ANGELINA COUNTY
INDIGENT HEALTH CARE
PO BOX 908, LUFKIN, TX 75902-0908
P. 936.6345431 F.936.632.4423

DOCUMENT REQUIREMENTS

PERSON IDENTIFICATION:
1. VALID PICTURE ID
2. SOCIAL SECURITY CARD

RESIDENT VERIFICATION:
1. RENT RECEIPT – COPY OF LEASE – TAX STATEMENT
2. TWO (2) CURRENT UTILITY BILLS WHERE YOU RESIDE
3. MAIL ADDRESSED TO YOU AT CURRENT ADDRESS
4. IF YOU LIVE WITH SOMEONE AND THE BILLS ARE IN THEIR NAME – LETTER FROM THE PERSON WITH WHOM YOU LIVE AND THEIR IDENTIFICATION
5. IF YOU LIVE ALONE AND SOMEONE ELSE IS PAYING THE BILLS FOR YOU – A LETTER FROM THAT PERSON AND THEIR IDENTIFICATION.

INCOME VERIFICATION:
1. LAST FOUR (4) CHECK STUBS
2. DOCUMENTATION ON ANY OTHER INCOME: UNEMPLOYMENT, SOCIAL SECURITY, SSI.SSD, WORKERS COMP, RETIREMENT, VA BENEFITS, DONATIONS, CHILD SUPPORT, SELF EMPLOYMENT INCOME
3. LAST FOUR (4) STATEMENTS ON CHECKING/SAVINGS ACCOUNTS
4. LAST TAX RETURN FILED

ADDITIONAL VERIFICATION:
1. FOOD STAMP INFORMATION
2. TITLE TO ANY AUTOMOBILES IN YOUR NAME
3. DIVORCE DECREE
4. IF YOU HAVE FILED FOR SOCIAL SECURITY OR SSI – DOCUMENTS ABOUT YOUR CASE – IS IT PENDING, DENIED, APPEALING

MEDICAL NECESSITY:
1. DIAGNOSIS SHEET FROM ANGELINA COUNTY & CITIES HEALTH DISTRICT

****THE INTERVIEW WILL BE IN ENGLISH ONLY. IF YOU DO NOT SPEAK ENGLISH, THEN YOU MUST BRING AND INTERPRETER WITH YOU ON THE DAY OF YOUR APPOINTMENT OR WE WILL RESCHEDULE THE APPOINTMENT.**

****SI USTED HABLA ESPANOL, SOLO ENTOCES DEBE TRAER UN INTERPRETE CON USTED EN EL DIA DE SU CITA O VAMOS A REPROGRAMAR LA CITA.**

FOR APPOINTMENT CALL (936) 634 – 5431

PHYSICAL LOCATION – 211 E SHEPHERD AVE, LUFKIN; WE ARE IN THE ANGELINA COUNTY ANNEX COMMISSIONERS COURT BUILDING BETWEEN 2ND AND 3RD STREETS. PLEASE REMEMBER THESE ARE ONE WAY STREETS.

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.

ANGELINA COUNTY
INDIGENT HEALTH CARE
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HOUSEHOLD MANAGEMENT/VERIFICATION OF SUPPORT

CLIENTS' NAME: _____ CASE NUMBER _____

I, _____, LIVING AT _____, AM MAKING THIS VOLUNTARY STATEMENT CONCERNING ASSISTANCE I HAVE GIVEN TO _____ DURING THE LAST SIX (6) MONTHS. I HAVE HELPED THE ABOVE NAMED BY PAYING:

____ BILLS ____ BUYING GROCERIES

____ RENT ____ PROVIDING TRANSPORTATION

_____ GIVING CASH MONEY ____ TAXES/INSURANCE

____OTHER: _____

I GIVE THEM MONEY EACH MONTH. (CIRCLE ONE) YES NO

I PAY THE ABOVE DIRECTLY. (CIRCLE ONE) YES NO

DO YOU GIVE THE CLIENT CASH OR MONEY ON A REGULAR BASIS? YES NO IF SO, HOW MUCH AND HOW OFTEN DO YOU DO THIS?_____

RELATIONSHIP TO APPLICANT:_____

NAME:_____ DATE:_____

ADDRESS: _____

CITY, STATE, ZIP: _____

PHONE #: _____

INFORMATION ABOVE IS ACCUATE AND TRUE

SIGNATURE: _____

ANGELINA COUNTY
INDIGENT HEALTH CARE
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RESIDENT VERIFICATION

This form is to be completed by someone who knows your situation. The person you select to complete this form should be someone who **DOES NOT LIVE WITH YOU & IS NOT A RELATIVE.**

CLIENTS' NAME: _____ CASE NUMBER _____

1. Give the names of all the people that live with the person listed above:

_____ _____

_____ _____

_____ _____

_____ _____

2. What is the physical address where these people live? _____

_____

3. How long have you known the client? _____
4. Are you related to this client? _____ If yes, how? _____

I understand that providing false information can result in a fine or imprisonment. I certify that the above information is true and correct.

NAME: _____ DATE: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

PHONE #: _____

INFORMATION ABOVE IS ACCUATE AND TRUE

SIGNATURE: _____

TEXAS
Health and Human Services

Form 3081
January 2020-E

County Indigent Health Care Program (CIHCP)

Appellant – Provider Assignment

County	Area Code and Phone No.	Case No.

Appellant Assignment

I certify that I am currently appealing the Social Security denial decision. As a condition of receiving CIHCP health care services, I give the above county my rights to recover the cost of health care services provided by the county and any third party, up to the amount of expenditures made on my behalf by the county.

Signature – Appellant

Printed Name – Appellant

Date

Appellant Address (Street, City, State and ZIP Code)

Provider Assignment

By signing this form, I agree to assign to the county my Medicaid reimbursement rights for services provided to this person and paid for by the county. I will not file claims with Medicaid for reimbursement of the county's payments. In accepting this agreement, I agree to meet the following conditions:

- All claims I submit to the county must comply with all claims processing requirements for the Texas Medicaid Program. The claim forms will be imprinted in bold face type with the following statements:
  - This is to certify that the foregoing information is true, accurate and complete.
  - I understand that ultimate payment of this claim may be from federal and state funds and that any falsification or concealment of a material fact may be prosecuted under federal and state laws.

The statements may be printed above my signature or if printed on the reverse side of the form, a reference to the statements must appear immediately preceding my signature.

- Any costs for processing claims as a result of this assignment will not be passed along to the county.
- I accept the amount paid by the county as payment in full for all services provided to the above-named appellant and I will not seek reimbursement for any difference between the amount paid by the county and the original billed amount from any person or entity.

This assignment is null and void if the appellant does not become Supplemental Security Income (SSI) Medicaid eligible.

Signature – Provider

Printed Name – Provider

Date

National Provider Identifier (NPI)/Medicaid Billing ID

Provider Area Code and Phone No.

Provider Address (Street, City, State and ZIP Code)

TEXAS
Health and Human Services

Form 3076
January 2020-E

County Indigent Health Care Program (CIHCP)

Case Record Information Release

Case Record Name:	Case Record No.

I do hereby authorize persons, organizations or establishments having information or records concerning me/us or my/our circumstances, to furnish such information to a representative of the County Indigent Health Care Program. I hereby grant permission for the CIHCP to obtain information which may have a bearing on my/our eligibility for assistance. This release form is valid for six months after the date signed.

Person or Agency to Whom Information will be Released:

☐ Specific Request (Specify in 1 and 2 below.)

1. Information Requested _____

2. Period covered (Dates) _____

☐ General Request (Any information available may be released.)

_____ _____

Signature – Applicant or Recipient — Date

_____ _____

Signature – Spouse — Date

_____ _____

Signature – Guardian, Power of Attorney, Parent of Minor Child — Date

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STATEMENT OF RESPONSIBILITY

Knowingly misrepresenting information is considered fraud according to the State of Texas Law. If you are deemed eligible and fraud is found to exist during your certification, and medical services have been provided to you by the Angelina County Indigent Health Care, your case will be denied and referred to the Angelina County District Attorney for prosecution to the fullest extent of the law.

I hereby certify the following:

1. The information I am providing to Angelina County Indigent Health Care is complete and correct.
2. I understand that I am required to report to Angelina County Indigent Health Care any changes in my circumstances.
3. I understand that providing incorrect information or failing to report changes in my circumstances will result in my repayment of benefits to Angelina County Indigent Health Care and prosecution for fraud.

I have read, fully understand, and agree to the above contents of this statement.

_____ _____

Applicant's Signature Date

ANGELINA COUNTY
INDIGENT HEALTH CARE
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TO ALL INDIGENT HEALTH CARE APPLICANTS

Welcome to the Angelina County Health Care Program. We are here to assist you with your medical needs. All persons making application for the program must provide a home address to qualify. If you receive mail at the Post Office, we must have your street address for home visits, along with direction to your home.

Our primary health care provider is Angelina County & Cities Health District; located at 503 Hill Street, Lufkin Tx. There is a Health District Provider on staff for your medical needs. If they feel you need to see a specialist, they will give you a referral letter prior to you seeing another doctor, in order to approve the charges incurred.

If you have been seeing another doctor prior to being on our program, you will need to get a release letter from that doctor and carry it with you to the Health District.

The hours for the Health District are 7:30am to 5:30pm, Monday through Thursday; and Friday, 7:30am to 4:30pm.

Any emergency room visits should be emergency issues only, all other issues should be seen through the Health District. Stand alone ER centers are not permitted; all ER services should be done through one of the two hospitals located within Angelina County.

I have read all the above and agree to go to the Angelina County & Cities Health District. I understand that I cannot get prescriptions filled that are written by another doctor, unless I have a *Letter of Referral* written by the Health District. _____ Please Initial

I also agree that the Indigent Health Care Office has my permission to discuss my case, as it is deemed necessary, with the Health District, the Pharmacy, the Hospital or the doctor I have been referred too.

_____ Please Initial

In 1996 the Federal Health Insurance Portability and Accountability Act and the Privacy Rule by the United States Department of Health and Human Services put into place the HIPPA rules. If you would like a copy of these rules, please ask for on. _____ Please Initial

_____ _____

Applicant's Signature Date