INDIGENT HEALTH CARE

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ELLIS COUNTY INDIGENT HEALTH CARE PROGRAM

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

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.

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.:

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: _____/_____/

Ellis County Indigent Healthcare

Fraud Policy

Sec. 61.043 Requires a County to adopt reasonable procedures for minimizing the opportunity for fraud. Ellis County adopts the following policy: Providing false or misleading information will be considered fraud. If it is determined that fraud exists, the individual will be denied future eligibility and will be required to reimburse the County for all money paid out for claims. Such cases will be reported to the Ellis County District Attorney's office for further investigation and/or prosecution.

Acknowledgement of Policy:

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

Signature: _____

Date: _____

RELEASE OF INFORMATION

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

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

- The State of Texas and any department or subdivision of the States of Texas, including but not limited to the following:
    1. Texas Department of State Health Services
    2. Texas Department of Health and Human Services
    3. Texas Attorney General
    4. Department of Family and Protective Services
    5. Texas Workforce Commission
    6. 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:
    1. Ellis County Community Supervision and Corrections
    2. Ellis County Sheriff's Office
    3. Ellis County Clerk's office
    4. Ellis County District Clerk's office
    5. Ellis County Tax office
- Veteran's Administration
- Ellis Central Appraisal District
- Social Security Administration
- Internal Revenue Services
- Any Medical Facility
- Any Insurance Carrier
- Any Charity Organization

Your Signiture _____

Date: _____

ELLIS COUNTY INDIGENT HEALTH CARE PROGRAM

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

- Report to IHC less than 14 days if my income changes, if I move, or if there are new members in my household. Any new job, new income, or money received must be reported. If I don't report a change that disqualifies me for services, I will have to pay for those services or I could face legal charges.
- Report if I apply for Social Security Disability, or if there are any changes in my SSI or SSDI case.
- Go only to my primary care physician unless he refers me to a specialist and the referral has been approved by the program. I understand that seeing a specialist on my own will result in my being responsible for those charges.
- See my primary care physician for non–emergency situations.
- I will use the emergency room only for true emergencies; otherwise,
- Always call ahead to make an appointment with my doctor and follow the doctor's orders.
- I will take my medicine as instructed.
- I will follow recommended diets and restrictions, i.e. No smoking, tobacco products, illegal drugs or alcohol.
- I understand the program will pay for only 3 prescriptions each calendar month, 30 days' supply only. Some drugs are restricted and generic drugs are recommended.
- Cancer patients: IHC will cover only X-rays (such as MRI's, CT's and other types of scans) and blood work up to a cap limit of $30,000. IHC will not cover for surgeries and treatment (radiation, Chemotherapy and etc.).
- Claims for medical services provided outside the State of Texas will not be paid by Ellis County Indigent Health.
- Ellis County does not pay for treatment of or hospital confinements for, drug or alcohol abuse or overdose. Self-inflicted injuries or abuse are also not covered.
- Ellis County IHC does NOT pay for: medicines that can be purchased without a prescription, restricted drugs (paid, psychiatric, lifestyle), ambulances services, major dental, vision, prenatal care and immunizations available at Texas Department of State Health Services.
- The program will cover up to $30,000 in medical bills or up to 30 days in the hospital each fiscal year, whichever comes first.

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

Signature	**Date**	**Witness**	**Date**

ELLIS COUNTY

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
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: _____