TEXAS
Health and Human Services

Date	Case Record No.
Office Address San Patricio County Indigent Health Program 313 N. Rechal St, Sinton, Texas 78387	
Area Code and Phone No. Ph: 361-587-3518 Fax: 361-587-3718	

County Indigent Health Care Program (CIHCP)

Request of Information

Your application for assistance is not complete. To determine your eligibility, we need the following additional information. **Only the checked boxes apply to you.**

- ☐ Mail Addressed to You or Another Household Member
- ☐ Texas Driver License or Other Official Identification
- ☐ Voter Registration Card
- ☐ Automobile Registration
- ☐ Notice of Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP) or Medicaid Benefits
- ☐ Checking Account Statement
- ☐ Savings Account Statement
- ☐ Paycheck or Paycheck Stubs
- ☐ Earnings Statement from Employer
- ☐ Other Items Listed Below
- ☐ Federal Income Tax Return
- ☐ Self-Employment Bookkeeping, Sales and Expenditure Records
- ☐ Social Security Award Letter, Check or Denial Notice
- ☐ Disability Insurance Award Letter or Check
- ☐ Unemployment Compensation Award Letter or Check
- ☐ Veterans Affairs Award Letter or Check
- ☐ Workers' Compensation Award Letter or Check
- ☐ Verification of Application for Social Security or Supplemental Security Income (SSI)
- ☐ Verification of Application for Other Assistance Programs

Please return the items checked above by

A decision about your eligibility will be made no later than 14 days after your application is completed, including all requested information. If we do not receive the information and you do not contact me, I assume that you do not want assistance. Call me if you have any questions.

Staff Signature	Area Code and Phone No.

_________ Statement from Provider (attached) If you live with relatives or friends, you must submit a statement from that person (s). The statement must include what is provided to you.
(examples: shelter, food, transportation, utilities, monies, personal items)

_________ Statement from self (attached) Brief statement of your past and/or present work history including employers name. Also, your current living arrangements, finances, level of education and health problems.

_________ SNAP Verification Letter

_________ Utility bill addressed to you or other household member

_________ Current Medicaid letters/card for spouse and or children

_________ SSI/RSDI/Social Security income letters for spouse and or children.

_________ Sign Form 3081

_________ Social Security update on your SSI/RSDI/SS claim information can be faxed by attorney/representative

_________ Prepaid burial policies

_________ Register with Texas Workforce and provide verification
or
Doctors Note if you are under his or her care.

_________ Copy of filing for Divorce or provide a notarized statement from estranged spouse.
Statement must include how long separated and if there is any monetary support.
Statement must also include a contact phone number and address.

_________ Bank statement showing how much you owe on your vehicle, and mileage of vehicle.

_________ Notice of privacy practice "HIPPA"

_________ Fraud Policy and Procedures

San Patricio County Indigent Health Care Program

FRAUD POLICIES AND PROCEDURES
COUNTY INDIGENT HEALTHCARE PROGRAM

The following Fraud Policy and Procedures have been adopted for County Indigent Health Care Program (IHC).

General Provisions

1. Indication of fraud-intention program violation consists of intentionally committing any of the following actions:
   a) Making a false and/or misleading statement;
   b) Misrepresenting, concealing, or withholding facts;
   c) Violating any provision of the County Indigent Health Care Program Act, regulations related to the Indigent Health Care Program, or State Statues relating to the use, or acquisition of Indigent Health Care Program.

2. Possible Misrepresentations-Situations are varied in which an applicant or recipient might intentionally withhold information or present false information to obtain assistance or benefits to which he/she is not entitled. Examples include, but are not limited to:

   a. Information misrepresented or concealed the time any of the San Patricio County IHC forms are completed;
   b. Information misrepresented at the time legal requirements (IHC Eligibility) are tested for initial certification or recertification;
   c. Information misrepresented concerning income or resources;
   d. Information misrepresented concerning composition of family group;
   e. Information misrepresented concerning county of residency;
   f. Information misrepresented concerning some element of need;
   g. Information misrepresented to obtain prescribed drugs over the authorized limit:
   h. Information misrepresented or concealed regarding concerning incapacity;
   i. Information misrepresented or concealed by a member of the recipient's family, authorized representative or any other individual(s) who assists recipient in obtaining medical services via IHC;
   j. Information misrepresented concerning child support payments, including payments being paid in arrears;
   k. Use of fictitious names and/or sources of identification;
   l. Misrepresentation on guardianship or custody of children in the household;
   m. Misrepresentation of dependent status for adults in the household, to include but not limited to, military dependents status and alien sponsorship;
   n. Misrepresentation of employment status.

3. In addition to IHC caseworkers investigating cases of suspected fraud, IHC may refer any case to the County Attorney for investigation of suspected fraud in which there has been an intentional falsification or omission, which was material in obtaining assistance. The IHC will evaluate all situations in which a recipient failed to report changes in

circumstances between reviews. If IHC changes were intentionally concealed, a referral to the County Attorney will be completed.

4. If evidence of fraud is confirmed an applicant/client will be determined ineligible for the IHC program.

Acknowledged:

IHC Client Signature	Printed Name	Date

SAN PATRICIO COUNTY INDIGENT HEALTH CARE OFFICE
NOTICE OF PRIVACY PRACTICES "HIPAA"

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED/DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE READ CAREFULLY

Each time you visit or communicate with the San Patricio County Indigent Health Care Program (IHC), the staff makes a record of this communication. Typically, this record contains information needed to determine and/or continue eligibility, i.e., residency, household status, income, potential eligibility for other programs; however, your files also contain Protected Health Information. Protected Health Information is information created or received by a health care provider, health plan, employer, or health care clearinghouse that relates to your past, present or future physical, mental health, or conditions; the provision of health care to you; or the past, present or future payment for the provision of health care to you and that identifies you or with respect to which there is a reasonable basis to believe the information can be used to identify you. IHC is required by the privacy regulation issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to maintain the privacy practices with respect to your Protected Health Information. This document is notice to you of IHC's privacy practices. IHC is required to abide by the terms of this notice currently in effect.

Indigent Health Care caseworkers and business associates contracted to maintain your health case records are usually the only individuals with access to these records. However, we may use or disclose your Protected Health Information without your written authorization for the following reasons:

- For treatment or payment for treatments authorized or to conduct health care operations of the IHC;
    - **Treatment:** For example, IHC must disclose diagnosis and test results from the referring primary care physician. When IHC obtains appointments or authorizes payment with specialty clinics.
    - **Payment:** For example, in order to pay for direct care, IHC must have dates of service, diagnosis, and CPT procedure codes on all bills.
    - **Health Care Operations:** For example, in coordinating with other agencies to provide service to our clients, IHC provides identification information and medical history.
- To individuals involved in your care such as family member or other relative, a close personal friend, or any other person you identify to us;
- To our Business Associates: In order to conduct our operations, it is sometimes necessary for IHC to share Protected Health Information with third parties with which we contract services. We will not disclose your Protected Health Information to our Business Associates without assurance from them that they will safeguard the confidentiality of the information;
- If the disclosed is required by law;

- To a health oversight agency for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations, inspections, licensures or disciplinary actions, civil administrative, or criminal proceedings or actions; or other activities necessary for appropriate oversight of the health care system, government benefit programs for which health information is relevant to beneficiary eligibility, entities subject to government regulatory program for which health information is necessary for determining compliance with program standards, or entities subject to civil rights laws for which health information is necessary for determining compliance;
- If IHC has reason to believe that an individual is a victim of abuse, neglect, or domestic violence, to a government authority including a social service or protective agency authorized by law to receive reports of abuse, neglect or domestic violence;
- In connection with administrative or judicial proceedings;
- To a law enforcement official for law enforcement purposes;
- To a public health authority for public health activities as required or authorized by law;
- To a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties authorized by law;
- To organ procurement organizations or other engaged in the procurement, banking or transplantation of cadaveric organs, eyes or tissue;
- For research as authorized by the privacy regulation;
- To avert a serious threat to health or safety of a person or the public;
- For specialized government functions such as for national security and intelligence activities or for the protection of the President or other persons authorized by 22 U.S.C. 2709 (a)(3) or for the conduct of investigations authorized by 18 U.S.C. 871 and 879;
- To you or to your personal representative upon written request; and
- To provide appointment reminders to you.

This office does not keep a copy of your medical records. These are kept by your treating physicians/facilities and would have to be requested from them. Our office only maintains your eligibility file, which includes billing information.

Your Privacy Rights Regarding Protected Health Information

Your eligibility records and the Protected Health Information contained therein are the physical property of San Patricio County Health Care Program. However, you have the following rights with respect to your own Protected Health Information.

- The right to request restrictions on uses and disclosures of your Protected Health Information to family members or personal representatives as otherwise permitted by law or to carry out treatment, payment, or health care operations. IHC is not required to agree to the requested restriction. If IHC agrees to a restriction, it will not use or disclose your Protected Health Information in violation of the restriction. Either you or IHC has the right to terminate an agreed upon restriction at any time. A request for a restriction on the uses and disclosures of your Protected Health Information must be in writing and must provide adequate detail of the restriction you are requesting.
- The right to receive confidential communications of your Protected Health Information by alternative means or at an alternative location (for example, at an address other than your

home address) if you provide a clear statement that the disclosure of all or part of your Protected Health Information could endanger you.

- The right to inspect and copy your Protected Health Information except for the following:
  - Psychotherapy notes.
  - Information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding.
  - Protected Health Information that is subject to the Clinical Laboratory Improvements Amendments of 1988, 42 U.S.C. 269a, to the extent the provision of access would be prohibited by law or is exempt from the Clinical Laboratory Improvements Amendments of 1988, pursuant 42 CFR 493.3(a)(2).
  - Requests to inspect and copy Protected Health Information must be in writing and signed by your or by your representative. If IHC denies a request for access to Protected Health Information, in whose or in part, it will notify you in writing of the denial. If we grant access, we will tell you what, if anything, you have to do to get access. We reserve the right to charge a reasonable, cost-based fee for making copies.
- The right to request an amendment of your Protected Health Information. Such request must be in writing and must provide a reason to support the requested amendment. IHC may deny a request for amendment of Protected Health Information. If it does so, it will notify you in writing of the reason for the denial. Requests for amendment of Protected Health Information should be directed to: San Patricio County Indigent Health Care Program, 313 N. Rachal Ave #225, Sinton, Texas, 78387.
- The right to receive an accounting of disclosures of your Protected Health Information covering six years prior to the date of a request for disclosure. However, IHC does not have to provide an accounting for the following types of disclosures:
  - Disclosures to carry out treatment, payment and health care operations;
  - Disclosures to you of your own Protected Health Information;
  - Disclosures incident to a use or disclosure otherwise permitted or required by law;
  - Disclosures made pursuant to an authorization signed by you;
  - Disclosures to person involved in your care or for other authorized notification purposes;
  - Disclosures for national security of intelligence purposes;
  - Disclosures to correctional institutions or law enforcement officials as required or authorized by law;
  - Disclosures as part of a limited date set; or
  - Disclosures made prior to April 14, 2003.
- The right to receive a copy of this Notice of Privacy Practices upon request. The law requires us to ask you to acknowledge receipt of your copy.

We will not disclose your Protected Health Information except as described in this notice without your written authorization. Your written authorization may be revoked by you in writing at any time by sending a written notice of revocation to San Patricio County Indigent Health Care Program, 313 N. Rachal Ave # 225, Sinton, Texas 78387.

How to get more information or to file a complaint?

If you have any questions and/or would like additional information, you may contact the San Patricio County IHC at 361-587-3518.

If you believe your privacy right have been violated, you may file a complaint with IHC and with the Secretary of the U.S. Department of Health and Human Services. Complaints filed with IHC should be in writing and directed to San Patricio County Indigent Health Care Program, 313 N. Rachal Ave # 225, Sinton, Texas 78387. Complaints to the San Patricio County Judge and Secretary of the U.S. Department of Health and Human Services must be in writing, must specify the entity that is the submit of the complaint, and must describe the acts or omissions to believe to be in violation of your privacy rights.

IHC will not intimidate or retaliate against any person who files a complaint about the treatment of his or her Protected Health Information.

SAN PATRICIO COUNTY INDIGENT HEALTH CARE PROGRAM RESERVES THE RIGHT TO CHANGE ITS PRIVACY PRACTICES AND TO MAIL THE NEW PROVISIONS EFFECTIVE FOR ALL PROTECTED HEALTH INFORMATION WE MAINTAIN. IF WE CHANGE OUR PRIVACY PRATCIES, WE WILL MAIL A REVISED NOTICE TO THE ADDRESS YOU HAVE SUPPLIED US ON YOUR APPLICATION.

This notice is effective as of September 1, 2021

Please verify by signing the attached form that you have received a copy of this NOTICE of PRIVACY PRACTICES.

SAN PATRICIO COUNTY INDIGENT HEALTH CARE PROGRAM
Authorization Form for the Use or Disclosure of Protected Health Information
"HIPAA"

Name ____________________ Social Security # ____________________

Address ____

Phone Number ________________ Date of Birth ____________________

I understand that, by my signature below, I am authorizing the use and/or disclosure of my Protected Health Information.

Description of the Protected Health Information for which I am authorizing use and/or disclosures

____

____

Person or organization authorized use and/or disclose the above-described Protected Health Information:

San Patricio County Indigent Health Care Program

Person or organization to which I authorize disclosure for the above-described Protected Health Information:

Name	Address/Phone	Relationship

The purpose for the authorized use and/or disclosure of my Protected Health Information is for ____.

This authorization expires on ________________________.

Signed ____________________ Date ____________________

This authorization may be revoked in writing by the individual at any time by providing a written notice of revocation to San Patricio County Indigent Health Care Program, 313 N. Rachal Ave # 225, Sinton, Texas 78387. San Patricio County Indigent Health Care may rely on this authorization until it receives the written notice of revocation or until the authorization expires. If the authorization has been provided in order to obtain insurance coverage and another law provides the insurer with the right to contest a claim under the policy or the policy itself, the notice of revocation of the authorization will not be effective.

Be aware that there is a risk that the person or organization to which your Protected Health Information is disclosed pursuant to this authorization will disclose this information to another party and that the information will no longer be subject to San Patricio County IHC privacy protections.

SAN PATRICIO COUNTY INDIGENT HEALTH CARE PROGRAM
Authorization Form for the Use or Disclosure of Protected Health Information
"HIPAA"

I have received a copy of the San Patricio County Indigent Health Care Program's Notice of Privacy Practices.

Signed ________________________________

Printed Name ____________________________

Date _________________________________

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.:

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

Note from Provider

If someone is providing Housing, Cash and/or Financial Assistance have them fill out this form.

Date: ______________________

Applicant's Name: ______________________
(Person Applying For San Patricio County Indigent)

Does this person live with you? Yes No

Do you give anyone in the household cash? Yes No

If "Yes" who do you give money to? ______________________ How Much? __________

How often do you give them money? __________ When did you start providing this help? __________

Do you expect them to pay the money back? Yes No If "Yes" when and how? __________

____

Do you provide any assistance for the household that is not in cash? Yes No

If "Yes" what type? Check all that apply: ___ Shelter ___ Food ___ Personal Items ___ Transportation

___ Other (please explain): ______________________

Do you pay any of their bills? Yes No If "Yes" which bills? __________

____

If "Yes" who do you give the money to? ______________________

If paid by check or money order, who do you make it out to? ______________________

Do you plan to continue providing assistance to this household? Yes No

If "Yes" how long? __________ If "No" date of last assistance. __________

Comments: ______________________

Print Provider Name and Relationship: ______________________

Provider Signature: ______________________

Mailing Address: ______________________

Contact Phone Number: ______________________

Note from Self

Date: ______________________

Please list your health problems and if any health problem is related to an injury (Please write in back if you need more space):

____

____

Please state your level of education: ______________________________

Please list your employment history for the last 3 months:

Employer Name: ____

Dates (start date and end date): _____________________________________

Reason for leaving employment: _____________________________________

If you have been unemployed, please state how long you have been unemployed and the reason why:

____

Who do you currently live with and how long have you lived there? ______________________

____

Do you have to pay for a place to stay, utilities or household expenses? Yes No
If you answered yes, please state what expenses you have to pay and how you pay them:

____

____

Do you receive monies from anyone to help pay rent and utilities or any other expenses? Yes No
If you answered yes, please state who you receive money from, how much they give or loan you, and how you will repay them:

____

Signature: ____

Print Name: ____

Mailing Address: ____

Phone Number: ____