100 is Received	Case Record Number	Appointment Date and Time, if applicable

APPLICATION FOR HEALTH CARE ASSISTANCE / SOLICITUD DE ASISTENCIA DE ATENCIÓN MÉDICA

Name (Last, First, Middle)/Nombre (Apellido, primer, segundo)	Home Telephone No./Teléfono de la casa	Other Telephone No./Otro número de teléfono

Have you ever used another name? If so, list other names you have used./¿Ha usado alguna vez otro nombre? Si es el caso, enumere los nombres que ha usado.

☐Yes/Si ☐No

Mailing Address (Street or P.O. Box)/Dirección Postal (Calle o Apdo.)	Apt.# /Apto.#	City/Ciudad	State/Estado	ZIP

Home Address, if different from above. If it is rural, give directions. / Domicilio particular, si es diferente a la dirección de arriba. Si es rural, explique cómo llegar.

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.** / En la tabla a continuación, llene la primera línea con información acerca de usted mismo. Llene las líneas restantes acerca de todos que viven en la casa con usted, los considere miembros de la unidad familiar o no.

Name (Last, First, Middle) Nombre (Apellido, primero, segundo)	Social Security Number (if available) Número de Seguro Social (si lo tiene a su disposición)	Sex Sexo Male/ Female Hombre/ Mujer	Date of Birth Fecha de nacimiento	What Relation to you? ¿Parentesco con usted?	Are you a sponsored alien? ¿Es usted un extranjero patrocinado?
				MYSELF Yo mismo	

The word "household" in Questions #2 - #16 refers to: you, your spouse, and anyone else that 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."
Las palabras "unidad familiar" en las preguntas #2- #16 se refiere a: usted, su esposo o esposa, y cualquier otra persona que vive con usted y con quien tiene una relación legal. No necesita incluir información de las personas quienes viven con usted que no son parte de su "unidad familiar."

2. **What is your household's county and state of residence (where you make your permanent home)?**
¿En qué condado y en qué estado viven (tienen su hogar permanente) usted y las personas de la unidad familiar?

County/Condado _____ State/Estado _____

Do you plan to remain in this county and state?
¿Piensa quedarse en este condado y este estado?..... ☐Yes/Si ☐No

3. **Living Arrangements/Vivienda**
Check all boxes that apply to your household./Marque todas las cajitas que se apliquen a su caso.

☐ **Own or paying for home**
Soy dueño de mi casa o la estoy comprando

☐ **Live in a house provided by someone else**
Vivo en una casa ajena

☐ **No permanent residence**
No tengo residencia permanente

☐ **Live with someone else**
Vivo con otra persona

☐ **Rent House/Apartment**
Rento una casa o apartamento

☐ **Jail**
Cárcel

4. **List your average monthly household expenses.**/Enumere los gastos mensuales de la unidad familiar.

Rent/Mortgage/Renta/hipoteca ..... $ _____

Utilities (gas, water, electric)/Servicios públicos (gas, agua, luz) ..... $ _____

Telephone/Teléfono ..... $ _____

Transportation, such as gas, car payments, bus/Transportación, tal como gasolina, pagos del carro, autobús ..... $ _____

Tax and Insurance on home per year/Impuesto y seguro anual de la casa ..... $ _____

Other/Otro ..... $ _____

Other/Otro ..... $ _____

Other/Otro ..... $ _____

Does anyone pay these household expenses for you?
¿Hay otra persona que paga estos gastos de la unidad familiar por usted? ..... ☐ Yes/Sí ☐ No

If Yes, who?/Si contesta "Sí," ¿ quién? _____

5. **Are you – or is anyone in your household – receiving ☐ TANF ☐ Food Stamp ☐ Medicaid benefits?**
¿Está usted o alguien de la unidad familiar recibiendo beneficios de TANF, estampillas para comida, y/o Medicaid? ..... ☐ Yes/Sí ☐ No

If Yes, who?/Si contesta "Sí," ¿ quién? _____

6. **Are you – or is anyone in your household – pregnant?**
¿Está usted o alguien de la unidad familiar embarazada? ..... ☐ Yes/Sí ☐ No **If Yes, who?** Si contesta "Sí," ¿ quién? _____

7. **Are you – or is anyone in your household – disabled?**
¿Está usted o alguien de la unidad familiar incapacitada? ..... ☐ Yes/Sí ☐ No **If Yes, who?** Si contesta "Sí," ¿ quién? _____

8. **Have you – or has anyone in your household – applied for SSI or SSDI?**
¿Alguna vez usted o alguien de la unidad familiar solicitó beneficios de SSI o SSDI? ..... ☐ Yes/Sí ☐ No

If Yes, who applied and when?
Si contesta "Sí," quién los solicitó y cuando? _____

9. **Do you – or does anyone in your household – have unpaid health care bills from the last three months?**
¿Tiene usted o alguien de la unidad familiar cuentas médicas sin pagar de los últimos tres meses? ..... ☐ Yes/Sí ☐ No

If Yes, which months?
Si contesta "Sí," ¿Cuáles meses? _____

10. **Do you – or does anyone in your household – have health care coverage (Medicare, health insurance, V. A., Tricare, etc.)?**
¿Tiene usted o alguien de la unidad familiar la cobertura médica (Medicare, seguro médico, V. A., Tricare, etc.)? ..... ☐ Yes/Sí ☐ No

If Yes, who?/Si contesta "Sí," ¿ quién? _____

11. **How much money do you have? For example, on your person, in your home, in bank accounts, or other locations?**
¿Cuánto dinero tiene usted; por ejemplo, en el bolsillo, en la casa, en las cuentas bancarias, o en otros lugares? ..... $

12. **How many cars, trucks, or other vehicles do you – and anyone in your household – have? List the year, make, and model in the chart below.**/¿Cuántos carros, camionetas u otros vehiculos tienen usted y las personas de la unidad familiar? Anote el año, la marca, y el modelo en la tabla a continuación. .....

	Year/Año	Make and Model/Marca y Modelo
1.		
2.		

	Year/Año	Make and Model/Marca y Modelo
3.		
4.		

13. **Do you – or does anyone in your household – own or pay for a home, lot, land, or other things?**
¿Tiene o paga usted o alguien de la unidad familiar una casa, un lote, un terreno, u otros bienes? ..... ☐ Yes/Sí ☐ No

14. **Did you – or did anyone in your household – sell, trade, or give away any cash or property during the last three months?**
Durante los últimos tres meses, ¿traspasó, vendió o regaló usted o alguien de la unidad familiar dinero o alguna propiedad? ..... ☐ Yes/Sí ☐ No

15. **Have you – or has anyone in your household – worked in the last three months?**
¿Ha trabajado usted o alguien de la unidad familiar en los últimos tres meses? ..... ☐ Yes/Sí ☐ No **If Yes, who?** Si contesta "Sí," ¿quien? _____

16. **List all of your household's income below. Be sure to 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.**/Haga una lista de los ingresos de la unidad familiar a continuación. Asegúrese de anotar: Cheques del gobierno; ingresos de trabajo o de capacitación; dinero que recibe de cobros de cuarto y comida; regalos en efectivo, préstamos, o aportaciones de sus padres, familiares, amigos, y otras personas; los ingresos del patrocinador; becas o préstamos de la escuela; manutención de niños, o pagos por desempleo.

Name of person receiving money Nombre de la persona que recibe el dinero	Name of agency, person, or employer who provides the money Nombre del patrón, la persona o la agencia que paga el dinero	Amount received Cantidad recibida	How often received? (daily, weekly, every two weeks, twice a month, monthly?) ¿Con qué frecuencia lo recibe? (¿diariamente, por semana, cada quincena, dos veces al mes, una vez al mes?)

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 re-certification for assistance; and that I may request, orally or in writing, a fair hearing about actions affecting receipt or termination of health care assistance.

A mi leal saber y entender, las declaraciones que he hecho, y mis respuestas a todas las preguntas, son verdaderas y correctas.

Me comprometo a dar al personal que verifica la elegibilidad y al condado toda la información necesaria para comprobar mis declaraciones sobre la elegibilidad.

Me comprometo a avisar, dentro de los 14 días, de cualquier cambio de:

- Ingresos
- Recursos
- Número de personas que viven conmigo
- Dirección
- Solicitud de SSI, TANF, o Medicaid o la entrega de cualquiera de estas.

Me han dicho y comprendo que esta solicitud será considerada sin discriminación por raza, color, religión, credo, origen nacional, edad, sexo, discapacidad, ni afiliación política; que puedo pedir una revisión de la decisión que se haga acerca de mi solicitud de asistencia o recertificación para asistencia; y que puedo pedir, oralmente o por escrito, una audiencia imparcial sobre cualquier acción que afecte la entrega o la terminación de asistencia de atención médica.

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.

Comprendo que al firmar esta solicitud, doy al condado el derecho a recuperar de cualquier tercero el costo de los servicios médicos proporcionados por el condado. Me comprometo a dar al condado la información necesaria para identificar y localizar cualquier otro fuente de pagos por mis servicios médicos.

Me han dicho y comprendo que si dejo de cumplir con las obligaciones especificadas en ésta podría considerarse como una retención intencional de información y podría dar lugar a la recuperación de pérdidas por medio de la devolución de pagos o por medio de la presentación de cargos criminales en mi contra.

BEFORE YOU SIGN, BE SURE EACH ANSWER IS COMPLETE AND CORRECT.
ANTES DE FIRMAR, ASEGÚRESE DE QUE CADA RESPUESTA SEA COMPLETA Y CORRECTA.

Signature – Applicant / Firma – Solicitante _____ Date / Fecha _____

Signature – Spouse / Firma – Esposo o Esposa _____ Date / Fecha _____

If the applicant is married and his/her spouse is a household member, the spouse may also sign and date this Form 100 even if the spouse is a disqualified household member. Si el/la solicitante está casado/a y su esposo o esposa vive en la misma casa, el cónyuge también puede firmar que su esposo o esposa también firme esta Forma 100, aunque no tenga derecho de recibir asistencia.

Signature - Person Who Helped Complete This Application / Date
Firma - Persona que ayudó a llenar esta solicitud / Fecha _____

Signature - Applicant's Representative / Date
Firma – Representante del solicitante / Fecha _____

Signature – Witness (if signed with "X") / Date
Firma – Testigo (si firma con "X") / Fecha _____

Address (Street, City, State, ZIP) and telephone number of anyone who helped complete this Form 100/Dirección (Calle, Ciudad, Estado, ZIP) y teléfono de la persona que ayudó a llenar esta Forma 100

ELLIS 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 _____

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 Ellis County Indigent Health Care.

Print Your Name: _____

Your Signature: _____ Date: _____/_____/2016

(Form date: 01/04/2016-08/31/2016)

ELLIS COUNTY

WAXAHACHIE, TX 75165

Ellis County Indigent Health Care Eligibility Office

BEHAVIORAL GUIDELINES

- All Applicants and Qualified Clients are required to comply with all State and County policies and guidelines to receive services through the Ellis County Indigent Health Care Program.

- All Applicants and Qualified Clients are required to comply with behavioral guidelines established by the States of Texas, Ellis County, Physician's and any specialist's offices they are referred to.

- Any Applicants or Qualified Clients who display disruptive or abusive language or abusive behavior may not be seen by a physician. Such disruptive, physical or combative confrontations are grounds for immediate termination from the Indigent Health Care Program.

- All qualified Clients are expected to comply with the medical regime proposed by the Physician's office or by the specialist office of whom they were referred. Qualified Clients may be terminated from the programs for repeated non-compliance.

- All qualified Clients are expected to give all Physician's, Primary Care or Specialist, at least 48 hours advance notice for cancellation of an appointment, if the client is unable to keep the appointment. The Client will be terminated from the Indigent Health Care Program for chronic failure to keep scheduled appointments.

- Failure to comply with these Behavior Guidelines will result in termination from the Indigent Health Care Program. A terminated Client may appeal a termination to the Ellis County Indigent Program Director. Any such appeal must be in writing and received by the Ellis County Indigent Program Director within 30 calendar days from the effective date of termination.

I have read and been provided a copy of the Behavioral Guidelines.

Client signature_____

Date: _____

Ellis County Indigent Program _____

Date: _____

ELLIS COUNTY INDIGENT HEALTH CARE FRAUD POLICY

Definition

Fraud is the deliberate misrepresentation of some material fact for the purpose of acquiring benefits.

Procedure

When the Indigent Health care (IHC) staff has reason to believe that fraud may have occurred, the following procedure shall be followed:

1. The IHC staff shall investigate all cases of suspected fraud and shall collect and document evidence.
2. Upon a finding of fraud, the client shall be administratively ineligible from IHC:

    - First offense 24 months from the date fraud was discovered client becomes ineligible from program.
    - Second Offense 36 months from date fraud was discovered client becomes ineligible for program.
    - Third Offense 48 months from date of fraud was discovered client becomes ineligible for program.

3. The IHC staff shall contact the client who is suspected of fraud by sending a certified letter informing him of the withdrawal of eligibility and explaining the allegations. If the client disputes the allegations, the client will be allowed to submit applicable supporting documents/verification for further consideration.
4. If the dispute remains unresolved, the IHC staff shall schedule and administrative hearing to allow the client to defend himself by confronting any adverse witness and by presenting his own argument and evidence. The IHC staff must disclose any evidence use to prove its case to the client so he has an opportunity to dispute it. The administrative hearing will be conducted by the Director of the Indigent Health Care Program with the IHC designee present. The administrative hearing shall be held at the office of the Indigent Health Care Program in Waxahachie during normal business houses. The client shall be given 30 day written notice of the date of the hearing. If the

client does not appear at the administrative hearing, the IHC designee may proceed with the presentation of the case only if proof of notice is present. The Director of the Indigent Health Care Program shall make a decision within ninety days of the hearing. The client shall have the right to appeal any unfavorable decision to the Ellis County Judge.

Consequences of Fraud

If, after due process, a person is found to have intentionally misrepresented information in order to receive benefits, that person:

- Shall reimburse Ellis County for the cost of benefits they did receive;
- Shall be administratively ineligible for Ellis County IHC benefits in accordance to Ellis County IHC Policies and Procedures; and
- May be subject to prosecution under the Texas Penal Code.

ELLIS COUNTY

WAXAHACHIE, TX 75165

ACKNOWLEDGEMENT OF ELLIS COUNTY FRAUD POLICY

I hereby understand that by signing this form I acknowledge that I have received a copy of Ellis County Indigent Health Care Fraud Policy.

Name: _____

Date: _____

Signature: _____

ELLIS COUNTY

WAXAHACHIE, TEXAS 75165

Ellis County Indigent Health Care Program Authorization for Background Checks

Name:_____

Social Security Number Date of Birth

_____

I hereby give permission to the Ellis County Indigent Health Care Program to obtain a background check from Texas Workforce Commission, department of Motor Vehicle Registration, Credit Bureau and any other sources that may need to be contacted to determine my eligibility for the Indigent Program.

Print Name Date

_____

_____

Signature_____

Subscribed and Sworn to (affirmed) before me this_____day of _____, at _____. Notary Public in and for the State of Texas. My Commission Expires on _____.

Notary Signature

_____

(seal)

ELLIS COUNTY INDIGENT HEALTH CARE

101 W. Main Street, Suite B105

Waxahachie, TX 75165

In order to eliminate fraud it is Ellis County Indigent Health Care's policy to investigate and verify information with regards to processing your application for Ellis County Indigent Health Care.

RELEASE FOR INFORMATION

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

Examples of entities which may be contacted are (this list is not all inclusive):

- 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's Office
  - Department of Family and Protective Services
  - Texas Workforce Commission
  - Texas Department of Insurance, Division of Workers' Compensation
- The County of Ellis and any Department or Subdivision of the County of Ellis, including but not limited to the following:
  - Ellis County Community Supervision and Corrections
  - Ellis County Sheriff's Office
  - Ellis County Clerk's office
  - Ellis County District Clerk's office
  - Ellis County Tax office
- Veteran's Administration
- Ellis Central Appraisal District
- Social Security Administration
- Internal Revenue Service
- Any Medical Facility
- Any Insurance Carrier
- Any Charity Organization

Print Your Name: _____

Your Signature: _____ Date: _____/_____/2016

(Form date: 01/04/2016-08/31/2016)

Ellis 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:

_____ **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? _____
How long? _____

I CERTIFY THE ABOVE INFORMATION IS CORRECT

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

Please return form to:
Indigent Health
101 W Main St. , B 105
Waxahachie, TX 75165