

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

For Office Us	se Only											
Status Application Review	Date Form 3064 Requested/Issued	Date Identifiable Fo 3064 Received		orm Case Record No.		Appo	Appointment Date and Time		Fime, if applica	able		
Name (Last, First, Middle)				Home Area Code and Phor			Phone No.	No. Other Area Code and F			No.	
Have you ever us	sed another name? If	f so, list other nar	mes you h	nave us	sed.							
Mailing Address (Street or P.O. Box)				Apt. No. City		City			State	ZIP Code	ZIP Code	
Home Address, i	f different from above	e. If it is rural, give	e direction	is.								
	elow, fill in the first lir you consider them h			ourself	f. Fill in the	e rema	ining lines for	everyone	who lives	in the house	with you,	
			Soci Security (if availa	y No.	Sex (Male Fema	e/	Date of Birth		Relation to You	Are you a sponsored alien?		
								SELF		○ Yes	○ No	
										○Yes	O No	
										○Yes	O No	
										○Yes	O No	
										○ Yes	ON₀	
										○Yes	O No	
										○ Yes	O No	
	household" in Questi ationship. You do not										you have	
2. What is your h	ousehold's county ar	nd state of reside	nce (wher	e you r	make you	perm	anent home)?					
County: Do you plan to remain in this county and state? O Yes O No												
3. Living Arrange	ments – Check all bo	exes that apply to	your hou	sehold								
☐ Own or paying for home ☐ Live in a house provi				ed by someone else			☐ No permanent residence					
Live with someone else Rent house or apartm				ntJail			☐ 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									
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?									

Area Code and Phone No.:

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 Agency, Person Amount Name of Person Receiving Money or Employer Providing Money 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 — Witness (if applicant signed with "X") Signature — Person Helping Complete Form 3604 Signature — Applicant's Representative

Address of Person Helping Complete Form 3064 (Street, City, State, ZIP Code):

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.