



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

For Office Use Only

Status <input type="radio"/> Application <input type="radio"/> Review	Date Form 3064 Requested/Issued	Date Identifiable Form 3064 Received	Case Record No.	Appointment Date and Time, if applicable
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Name (Last, First, Middle)	Home Area Code and Phone No.	Other Area Code and Phone No.
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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
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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?
					<input type="radio"/> Yes <input type="radio"/> No
					<input type="radio"/> Yes <input type="radio"/> No
					<input type="radio"/> Yes <input type="radio"/> No
					<input type="radio"/> Yes <input type="radio"/> No
					<input type="radio"/> Yes <input type="radio"/> No
					<input type="radio"/> Yes <input type="radio"/> No
					<input type="radio"/> Yes <input type="radio"/> 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? _____

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.

Chambers County Indigent Health Care

NOTICE OF PRIVACY PRACTICES, Effective February 17, 2010

We believe your health information is personal. We will keep records of the care and services that you receive at either of our facilities. We are committed to keeping your information private, and we are also required by law to respect your confidentiality.

USES & DISCLOSURES:

The following categories describe some of the way we use and disclose health information:

For Treatment: We may use health information about you to provide you treatment or services. We may disclose health information about you to doctors, nurses, technicians, medical students, or other clinic or hospital personnel who are involved in taking care of you at either facility. Different departments of the hospital may also share health information about you in order to coordinate different things you may need, such as prescriptions, lab work, meals and x-rays.

We may also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you're discharged.

For Payment: We may use and disclose health information about your treatment and services to bill and collect payment from you, your insurance company or a third party payer. For example, we may need to give your insurance company information about your surgery so they will pay us to reimburse you for the treatment. We may also tell your health plan about treatment you are going to receive to determine whether your plan will cover it.

For Health Care Operations: Members of the medical staff and/or quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. The results will then be used to continually improve the quality of care for all patients we serve. For example, we may combine health information about many patients to evaluate the need for new services or treatment. We may disclose information to doctors, nurses, and students for educational purposes and we may combine health information we have with that of other facilities to see where we can make improvements. We may remove information that identifies you from this set of health information to protect your privacy.

We may also use and disclose health information: To business associates we have contracted with to perform the agreed upon service and billing for it, to remind you that you have an appointment for medical care, to access your satisfaction with our services, to tell you about possible treatment alternatives, to tell you about health-related benefits or services, for population based activities relating to improving health or reducing healthcare costs, and for conduction training programs or reviewing competence of healthcare professionals. When disclosing information, primary appointment reminders and billing/collection efforts, we may leave messages on your answering machine or voice mail.

Business Associates: There are some services provided in our organization through contracts with business associates. Examples include physician services in radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you, your insurance company or a third-party payer for services rendered. We, may limit the use, disclosure or request to the minimum necessary to accomplish the intended purpose. To protect your health information, however, we require the business associate to appropriately safeguard your information and we will notify you following a breach of protected health information.

Directory: We may include certain limited information about you while a patient at our hospital. The information may include your name and your general condition (e.g. good, fair) and your religious affirmation. This information may be provided to members of the clergy and except for religious affiliation, to other people who ask for you by name. During your registration process, you may opt out of such listings. The Acknowledgement of Your Hospital Stay part of you admitting form provides directory listing options.

Individuals Involved in Your Care of Payment for Your Care: While a hospital patient, we may release medical condition information about you to a friend or family member who is involved in your medical care or who helps pay for your care, or who you authorize to receive medical condition information. In addition, we may disclose health information without your written permission.

Research: We may disclose information to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research and granted a waiver of the authorization requirement.

Future Communications: We may communicate to you via newsletters, mail outs or other means regarding treatment options, health related information, disease management programs, wellness programs, or other community based initiatives or activities our facility is participating in. If you do not want to be contacted for marketing efforts, notify the Privacy Official at the phone number provided on the notice to opt out of marketing and/or fundraising efforts on behalf of Chambers County Indigent Healthcare or any of its covered entities. Chambers County Indigent Healthcare will not use your health information to contact you for marketing purposes or sell your health information without your written permission.

Organized Health Care Agreement: This facility and its medical staff members have organized and are presenting you this document as a joint notice. Information will be shared as necessary to carry out treatment, payment and healthcare operations. Healthcare providers and caregivers may have access to protected health information in other offices to assist in reviewing past treatment as it may affect treatment at the time.

Affiliated Covered Entity: Protected health information will be made available to facility personnel at local affiliated facilities as necessary to carry out treatment, payment and health care operations. Caregivers at other facilities may have access to protected health information at their locations to assist in reviewing past treatment information as it may affect treatment at this time. Covered entities are prohibited from using genetic information for the purpose of underwriting.

- As required by law: We may also use and disclose health information for the following types of entities, including but not limited to: Food and Drug Administration, Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability, Correctional Institutions, Workers Compensation Agents, Organ and Tissue Donation Organizations, Military Command Authorities, Health Oversight Agencies, Funeral Directors, Coroners and Medical Directors, National Security and Intelligence Agencies, Protective Services for the President and Others.

**Chambers County Indigent Health Care
PO Box 489
Anahuac, TX 77514
409-267-2770
Fax: 409-267-6488**

Acknowledgment of Receipt of Notice of Privacy Policy

I have received a copy of the Chambers County Notice of Privacy Policy.

Signed: _____

Printed Name: _____

Date: _____

(After signing above, please return this acknowledgment to our office.)

The County of Chambers
Indigent Health Care Office
P.O. Box 489
Anahuac, TX 77514
(409)267-8306

STATEMENT OF SUPPORT / CONTRIBUTIONS

To be completed by: _____

In order to determine eligibility assistance for _____
We must verify all sources of income/assistance available to his/her family. Please complete the information requested below regarding assistance/money you have given this family in the last three months. Sign your name in the space for the person completing the form. **PLEASE ANSWER ALL QUESTIONS.**

MONTH'S OF _____

1. Do you provide cash assistance? _____
If so, how much do you give each month? _____
Is this money considered a gift or a loan? _____
If money is a loan when is client expected to repay and in what amounts? _____
2. Do you provide shelter and utilities? _____
If so, do you charge this person for rent and utilities? _____
3. Do you pay any of their bills? _____
If so, do you give them money or pay the bills directly to company? _____
4. Do you provide household and personal needs for this person? _____
If so, please explain what you do. _____
5. Do you provide any other type of assistance? _____
If so, please explain. _____
6. Has a change in assistance occurred? _____
If so, when? _____
7. Do you anticipate any change in assistance in the near future? _____

Signature of Person Completing This Form

Date

Address

Phone No.

Chambers County Indigent Health Care
PO Box 489
Anahuac, TX 77514
409-267-2770
Fax 409-267-6488

We will need copies of the following information in order to complete your case:

****2 Forms of identification for EVERYONE in your household**

Driver's License, Social Security Card, Birth Certificate, Voter Registration Card, Shot Records, School Records

****Proof of Residency**

Current utility bill (electric, water), Rent receipt, Voter Registration Card, letter from landlord or friend

****Proof of Income for Last 2 Months**

Check stubs, Letter from Employer, Award Letters

****Medicaid Cards**

(if applicable)

****Bank Statements**

Checking and/or Savings

****Vehicle Registration or Title**