## APPLICATION FOR HEALTH CARE ASSISTANCE

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:

Where You Live and Plan To Continue Living

Possible Proof: Mail that you received at your address; school records; voting records; property tax, rent or mortgage receipts; Texas driver's license; other official identification.

What You Own and What It Is Worth

Possible Proof: Property tax appraisals, estimates from car dealers, ads selling similar items, statements from real estate agents, bank statements.

Your Income

Possible Proof: Pay check stubs, pay checks, W-2 tax forms or income tax returns, sales records, statements from employers, award letters, legal documents, statements from persons giving you money.

Other Health Care Coverage

Possible Proof: Award or claim letters, insurance policies, court documents, other legal papers.

Information on social security numbers should be given if this information is available. Information on sex (Male/Female) is voluntary. These types of 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, if you have answered all the questions on the application, and if you 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.

## SOLICITUD DE ASISTENCIA DE ATENCIÓN MÉDICA

El Programa de Atención Médica para Indigentes del Condado (CIHCP) ayuda a la gente a pagar los servicios médicos que necesita. La elegibilidad para esta ayuda depende de los ingresos del solicitante, sus posesiones, el lugar donde vive, otra ayuda que recibe o que podría recibir, y otras consideraciones. Asegúrese de:

1.) Poner su nombre y dirección;
2.) Firmar y fechar la tercera página de la solicitud; y
3.) Conteste tantas preguntas que pueda sobre esta solicitud.

Entregue su solicitud, o échela al correo, hoy mismo aun si no ha podido contestar todas las preguntas.

### SUS RESPONSABILIDADES

Puede que le pidan pruebas de lo que escriba en su solicitud o de lo que diga en su entrevista. Si necesita ayuda para obtener las pruebas, la persona que le haga la entrevista le puede ayudar. Estos son algunos ejemplos de información que puede que tenga que probar y de documentos que le puede servir de prueba:

El Lugar Donde Vive O Donde Tiene Su Hogar Permanente

Posibles Pruebas: Correo que recibió en esa dirección; expedientes de de la escuela; registros de votante; recibos de impuestos, renta o hipoteca; la licencia para manejar de Tejas; otra identificación oficial.

Las Posesiones Que Tiene Y Cuanto Vale Cada Una

Posibles Pruebas: El avalúo para impuestos sobre la propiedad, avalúos hechos por vendedores de carros, anuncios de la venta de articulos parecidos, declaraciones de agentes que venden propiedades, estado de cuentas del banco.

Los Ingresos Que Tiene

Posibles Pruebas: Talones del cheque de paga, cheque de paga, comprobante de salaries e impuestos (Forma W-2), declaración de impuesto federal, el historial de ventas, declaraciones de empleadores, carta de concesión, documentos legales, declaraciones de personas que le dan dinero.

Otra Cobertura Para Gastos Médicos

Posibles Pruebas: Cartas de reclamación o de concesión, pólizas de seguros, papeles de la corte u otros documentos legales.

Si tiene a su disposición los números de seguro social, debe darlos. La información sobre el sexo (Hombre/Mujer) es voluntaria. Esta información no afectará su elegibilidad.

Debe dar información sobre seguros médicos y de cualquier tercero que tenga la responsabilidad de pagar los servicios médicos pagados por el condado en beneficio de usted y miembros de la unidad familiar. Al firmar y presentar esta solicitud, usted se compromete a darle al condado el derecho de recuperar el costo de servicios de un tercero.

Pueden pedirle que solicite Medicaid, Asistencia Temporal a Familias Necesitadad (TANF), o Seguridad de Ingreso Suplemental (SSI). Si le han pedido que solicite beneficios de alguno de estos programas o si usted ya los solicitó y está esperando la respuesta, su solicitud de CIHCP puede ser detenida hasta que decidan que no es elegible para los programas mencionados. Si no es elegible para estos programas, si ha contestado todas las preguntas de la solicitud, y si ha dado todos los comprobantes que piden, ya pueden procesar su solicitud. Entonces, el CIHCP tiene un plazo de 14 dias para determinar su elegibilidad.

Después de entregar su solicitud, usted debe reportar dentro de un plazo de 14 dias cualquier cambio de dirección, ingreso, recursos, el número de personas que viven con usted, o si solicita o recibe Medicaid, TANF, o SSI.

| FOR OFFICE USE ONLY / PARA USO DE LA OFICINA | | | | |
|---|---|---|---|---|
| Status<br>☐ 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? Sí es el caso, enumere los nombres que ha usado.

☐Yes/Sí ☐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)<br>Nombre (Apellido, primero, segundo) | Social Security Number<br>**(if available)**<br>Número de Seguro Social<br>(si lo tiene a su disposición) | Sex<br>Sexo<br>Male/ Female<br>Hombre/ Mujer | Date of Birth<br>Fecha de nacimiento | What Relation to you?<br>¿Parentesco con usted? | Are you a sponsored alien?<br>¿Es usted un extranjero patrocinado? |
|---|---|---|---|---|---|
| | | | | MYSELF<br>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/Sí ☐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 vehiculos 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 "Si," ¿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; o pagos por desempleo.

| Name of person receiving money<br>Nombre de la persona que recibe el dinero | Name of agency, person, or employer who provides the money<br>Nombre del patrón, la persona o la agencia que paga el dinero | Amount received<br>Cantidad recibida | How often received?<br>(daily, weekly, every two weeks, twice a month, monthly?)<br>¿Con qué frecuencia lo recibe?<br>(¿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 dícho 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 may 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, el cónyuge también puede firmar 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<br>Firma - Persona que ayudó a llenar esta solicitud / Fecha | Signature - Applicant's Representative / Date<br>Firma – Representante del solicitante / Fecha | Signature – Witness (if signed with "X") / Date<br>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

# Burnet County Indigent Health Care Program

## Verification of Application for Assistance

To Whom It May Concern:

Please be advised that _____ has submitted an

application for assistance for the **Burnet** County Indigent Health Care Program

on _____.

Our office will make an eligibility decision within 14 days from the date **ALL NECESSARY DOCUMENTS** were received.

If you have any questions or comments, please contact this office.

Sincerely,

| _____ | _____ | _____ |
|---|---|---|
| Print Name<br>BCIHS Staff | Signature | Date |

cc: client files

Burnet County Indigent Health Care
220 S. Pierce
Burnet, TX 78611

khardin@burnetcountytexas.org
(C) 512-755-1558
(F) 512-715-0370

# Burnet 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 (CIHCP).

**General Provisions**

I. 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 CIHCP Act, the CIHCP regulations, or State Statues relating to the use, or acquisition of CIHCP

II. 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 Burnet County IHCP forms are completed;
   b. Information misrepresented at the time legal requirements (CIHCP 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 CIHCP;
   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.

III. The IHC refers any case to the County Judge or 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 Judge or County Attorney will be completed.

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

**Acknowledged:**

| IHC Client Signature | Printed Name | Date |
|---|---|---|

Burnet County Indigent Health Care
220 S. Pierce
Burnet, TX 78611

KHardin@burnetcountytexas.org
(C) 512-755-1558
(F) 512-715-0370

# Burnet County Indigent Health Care Program

Client Rights & Responsibilities

## I understand as a client of Indigent Health Care Program (IHC) I must:

- Report to the IHC Coordinator in less than 14 days if my income changes, if I move, or if there are new members in my household (for example getting married, or a child or spouse moving back in with me). Any new job, new income, or money received must be reported. I understand that failure to report changes that may disqualify me for services, I will have to pay for those services or I could face legal charges.
- Report if I apply for Social Security Disability, or if there are any changes in my SSI or SSDI case.
- Go only to one primary care physician (PCP). I will only visit specialists referred by my physician. I understand that the program may not pay for a specialist if the referral is not from my assigned physician.
- See my primary care physician for non-emergency situations.
- Always call ahead to make an appointment with my physician and to follow physician orders.
- I will take my medication as instructed by my physician.
- I will follow recommended diet and restrictions from my physician (i.e. no smoking, tobacco products, or alcohol).
- Carry my BCI eligibility cared when I go to the doctor, hospital, or pharmacy. I may not receive services without presenting my card.
- Notify or have my physician notify the IHC Coordinator of any procedures or appointments that I have scheduled.
- Contact the IHC coordinator for a replacement card should my card becomes lost.
- I must call the IHC coordinator and request to **reapply for BCI assistance** **2 weeks prior** to the end of my eligibility.
- Use HEB pharmacy in Burnet or Marble Falls for prescriptions. I understand that BCI will only pay for three prescriptions each calendar month for a 30-day supply. Some medications are restricted.
- **Immediately after my first appt. with my doctor, I will call the IHC coordinator and provide my physicians full name, to be added to MEDIMPACT, otherwise, my medication will not be covered.**
- If I receive bills for physician, hospital, or pharmacy services I will request that those be sent to Burnet County IHC immediately.

## I also understand that:

- Claims for medical services provided outside the State of Texas will not be paid by Burnet County IHC, unless prior arrangements have been made and services pre-approved by program administrators.
- Burnet County IHC does not pay for treatment of, or hospital stays related to drug, alcohol abuse or overdose.
- Burnet County IHC does not cover self-inflicted injuries or abuse.
- Burnet County IHC does **NOT** pay for any medications that can be bought without a prescription, restricted medications (pain, psychiatric, lifestyle), ambulance services, major dental, vision, prenatal care, or any immunizations that are available at State Health clinics.
- The program covers up to $30,000 in medical bills or up to 30 days of hospitalization each fiscal year (September 1st through August 31st); whichever occurs first.

**I have read (__) or have had read to me (__) the above information and my questions have been answered. I understand and agree to these terms.**

Signature Date Witness Date

Burnet County Indigent Health Care
220 S. Pierce
Burnet, TX 78611

khardin@burnetcountytexas.org
(C) 512-755-1558
(F) 512-715-0370

TEXAS Health and Human Services

**Form/Formulario 108**

# COUNTY INDIGENT HEALTH CARE PROGRAM
# CASE RECORD INFORMATION RELEASE
## PROGRAMA DEL CONDADO DE ATENCIÓN MÉDICA AL INDIGENTE
## REVELACIÓN DE INFORMACIÓN DE EXPEDIENTE DE CASO

| **Case Record Name**/Nombre en el expediente de caso | **Case Record Number**/Número de expediente de caso |
|---|---|
| | |

**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 County Indigent Health Care Program 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.**

Yo, por este medio, autorizo a las personas, organizaciones o establecimientos que tengan información o documentos sobre mí/nosotros o sobre mis/nuestras circunstancias para que den dicha información a un representante del Programa del Condado de Atención Médica al Indigente.

Yo, por este medio, doy permiso al Programa del Condado de Atención Médica al Indigente para que obtenga la información que pudiera incidir en mi/nuestro derecho a recibir asistencia.

Este formulario de revelación es válido por seis meses a partir de la fecha en que se firma.

**Person or Agency to Whom Information Will Be Released**/Persona o agencia a quien se revelará la información

☐ **Specific Request (Specify in 1 and 2 below.)**
Petición específica (especifique en 1 y 2 a continuación).

1. **Information Requested**/Información pedida: _____

2. **Period Covered (Dates)**/Periodo cubierto (fechas): _____

☐ **General Request (Any information available may be released.)**
Petición general (puede revelarse toda la información disponible).

_____

_____

_____ _____

**Signature- Applicant or Recipient**/Firma – Solicitante o beneficiado — **Date**/Fecha

_____ _____

**Signature – Spouse**/ Firma - Cónyuge — **Date**/Fecha

_____ _____

**Signature – Guardian, Power of Attorney, Parent of Minor Child**/ Firma - Tutor, poder notarial o padre/madre del menor — **Date**/Fecha

## PURPOSE

Use as the household member's authorization to release information that will help determine the household's CIHCP eligibility.

## PROCEDURE

Complete an original and one copy of the Form 108.

Issue the original Form 108 to the person or agency that will provide the requested information.

File the copy of the Form 108 in the case record.

## DETAILED INSTRUCTIONS

Enter the case record name.

Enter the case record number.

Enter the name of the person or agency to whom information will be released.

Specific Request. Check this box if the client wants to limit the release of information to specific items or a specific time period.

- Enter the type of Information Requested, such as:
  - Type and amount of benefits,
  - Amount of income, or
  - Degree of disability.
- Enter the Period Covered for specific information to be released, such as:
  - "for September 2002" and
  - "pertinent to the September certification."

General Request. Check this box if there are no restrictions on the type of information to be released.

The person about whom the information is being requested must sign and date Form 108.

One witness signs and dates Form 108, if applicable.

## FORM RETENTION

Maintain the records at least until the end of the third complete state fiscal year following the date on which the application is submitted.

# BURNET COUNTY INDIGENT HEALTH CARE OFFICE

NOTICE OF PRIVACY PRACTICES
"HIPPA"

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

## PLEASE READ CAREFULLY

Each time you visit or communicate with the Burnet County Indigent Health Care Program (BCIHCP), 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. BCIHCP is required by the privacy regulation issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPPA") to maintain the privacy practices with respect to your Protected Health Information. This document is notice to you of BCIHCP's privacy practices. BCIHCP 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 BCIHCP.
  **Treatment:** For example, BCIHCP must disclose diagnosis and test results from the referring primary care physician. When BCIHCP obtains appointments or authorizes payment with specialty clinics.
  **Payment:** For example, in order to pay for direct care, BCIHCP 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, BCIHCP 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 BCIHCP 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 BCIHCP 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
- 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 Burnet County Health Care Program. However, you have the following right 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. BCIHP is not required to agree to the requested restriction. If BCIHCP agrees to a restriction, it will not use or disclose your Protected Health Information in violation of the restriction. Either you or BCIHCP 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 you 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, and
    - 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 BCIHCP 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. BCIHCP 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: Burnet County IHC Administrator, Burnet County Indigent Health Care Program, 220 S. Pierce, Burnet, TX 78611.
- The right to receive an accounting of disclosures of your Protected Health Information covering six years prior to the date of a request of r disclosure. However, BCIHCP 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 Burnet County IHC Administrator, Burnet County Indigent Health Care Program, 220 S. Pierce, Burnet, TX 78611.

## 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 Burnet County IHC Administrator at 512-755-1558.

If you believe your privacy right have been violated, you may file a complaint with BCIHCP and with the Secretary of the U.S. Department of Health and Human Services. Complaints filed with BCIHCP should be in writing and directed to Burnet County IHC Administrator, Burnet County Indigent Health Care Program, 220 S. Pierce, Burnet, TX 78611. Complaints to the Burnet 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.

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

**BURNET COUNTY INDIGENT HEALTH CARE PROGRAM RESERVES THE RIGHT TO CHANGE ITS PRIVACY PRACTICES AND TO ME THE NEW PROVISIONS EFFECTIVE FOR ALL PROTECTED HEALTH INFORMATION WE MAINTAIN. SHOULD 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 July 21, 2009

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

Burnet County Indigent Health Care
220 S. Pierce
Burnet, TX 78611

khardin@burnetcountytexas.org
(C) 512-755-1558
(F) 512-715-0370

**BURNET COUNTY INDIGENT HEALTH CARE PROGRAM**

Authorization Form for the Use or Disclosure
of Protected Health Information
"HIPPA"

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:
**Burnet 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 Burnet County IHC Administrator, Burnet County Indigent Health Care Program, 220 S. Pierce, Burnet, TX 78611. Burnet 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 tin order to obtain insurance coverage and other 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 Burnet County IHC privacy protections.

Burnet County Indigent Health Care
220 S. Pierce
Burnet, TX 78611

khardin@burnetcountytexas.org
(C) 512-755-1558
(F) 512-715-0370

**BURNET COUNTY INDIGENT HEALTH CARE PROGRAM**

Authorization Form for the Use or Disclosure
of Protected Health Information
"HIPPA"

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

Signed_____

Printed Name_____

Date_____

Burnet County Indigent Health Care
220 S. Pierce
Burnet, TX 78611

khardin@burnetcountytexas.org
(C) 512-755-1558
(F) 512-715-0370

# Burnet County Indigent Health Care Program

## STATEMENT OF SUPPORT

I/WE _____ assist _____
**(Household providing support)** **(Applying individual/household)**

by providing the following: (Check **ALL** sections either *"Yes"* or *"No"*)

Yes____No____CASH (If yes, how much per month? $_____)

Yes____No____PAYMENT OF MEDICAL BILLS AND/OR PRESCRIPTION NEEDS

Yes____No____PAYMENT OF UTILITIES

Yes____No____FOOD AND/OR CLOTHING

Yes____No____PAYMENT OF HOUSE LOAN OR RENT

Yes____No____OTHER (i.e. – cell phone, transportation, entertainment, personal hygiene, etc.)

Yes ___No____The above household **DOES NOT** live with me/us.

Yes____No____The above household **DOES** live with me/us. He/She has lived with me/us since

_____
Month Day Year

Signature _____ Date_____
**(Household providing support)**

Street Address_____

City_____State_____Zip_____Telephone Number_____

*CIHCP Staff witnessing the signing of this Support Statement***_____

**Must be notarized **OR** must have copy of Signatory's valid ID if **NOT completed in front of a CIHCP Staff.** See below.

Before me, the undersigned authority, did personally appear _____, who upon oath, swears that the foregoing statement is true and correct. Signed this _____day of _____, 20 ____ by me, the undersigned authority, in and for the county of _____ _____, State of Texas.

_____ _____
NOTARY PUBLIC DATE

Burnet County Indigent Health Care
220 S. Pierce
Burnet, TX 78611

khardin@burnetcountytexas.org
(C) 512-755-1558
(F) 512-715-0370

Updated: 05/29/19

# Burnet County Indigent Health Care Program

Burnet County Indigent Healthcare Program is a county program that provides medically necessary health care benefits to individuals who meet the income, resource, residency, and household criteria; and who are categorically ineligible for the Texas Medicaid Program.

Burnet County Indigent Healthcare is at 1008 N Water Street, Burnet, Texas 78611 on Tuesdays; the Marble Falls Resource Center at 1016 Broadway, Marble Falls, TX 78654, on Thursdays; or call 512-755-1558 to have an application mailed to you.

BCIHC pays for covered services and all services must be medically necessary. You may be responsible to pay for some services if you choose to receive services that are not covered or are not considered medically necessary.

Burnet County is the payor of last resort. Applicants are not eligible for IHC benefits if they are eligible for any other Federal, State, or private benefits, i.e. Medicaid, Medicare, VA, CHIPS or other insurance. Program rules and eligibility standards are set by the State of Texas.

---

Burnet County will use rules and procedures found in the County Indigent Health Care Program Handbook published by the Texas Department of State Health Services.

The rules are as follows:

1. Application forms must be completed.
2. Verification of income, residence, household composition, and resources are required.
3. Net income cannot exceed 21% of the eligible Federal Poverty Guideline.
4. Liquid resources and assets cannot exceed $2000. The equity value of a vehicle greater than $4650 is counted against the $2000 limit. Personal property and homestead are exempt assets.
5. Eligible persons must be a resident of Burnet County.
6. Applicants must provide **all requested** information and documentation or applications will be denied.
7. Applicants have the right to appeal adverse decisions.

***What is Covered Services:***

* Physician services
* Annual physical examinations
* Immunizations
* Medical screenings
* Inpatient and Outpatient Hospital Services
* Rural Health Clinics
* Laboratory and x-ray services
* Family Planning Services
* 3 Prescriptions per month
* Skilled nursing facility services

***What is NOT Covered:***

* Ambulatory surgical center services (freestanding)
* Diabetic supplies and equipment
* colostomy supplies and equipment
* durable medical equipment
* home and community healthcare services
* Physician Assistants services
* Counseling services provided by LCSW, LMFT, LPC
* Dental care
* Federally qualified health centers services
* Vision Care including eyeglasses
* Emergency medical services
* Physical & Occupational Therapy Services
* Other medically necessary services or supplies that the local governmental municipality/entity determines cost effective

# Burnet County Indigent Health Care Program

---

***Office Locations:*** ***(TUESDAYS-WALKINS WELCOMED 8:30-4:00)***

**Office Location**: Burnet Public County Defender's Office
1008 N Water St.
Burnet, TX 78611
**Cell:** (512)-755-1558 / **Fax:** (512)-715-0370

**Mailing Address**: Burnet County Indigent Health Care
220 S. Pierce
Burnet, TX 78611

***(THURSDAYS-WALKINS WELCOMED 8:30-4:00)***

**Office Location**: Marble Falls Community Resource Center
1016 Broadway
Marble Falls, TX 78654

---

## All eligible Indigent Health Care clients are required to register for work with Texas Workforce Solutions

Please go to the following location to register:

Texas Workforce Center
1001 Buchanan Dr. # 1
Burnet, TX 78611
(512)-756-6769

**Important!** When you submit your completed application, please take this letter with you and ask them to sign and date or print out as verification that you have registered for work.

This letter along with the Texas Workforce Center date stamp or printout must then be returned to our office. If not your application will be denied.

**Received by TWC (name & date):** _____

**Applicant Name:** _____

Burnet County Indigent Health Care
220 S. Pierce St.
Burnet, Texas 78611
c.512-755-1558
f.512-715-0370