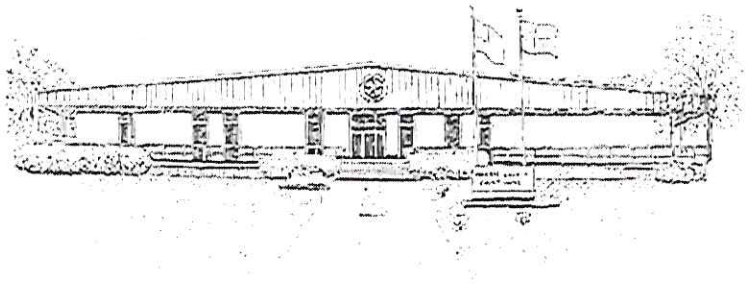


MORRIS COUNTY INDIGENT HEALTHCARE PROGRAM

APPLICATION

Vicki Jones – County Indigent Healthcare Coordinator

500 Broadnax, Ste B. Daingerfield, Tx 75638

Phone: (903) 645 - 3691

Fax: (903) 645 – 5729

Vicki.jones@co.morris.tx.us

ABOUT THE PROGRAM

Morris County's Indigent Health Care Program is the payor of last resort for eligible Morris County community members who meet the program's eligibility criteria. The Indigent Health Care Program is administered based on Chapter 61 Indigent Health Care and Treatment Act. Covered services must be medically necessary and provided by a member of the medical community who will accept the program as a funding source.

Since the program is the payor of last resort, applicants and clients will be required to seek and accept any income or other benefits they are legally entitled to, such as but not limited to, programs with Health Humans Services Commission (Medicaid or Temporary Aid to Needy Families), Social Security Administration programs (SSI, SSDI, Survivors and/or Retirement Benefits), Crime Victims Compensation, and Veteran's Administration.

ELIGIBILITY CRITERIA

- **Residence**: The applicant must live in the county in which s/he applies and must intend to remain there. Applicant may not move to the county for the program.
- **Household:** A CIHCP household is a person living alone or two or more persons living together where legal responsibility for support exists, excluding disqualified persons. A disqualified person is one who receives or is categorically eligible to receive Medicaid.
- **Resources**: A household is eligible if the total countable household resources do not exceed $3,000.00 when a person who is aged or disabled and who meets relationship requirements lives in the home or $2,000.00 for all other households.
- **Income:**

A household is eligible if its monthly net income (unearned income) does not exceed 21% of the Federal Poverty Guideline (FPG).

A household is eligible if its monthly net income (earned income) does not exceed 50% of the Federal Poverty Guideline (FPG)

BASIC HEALTHCARE SERVICES

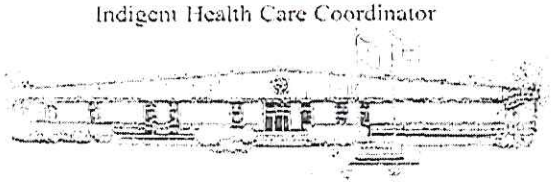
- Physician services include services ordered and performed by a physician that are within the scope of practice of their profession as defined by state law.
- Annual physical examinations are examinations provided once per calendar year by a physician or a physician assistant. Associated testing, such as mammograms, can be covered with a physician referral.
- Immunizations are given when appropriate.
- Medical screening services include blood pressure, blood sugar, and cholesterol screening.
- Laboratory and x-ray services are professional and technical serviced ordered and provided under the personal supervision of a physician in a setting other than a hospital (inpatient or outpatient).
- Family planning services are preventive health care services that assist an individual in controlling fertility and achieving optimal reproductive and general health.
- Skilled Nursing Facility (SNF) services must be medically necessary, ordered by a physician, and provided in the SNF that provides daily services on an inpatient basis.
- Prescriptions This service includes up to three prescription drugs per month. New and refilled prescriptions county equally toward this three prescription drugs per month total. Drubs must be prescribed by a physician or other practitioner within the scope of practice under law.
- Rural Health Clinic services must be provided in a freestanding or hospital-based rural health clinic by physician, a physician assistant, an advanced practice nurse, or a visiting nurse.
- 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.
- 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, and must be diagnostic, therapeutic, or rehabilitative. Outpatient hospital services include hospital-based ambulatory surgical center (HASC) services.

OPTIONAL HEALTHCARE SERVICE

- Limited eyecare pertaining to diabetes, glaucoma, and cataracts ***only***

MORRIS COUNTY

Vicki Jones
Indigent Health Care Coordinator



THIS IS A LIMITED PROGRAM WITH LIMITED FUNDING. ONCE THE COUNTY HAS EXPENDED ALL FUNDS AVAILABLE FOR THIS PROGRAM FOR THE FISCAL YEAR, THERE WILL BE NONE FOR ANYONE. PLEASE DO NOT APPLY 'JUST BECAUSE.'

A COMPLETED APPLICATION WILL BE DETERMINED WITHIN FOURTEEN (14) DAYS AFTER THE APPLICATION AND ALL REQUESTED VERIFICATION HAS BEEN RECEIVED BY THE COORDINATOR. THE COMPLETED APPLICATION WILL REQUIRE BUT MAY NOT BE LIMITED TO THE FOLLOWING TYPES OF VERIFICATION:

1. Copies of identification for each member of the household; such as, Texas driver license or ID and Social Security Card
2. Copy of auto registration or insurance card of the vehicle you own or the one you use.
3. Verification of all earned or unearned income for each member applying for assistance. Such as: Paycheck or pay stub, award letter for pension, SSI, Social Security, unemployment, Medicaid, or letter of assistance from anyone or any organization that is giving you assistance.
4. If anyone in the household has applied for benefits such as SSI, Medicaid. Texas Rehabilitation Commission, food stamps or other help and is waiting for a decision, verification of the application date for the program should be included.
5. If anyone in the household has applied for benefits, such as SSI, Medicaid, TRC, etc. and has been DENIED, INCLUDE A COPY OF THE DENIAL LETTER.
6. Chart showing the cash value of any life insurance policy.
7. An Authorization to Furnish Information signed by both spouses.
8. An Indigent Health Care application signed by both spouses.
9. Third party statement from whoever is providing for your support
10. Copies of current checking and savings account statements.

Circle one:

Single * Married * Separated * Divorced * Living Together * Widowed/Widower

12. THIS IS A PROGRAM OF LAST RESORT! Have you applied to any of the following for assistance?
    a. Texas Workforce Commission
    b. Texas Department of Human Services
    e. Texas Rehabilitation
    d. Social Security Administration — SSI Medicaid — Medicare
    e. Veteran's Services
13. If you are able to work, you should be actively looking for employment.

500 BROADNAX • DAINGERFIELD TEXAS 75638 • PHONE 903-645-3691 • FAX 903-645-5729

PHARMACY LOCATIONS THAT TAKE OUR PROGRAM:

Thurman's Pro-Med Pharmacy
402 North Madison Avenue
Mt Pleasant TX 75455
903-572-6337

Thurman's Pro-Med Pharmacy
201 Main St P O Box 1140
Naples TX 75568
903-897-0011

702 West Houston
Linden TX 75563
903-756-7923

The Med-Shop
111 East 2nd Street
Hughes Springs TX 75656
903-639-3508

MorrisCare Pharmacy - Delivers
213 W Scurry St., Ste C
Daingerfield, Texas 75638
903-289-1900

Powers Pharmacy
Limit of three (3) prescriptions per month.
Prescriptions are limited to a 30-day supply. This is set by the State of Texas. (IF the pharmacy accidently fills a 60 day or 90 day supply, it will count against the three per month. You cannot request or demand that anything over 30-days to be filled.)
****Please treat the pharmacist and staff with respect. They can refuse service.****

NOT COVERED: anything that can be obtained over-the-counter, controlled substances, or anti-depressants.
****

EYE GLASSES:
I have been informed about a low-cost place to obtain glasses.
Two pairs of single vision glasses plus exam for $69. Their frames. Nothing designer. No bifocals or trifocals. If you need bifocals, you would get one pair for reading and one pair for far vision. Anything other than the basic glasses costs extra. For example: Tint is $7 per pair--$14 for the two pair. If they ask if you want scratch resistance coating, designer case, anything at all, be sure to ask, "How much does that cost?" The basic two pairs of glasses with exam is $69.
America's Best Contacts & Eyeglasses 903-475-1021
Northwest Village, 1715 W Loop 281, Longview TX 75604

MORRIS COUNTY INDIGENT HEALTH CARE

DISABLED APPLICANTS MUST APPLY FOR SSI (DISABILITY) WITH THE SOCIAL SECURITY ADMINISTRATION

2304 West Ferguson Road

Mt. Pleasant Texas

ALL OTHER INDIGENT HEALTH CARE APPLICANTS ARE REQUIRED TO REGISTER FOR WORK WITH TEXAS WORKFORCE CENTER

You should go to Texas Workforce Center at the following location:

312 N Riddle

Mt. Pleasant Texas

Phone: 903-572-9841

Fax: 903-572-0159

You must bring proof of filing with either agency.

Assistance Available in Morris County

Utility Help: Many local churches help
Community Services of Northeast Texas
200 W Marshall, Pittsburg 903-856-5861
304 E Houston, Linden 903-756-5596
Christian Service Center 903-645-5510
Tues & Fri 9-11:30 & Wed 2-5 pm

Food:
Daingerfield Church of Christ 903-645-2896
818 W Watson Blvd Also help with rent/water
Food Tuesdays 9 am – noon
Daingerfield Catholic Church 903-645-5722
2nd Monday – pick up at 2 pm (fresh produce)
People line up before then.
Pentecost Temple of God 1239 CR 4119 903-645-4090
Call Mon & Wed for pickup Tues & Thurs 9 am – 3 pm
Cason First Baptist Church 2nd Tuesday 8 am
Mt Mitchell Church of Christ, Omaha 903-645-7817

Clothing:
Christian Service Center 903-645-5510
208 Coffey St Daingerfield
Tues & Fri 9 am – noon Wed 2-5 pm
The Lord's Food Pantry 903-573-5005
209 Coffey St, Daingerfield
3rd Monday 1-4 pm
Community Food Bank – Old Arkla Gas Building
3rd Saturday – Hwy 67, Naples
Golden Blessings – Seniors Monday – Friday Noon
Church on the Rock 909 Linda Dr Daingerfield
Safe-T-Store & Food Pantry Mt Pleasant 903-577-9035
Home Delivered Meals 877-317-2121
Community Services Meals-on-Wheels 903-665-8507
877-586-2481
The Lord's Food Pantry 903-573-5005
Tues-Thurs 9-4 209 Coffey St, Daingerfield

Housing:
Housing Authority – Daingerfield 903-645-2636
Housing Authority – Hughes Springs 903-639-2251
Housing Authority – Hughes Springs 903-639-2871
Housing Authority – Naples 903-897-5336
Housing Authority – Omaha 903-884-2300
ARK-TEX Council of Governments 903-884-3708
Country Square Apts – Lone Star 903-656-3246
Lone Star Seniors Apts 903-656-2995
Women's Shelter 903-572-0973

Rent Voucher:
Ark-Tex Council of Governments 903-832-8636
HUD 800-569-4287
USDA Rural Development 903-572-5411
1809 W Ferguson Road, Ste E
Mt Pleasant TX 75455
Repairs
Loans for very low income for new construction or new manufactured home

Transportation:
Trax Bus: Rural transportation requires 24 hour advance notice
866-575-9014 or 877-633-8747
Transportation MEDICAL:
Community Council Linden 877-633-8747

Emergency Shelter:

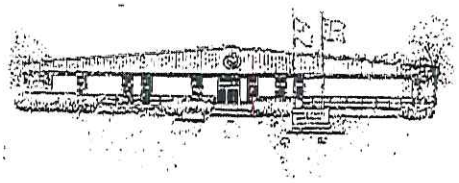
American Red Cross	Texarkana	903-793-5602
Friendship Center	Texarkana	903-792-1301
Randy Sam's Shelter	Texarkana	903-792-7024
Salvation Army	Texarkana	903-774-2701

800-372-4464 or 903-832-8636 for Appointment:
CHIP (Children's Health Insurance Program)
CJHIP Perinatal Children's Medicaid
Medicaid Foodstamps TANF
Women's Health Program
Medicaid for long-term care services
Medicaid for elderly and people with disabilities
AIDS/HIV Helpline-N Texas 800-924-AIDS/Dallas 214-559-AIDS
AIDS Resource Center 214-521-5124
AA-Fellowship Baptist Church 903-645-7550
Al-Anon – Alateen 800-425-2606
Chuck Wagon Cowboy Ministries Recovery Program
1611 E 1st St, Hughes Springs 903-702-2670
Adult Protective Services Daingerfield 903-645-2283
AMC Cancer Information 800-822-2762
American Cancer Society 800-227-2345
American Diabetes Association 800-342-2383
Diabetic Supplies: Allen-Med (test strips, etc) 800-333-1412
www.NeadyMeds.org 800-503-6897
www.rxassist.com
Area Agency on Aging 800-372-4464
Adult Learning Center: Mt Pleasant 903-987-2935
Naples 903-575-2130
Blind: Daingerfield Lions Club 903-645-3622
Commission for the Blind 903-831-3846
Child Care CMS 800-874-3226 or CCMS 800-676-8283

Child and Elder Abuse Hotline 800-252-5400
Child Protective Services 903-572-3483 or 903-645-2283
Child Welfare Board 903-533-4174
CIDC (Critically Ill and Disabled Children) 903-656-3358
Austin 800-252-8023
Deaf: DARS office DHHS 903-581-7542 866-606-3122
East Texas Deaf & Hard of Hearing 903-534-8111
Starkey www.starkeyfoundation.com 800-328-8602
Abilities Success, Inc. – Tyler 903-705-4321
Dental: Prime Care – Marshall 903-938-1146
Wellness Pointe – Longview 903-212-4700
Department on Aging & Disability Svs DADS 903-572-3483 x240
Department of Human Services 903-645-2283
East Texas Legal Service 903-758-9123
Lakes Regional MHMR 400 Airport Rd Terrell 903-524-4159
Mt. Pleasant MHMR 1300 W 16th 903-572-8783
Safe-T-Crisis Center Mt Pleasant 903-575-9999
Texas Department of Human Resources 903-645-2283
Texas Rehab 903-255-3220 903-255-3212 903-255-3216
Texas Veteran Service Officer-Morris County 903-645-3691
Texas Veterans Hot Line 800-252-8387
Texas Veterans Waco 258-299-9974
Texas Workforce Commission 903-572-9841
Vision: Texas Workforce Commission 903-251-4817
WIC (Women, Infants & Children) 903-645-2005
Prescription Card: www.texasrxcard.com
www.nacorx.org www.rxassist.com

MORRIS COUNTY

Vicki Jones
Indigent Health Care Coordinator



MORRIS COUNTY INDIGENT HEALTH CARE

APPLICATION REQUIREMENTS

The Morris County Indigent Health Care Program (MCIHCP) requires that all blank spaces on the application be completed at the time of submission. Applications that are incomplete or without the required information will result in your application being denied or returned to you.

The following information, as it applies to you, is required:

MARITAL STATUS: • Single • Separated • Married • Divorced • Widowed

PROOF OF IDENTIFICATION for each applicant:

- Texas Driver's License or Texas ID Card
- Resident Alien Card/Visa/Passport/Work Permit
- Social Security Card, if available
- Current identification from your home country

ALL FORMS OF IDENTIFICATION MUST BE CURRENT ANO UP-TO-DATE

PROOF OF RESIDENCE IN MORRIS COUNTY

- Texas Driver's License or Texas ID with same address as your application
- Voter's Registration Card with same address as your application
- Current utility bill showing the same address as on your application (regardless of name on bill — as long as you are jiving there)

INCOME

- Four (4) most recent paycheck stubs (NOTE: if you have unpaid medical bills from the past 3 months, then we need ail paycheck stubs for those months as well.)
- If paid in cash, you must bring a statement from your employer verifying your income • if self-employed, bring current records or self-employment form
- Current Social Security award letter for you, spouse, and any children receiving it
- Current verification for Worker's Compensation medical benefits OR denial of benefits • Current proof of any fixed income, such as: widow's benefits, retirement, pension, dividend payments, unemployment. worker's compensation, et

RESOURCES

- Bank statements for checking or savings accounts • Verification of stock, bond, or retirement accounts
- Automobile registration or title for alt vehicles in the household and loan information if applicable

VERIFICATION OF OTHER ASSISTANCE

- Current award/denial letters for Medicaid, TANF, SSI, Housing, Food Stamps or any other assistance program (bring all that apply)

500 Broadnax • Daingerfield Texas 75638 • Phone: 903-645-3691 • Fax: 903-645-5729

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 vehículos 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 must 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, se requiere 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

TEXAS
Health and Human Services

STATEMENT OF SELF-EMPLOYMENT INCOME
DECLARACIÓN DE INGRESOS DEL NEGOCIO PROPIO

See Instructions on Page 2./Vea las Instrucciones en la página 2.

Case Record Name	Case Record Number

1. **Name of Person Having Self-Employment Income**/Nombre de la persona que tiene ingresos de negocio propio.

   _____

2. **Give the number of months covered by this income statement.**
   Dé el número de meses que cubre esta declaración de ingresos. ..... ☐

3. **Describe what you did to earn this money.**/Describa lo que hizo para ganarse este dinero.

   _____

   _____

4. **List your business expenses and income. IMPORTANTE: Attach receipts, invoices, or other verifying papers.**
   Anote los gastos y ingresos de su negocio. IMPORTANTE: Adjunte recibos, facturas, u otros comprobantes.

Date Fecha	EXPENSES GASTOS	Amount Cantidad
		$

Total Expenses Total de Gastos	$

→

Date Fecha	INCOME INGRESOS	Amount Cantidad
		$

SUBTOTAL	$
Enter expenses here and subtract. Anote el total de gastos y reste.	—
NET SELF-EMPLOYMENT INCOME INGRESOS NETOS DEL NEGOCIO PROPIO	$

The above information is true, correct, and complete to the best of my knowledge. I understand that giving false information to the county could result in my being disqualified for fraud./Según mi leal saber y entender, toda esta información es cierta, correcta y completa. Comprendo que si doy información falsa al condado puedo ser descalificado por fraude.

Signature of anyone helping you to prepare this form / Date Firma de la persona que le ayudó a llenar la forma / Fecha	**Signature / Firma**	**Date / Fecha**

If you or any member of your household has any kind of self-employment income, fill out this form and attach it to your application. You may attach a copy of the latest income tax forms in place of this form. If your accounting system is not the same as this form, you may substitute a copy of your accounting statement. You must answer all questions and sign and date at the bottom. **Use additional sheets of paper if you need to.** Sign and date each sheet. Remember, this is your sworn statement. You will need to bring with you to the interview: bills, receipts, checks or stubs, and any other business records you have. Your worker will need to see them. **Your records will be returned to you.**

Self-employment Income. This is any money you earn working for yourself. It is not money you earn working for someone else. If you are in doubt, ask your caseworker.

Questions 1, 2, and 3. These questions are self-explanatory.

Question 4. List your business income and expenses. In the boxes on the left side of the form, list your business **expenses** (see the information below). Write in the dates you paid the expenses and the amount of each expense. Add the amounts, and enter your total in the box "total self-employment expenses." In the boxes on the right side of the form, list your **income** (see the information below). List the dates you received the income, your sources of income, and the amounts. Add the amounts, and enter your total in the box "total self-employment income." Subtract your expenses from your total self-employment income, and enter your "net self-employment income."

Expenses are your costs of doing business. Examples of expenses are supplies, repairs, rent, utilities, seed, feed, business insurance, licenses, fees, payments on principal of loans for income-producing property, capital asset purchases (such as real property, equipment, machinery, and other durable goods and capital asset improvements), your social security contribution for people who worked for you, and labor (not salaries you pay yourself). If you claim labor costs, list each person and the amount you paid them. If you have any other kinds of business expenses, be sure to list them and the date they were paid.

You may not claim:

- Rent, mortgage, taxes, or utilities on your business if it operates out of your home (unless these costs are separate from the costs of your home);
- Cost of goods you buy for the business but use yourself;
- Net business loss from a prior period and
- Depreciation.

If you are in doubt, bring proof of the expense and ask your worker.

Income includes money from sales, cash receipts, crops, commissions, leases, fees, or whatever you do or sell for money. If you have any other kind of income from your business, be sure to list it. Be sure to list the dates income was received.

Who must sign. The form must be signed by the applicant, spouse, or authorized representative. Anyone may help you complete the form, but that person must also sign and date the form. Ask your worker if anyone else needs to sign the form.

Si usted u otra persona de su casa tiene algún tipo de ingresos de negocio propio, llene esta forma y adjúntela a su solicitud. En lugar de esta forma, puede adjuntar una copia de la declaración de impuestos sobre ingresos más reciente. Si el sistema de contabilidad que usa no es igual al de esta forma, puede substituir la forma con una copia de su registro de contabilidad. Tiene que contestar todas las preguntas y firmar y fechar la forma al final. **Use hojas adicionales si las necesita.** Firme y feche cada hoja. Recuerde que ésta es una declaración jurada. Tiene que llevar a la entrevista: cuentas, recibos, cheques o talones de cheques y cualquier otra documentación que tenga del negocio. El trabajador tendrá que verlos. **Estos documentos le serán devueltos.**

Ingresos del Negocio Propio. Este término se refiere al dinero que gana cuando trabaja por su propia cuenta. No es el dinero que recibe cuando trabaja para otra persona. Si tiene alguna duda, consulte con su trabajador de casos.

Preguntas 1, 2, y 3. Estas preguntas no necesitan más explicación.

Pregunta 4. Apunte los ingresos y gastos de su negocio. En las cajas del lado izquierdo de la forma, enumere los **gastos** de su negocio (vea la información abajo). Ponga la fecha en que pagó los gastos y la cantidad de cada gasto. Sume las cantidades y ponga el total en la caja que dice "total de gastos del negocio propio". En las cajas a la derecha de la forma, enumere los **ingresos** (vea la información abajo). Ponga la fecha en que recibió cada ingreso, la fuente del ingreso y la cantidad. Sume las cantidades y ponga el total en la caja que dice "total de ingresos del negocio propio". Reste los gastos del total de ingresos del negocio propio y anote sus "ingresos netos del negocio propio".

Los gastos son los costos de un negocio. Algunos ejemplos de posibles gastos son: provisiones, reparaciones, renta, servicios públicos, semilla, forraje, seguro del negocio, licencias, cuotas, pagos del capital de préstamos para propiedades que generan ingresos, compras de bienes de capital (como bienes raíces, equipo, maquinaria y otros bienes duraderos y mejoras de bienes de capital), su aportación al seguro social de las personas que trabajan para usted y sueldos (pero no los que se paga a sí mismo). Si declara el costo de sueldos, ponga el nombre de cada persona y la cantidad que le pagó a cada quien. Si tiene cualquier otro tipo de gastos del negocio, asegúrese de anotarlos y poner la fecha en que los pagó.

No puede declarar:

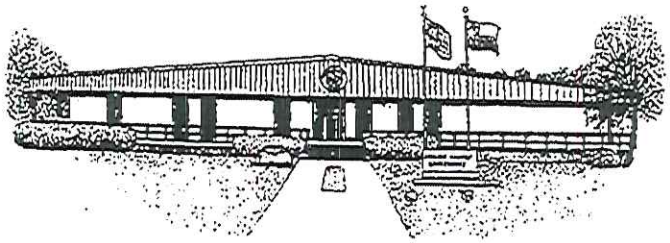
- El pago de la renta, la hipoteca, los impuestos o los servicios públicos del negocio si lo opera de su casa (a no ser que estos costos son aparte de los costos de la casa);
- El costo de artículos que compra para el negocio pero que usa personalmente;
- La pérdida neta del negocio de un periodo anterior; and
- La depreciación.

Si tiene alguna duda, lleve comprobantes del gasto y consulte con el trabajador.

Los ingresos son, entre otros, el dinero de ventas, el ingreso de caja, las cosechas, las comisiones, las rentas, las cuotas o cualquier cosa que hace o que vende por dinero. Si usted tiene cualquier otro tipo de ingresos del negocio, asegúrese de anotarlo. No olvide poner las fechas en que recibió el ingreso.

Quién debe firmar. El solicitante, su cónyuge o su representante autorizado para firmar la forma. Cualquier persona puede ayudarle a llenar la forma, pero esa persona también tiene que firmar y poner le fecha en la forma. Consulte con el trabajador para saber si alguien más tiene que firmar.

With a few exceptions, you have the right to request and be informed about the information that the county obtains about you. You are entitled to receive and review the information upon request. You also have the right to ask the county to correct information that is determined to be incorrect (Government Code, Sections 552.021, 552.023, 559.004). To find out about your information and your right to request correction, please contact your local county office. / Con algunas excepciones, usted tiene el derecho de saber qué información obtiene sobre usted el condado de pedir dicha información. Si desea recibir y estudiar la información, tiene el derecho de solicitarla. También tiene el derecho de pedir que el condad corrija cualquier información incorrecta (Código Gubernamental, Secciones 552.021, 552.023, 559.004). Para enterarse sobre la informacion y el derecho de pedir que la corrijan, favor de ponerse en contacto con la oficina local del condado.



MORRIS COUNTY

MORRIS COUNTY INDIGENT HEALTH CARE
BEHAVIORAL GUIDELINES

- All Applicants and Qualified Clients are required to comply with all State and County policies and guidelines to receive services through the Morris County Indigent Health Care Program (MCIHCP).
- Alt Applicants or Qualified Clients are required to comply with behavioral guidelines established by the State of Texas.
- All Applicants or Qualified Clients who are rude and display disruptive or abusive language and behavior will not be seen. Our Personnel will be protected from dangerous situations; 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 their health care providers: doctors, clinics, hospitals, etc.
- Medical Regime includes but is not limited to any instructions to refrain from use of alcohol, illicit drugs, and tobacco; as well as instructions for diet and exercise.

I HAVE READ AND UNDERSTAND ALL OF THE ABOVE GUIDELINES AND UNDERSTAND THAT FAILURE TO COMPLY WITH THESE GUIDELINES COULD RESULT WITH SUSPENSION FROM THE PROGRAM:

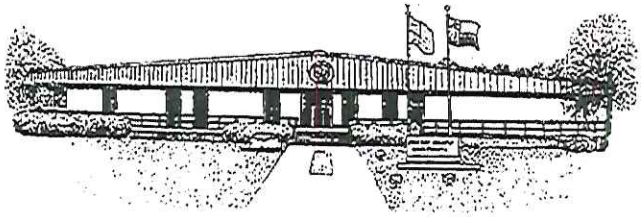
_____ _____

Applicant's Signature Date

_____

Printed Name of Applicant

500 BROADNAX · DAINGERFIELD TEXAS 75638 · PHONE 903-645-3691 · FAX 903-645-5729



MORRIS COUNTY

MORRIS COUNTY INDIGENT HEALTH CARE
FRAUD POLICY

I. If a person knowingly provides false information for the purpose of qualifying for indigent health care, he or she is subject to Section 37.10 of the Texas Penal Code — Tampering with Government Record, Class 'A' Misdemeanor; and/or subject to Section 32.46 of the Texas Penal Code — Securing Execution of Document by Deception.

II. If a person knowingly, within the previous 24 months, transferred a countable resource for less than fair market value to qualify for indigent health care, that person's household is ineligible for two (2) years beginning with the date the resource was transferred, and if a person fails to disclose such a transfer, that person would also be subject to the criminal sanctions as set out in Section i.

III. If a person fails to report a change in income, resources, or residence for the purpose of remaining eligible, he or she is liable for any benefits received while ineligible; and subject to criminal sanctions listed in Section I; and subject to Section 31.03 and/or Section 31.04 of the Texas Pena' Code, Theft and Theft of Services, respectively Class 'C' Misdemeanor to Second Degree Felony, depending on the value of the property or services taken.

IV. If a person knowingly alters an authorization document received from the indigent health care program for the purpose of changing the nature of health care authorized or the beneficiary of the health care authorized, he or she is subject to Section 37.10 of the Texas Penal Code, Tampering with Governmental Record, Class 'A' Misdemeanor. If the alteration involves the dispensing of controlled substances, the person is subject to Criminal sanctions pursuant to the Dangerous Drugs Act and the Controlled Substances Act.

The laws cited here are for illustrative purposes.

Upon finding of fraud, the client shall be administratively ineligible for IHC as follows:

First offense	24 months from the date fraud was discovered
Second offense	36 months from the date fraud was discovered
Third offense	48 months from the date fraud was discovered
Additional offenses	+12 months for each additional offense

CONSEQUENCE OF FRAUD

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

- Shall reimburse Morris County for the cost of benefits they were ineligible to receive
- Shall be administratively ineligible for Morris County IHC benefits in accordance with the above policy

If you do not know the answer to a question you are asked or on the application, do not guess. I have read the above information and understand its contents.

Signature _____ Date _____

Printed Name _____

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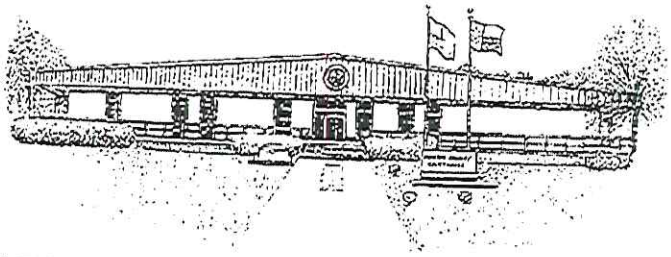

MORRIS COUNTY INDIGENT HEALTH CARE

STATEMENT OF SERVICES

- Clients are expected to seek ALL non-emergency medical care from their primary care physician. Make certain that your physicians understand the Indigent Health Care Program. They may call this office for clarification.
- Hospital emergency rooms are not to be used except in matters of true emergency. If you seek routine medical attention — such as for a common cold — from an emergency room, you may be held responsible for the hospital bill and all related emergency room physician/lab bills.
- Morris County will pay for up to three (3) prescriptions per month and up to $30,000 per year in hospital, doctor, lab, x-ray, and skilled nursing facility expense OR 30 days of hospitalization, whichever comes first.
- Clients can be held responsible for the balance of charges not paid by Morris County, including full payment for prescriptions exceeding 3 per month.
- Clients are responsible for informing providers of their eligibility with the Morris County Indigent Health Care Program and for informing these providers of our billing address.
- Morris County Indigent Health Care is not responsible for any medical claims received after our deadline. (Either 95 days from the date of service OR 95 days from the date of your completed application.) *If a provider sends a bill to you, YOU MUST contact that provider and give them the above information so that they can bill our office.
- Clients MUST notify our office within fourteen (14) days of any change of situation, such as changes in: income, address, property (including vehicles), household members, application/receipt of SSI, TANF, or Medicaid. Failure to notify this office within the fourteen days may result in your becoming ineligible for this program.
- This program does NOT pay for ambulance, eye exams or glasses, dental, medical equipment, replacements of any sort including but not limited to knee or hip, etc.

If a change occurs that makes you ineligible and you fail to report the change as required, you may be held responsible for payment of any medical services received after you became ineligible, or you may be subject to prosecution under the Texas Penal Code.

I HAVE READ AND UNDERSTAND ALL CONDITIONS AS STATED ABOVE:

_____ _____

Signature Date

_____

Printed Name

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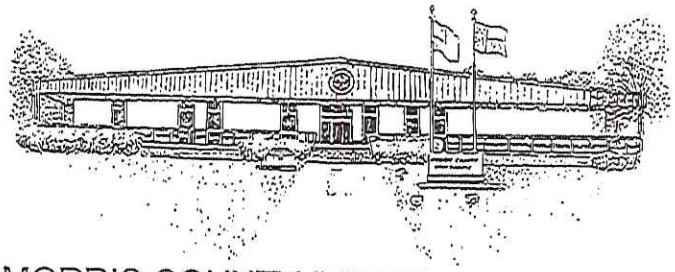
MORRIS COUNTY



MORRIS COUNTY INDIGENT HEALTH CARE

AUTHORIZATION FOR BACKGROUND CHECK

APPLICANT: _____ SS: _____ DOB: _____

SPOUSE: _____ SS: _____ DOB: _____

ADDRESS: _____

I understand that as part of the application process for benefits from the Morris County Indigent Health Care Program (MCIHCP) I am required to provide certain written documents to the MCIHCP office. I realize that my failure to provide such documentation will delay the receipt of benefits, if any, that I may be eligible to receive.

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

I, _____ and spouse, if applicable, _____ hereby authorize any public agency including the Social Security Administration, Medicaid, and Medicare to furnish Morris County or its agent information related to assets or any other sources of income to me held in my name and/or criminal history. I hereby release Morris County and all of its agents and employees, the public agencies providing such information and all employees of public agencies furnishing information, and all liability resulting from the furnishing of this information to Morris County. I certify that the statements made by me on this form and on my application for health care services are true, complete, and correct to the best of my knowledge and belief and are made in good faith. I understand that any false statements made herein or on my application for MCIHCP services will void further consideration for eligibility as it relates to my application for such services. I know and understand the MCICHP Fraud Policy.

I am aware that I must reapply for Indigent Health Care benefits every six months, and that if I do not reapply that I could lose any benefits I might have been receiving.

I have read all of the above, and I understand it.

Signature: _____ Date: _____

Signature: _____ Date: _____

500 Broadnax Daingerfield TX 75638 903-645-3691 Phone 903-645-5729 Fax

Form 113

COUNTY INDIGENT HEALTH CARE PROGRAM (CIHCP)
APPELLANT/PROVIDER ASSIGNMENT – CESIÓN DEL APELANTE Y DEL PROVEEDOR

County	Telephone No.	Case Number

APPELLANT ASSIGNMENT/CESION DEL SOLICITANTE DE SSI

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-named county my rights to recover the cost of health care services provided by the county from any third party, up to the amount of expenditures made on my behalf by the county.

Certifico que estoy apelando la decisión del Seguro Social. Como condición de recibir los beneficios de salud de CIHCP, cedo al condado nombrado arriba mi derecho a recobrar de cualquier tercera persona, el costo de servicios de salud provistos por el condado hasta cubrir los gastos incurridos por el condado o por TDH en beneficio mío.

Signature – Appellant/Firma – Solicitante de SSI _____ Date/Fecha _____

Name of Appellant/Nombre del Solicitante de SSI	Address (Street, City, State, ZIP)/Dirección (Calle, Ciudad, Estado, ZIP)

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 assignment, 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 boldface type with the following statements:
  1. "This is to certify that the foregoing information is true, accurate, and complete."
  2. "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 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 SSI MEDICAID ELIGIBLE.

Signature – Provider _____ Date _____

Provider's Name	National Provider Identifier (NPI, the 10-character Medicaid Billing ID #)	Telephone No.
		( )
Physical Address (Street, City, State, ZIP)		

COUNTY INDIGENT HEALTH CARE PROGRAM
EMPLOYMENT VERIFICATION

Date/Fecha	Case Record No./Núm de Caso
Office Address and Telephone No./Oficina y Teléfono Fax:	

Employee	Social Security Number

This individual is a member of a household applying for health care assistance from the County Indigent Health Care Program. To determine this household's eligibility, it is necessary to verify all earnings. Since this individual is/was/will be your employee, your help is needed.

Please completely and accurately provide the information requested on the back of this letter. If a question does not apply, mark it N/A. After you complete this form, give it to your employee, mail it in the envelope provided, or fax it to the number listed above.

This information is needed by this date: _____. If you could send it before this date, it would be most appreciated.

Thank you for helping. If you have questions, please feel free to call.

I give my permission to release the information requested on this form.
Yo doy mi permiso para que mi empleador dé la información que se pide en esta forma.

_____ Signature / Firma

_____ Date / Fecha

Comments: _____

EMPLOYMENT VERIFICATION

Employee Name (as shown on your records)	
Employee Address – Street, City, State, ZIP (as shown on your records)	
Is/was/will this person (be) employed by you? ☐ Yes ☐ No If yes → ☐ Permanent ☐ Temporary	Is FICA or FIT withheld? ☐ Yes ☐ No
Rate of Pay $ ☐ Per Hour ☐ Per Day ☐ Per Week ☐ Per Month ☐ Per Job	Average Hours per Pay Period / How often is employee paid?

On the chart below, list all wages received by this employee during the months of: _____

Date Pay Period Ended	Date Employee Received Paycheck	Actual Hours	Gross Pay	Other Pay * (Bonuses, Commissions, Overtime, Pension Plan, Profit Sharing, Tips)

* In Comments Section below, please explain when and how Other Pay is received.

Date Hired	Date First Paycheck Received	If employee is/was on Leave Without Pay Start Date: End Date:

If this person is no longer in your employ
Date Final Paycheck Received: Gross Amount of Final Paycheck: $

Is health insurance available?
☐ Yes ☐ No If Yes, employee is → ☐ Not Enrolled ☐ Enrolled for Self Only ☐ Enrolled with Family Members

Comments: _____

_____ _____
Signature and Title of Person Verifying This Information Date

Company or Employer	Address (Street, City, State, ZIP)	Telephone Number (Include area code.)

THE FOLLOWING

TWO (2) PAGES

ARE TO BE

COMPLETED

BY ANYONE

GIVING YOU ASSISTANCE.

MAKE CERTAIN ALL BLANKS ARE FILLED!

RETURN WITH YOUR APPLICATION

MORRIS COUNTY
INDIGENT HEALTH CARE

I (We) _____ help _____
(Household providing support) (Applicant)

by providing the following things:

_____ How much cash do you give each month? _____

_____Pay utilities directly to company

_____Pay medical bills and/or prescriptions directly to DR. or pharmacy

_____ Food and clothing at the time of purchase

_____ Payment of house loan or rent directly to landlord or the loan company

_____ Other_____

_____ The above Applicant does live with me/us

_____ The above Applicant does not live with me/us.

I state that the above named Applicant_____is _____is not employed.

The above statements made by me (us) regarding the above household are true and correct. I understand that this statement will be part of a government record, and that any false entry made with the intent to defraud Morris County or any other person may constitute a third degree felony, punishable by a fine not to exceed $10,000 and confinement in the State Penitentiary for the period of two to ten years

_____ _____
Date Signature of person(s) providing support

_____
Street Address

_____
Mailing Address

_____
City-Zip / County

Phone Number _____

CONTRIBUTIONS FORM

Name: _____

The person named above has stated that you provide help to their household. Please provide dates, amounts, and whether this assistance will continue.

When did the assistance start?: _____

Was your help a loan? YES NO (please circle) *A loan is money that is expected to be repaid and the household can explain how and when the money will be paid back.*

Date	Amount	Person Receiving Loan	Date to be Re aid/How to be Re aid

Did you make a contribution to the household? YES NO (please circle) *A contribution is money you give to the household that is not expected to be paid back.*

Date	Amount	Person Receiving Money	Purpose of the Contribution

Did you pay any bills for the household as a vendor payment? YES NO (please circle) *A vendor payment is a payment you make directly to the person or company that bills the household for a service or directly to the company for a purchase.*

Date	Amount	Person Billed	Person/Company Paid	Purpose

Printed Name: _____ Address: _____

Signature: _____ Phone: _____

Relationship: _____ Date: _____

Return this form to:

MORRIS COUNTY INDIGENT HEALTH CARE

County Judge's Office - Morris County Courthouse

500 Broadnax Street, Daingerfield Texas 75638

Phone 903-645-3691 Fax 903-645-5729