

Application for Assistance

Please provide the following information:

1. Completed Application
2. Verification of residence using a current utility bill showing you or your spouse's name and physical address, or one of the following: school records, property tax, rent or mortgage receipt.
3. Official Picture ID
4. Proof of current income, in the form of at least 2 recent check stubs

OR

Proof of unearned income such as Social Security Award Letters, Insurance Policies, court documents, or Workman's Comp Award Letter.

OR

Statements completed by anyone providing you any type of assistance

Please return this information to the hospital within 15 days of receiving this application.

If you have any questions, please contact:

Rolling Plains Memorial Hospital

200 East Arizona Ave

Sweetwater, TX 79556

325-219-6244

Applicant Name: _____
New App: _____
Renewal App: _____

Received Date: _____

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.



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
---	---------------------------------	--------------------------------------	-----------------	--

Name (Last, First, Middle)	Home Area Code and Phone No.	Other Area Code and Phone No.
----------------------------	------------------------------	-------------------------------

Have you ever used another name? If so, list other names you have used.
 Yes No

Mailing Address (Street or P.O. Box)	Apt. No.	City	State	ZIP Code
--------------------------------------	----------	------	-------	----------

Home Address, if different from above. If it is rural, give directions.

1. On the chart below, fill in the first line with information about yourself. Fill in the remaining lines for everyone who lives in the house with you, whether or not you consider them household members.

Name (Last, First, Middle)	Social Security No. (if available)	Sex (Male/ Female)	Date of Birth	Relation to You	Are you a sponsored alien?
					<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.

<input type="checkbox"/> Own or paying for home	<input type="checkbox"/> Live in a house provided by someone else	<input type="checkbox"/> No permanent residence
<input type="checkbox"/> Live with someone else	<input type="checkbox"/> Rent house or apartment	<input type="checkbox"/> 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 Income (SSDI)?

Yes No If Yes, who applied and when? _____

9. Do you or does anyone in your household have unpaid health care bills from the last three months? Yes No

If Yes, which months? _____

10. Do you or does anyone in your household have health care coverage (Medicare, health insurance, Veterans Affairs, Tricare, etc.)?

Yes No If Yes, who? _____

11. How much money do you have in your wallet, in your home, in bank accounts or other locations?

12. How many cars, trucks or other vehicles do you and anyone in your household have? List the year, make and model below.

Year	Make and Model	+
1		-

13. Do you or does anyone in your household own or pay for a home, lot, land or other things? Yes No

14. Did you or did anyone in your household sell, trade, or give away any cash or property during the last three months? Yes No

15. Have you or has anyone in your household worked in the last three months? Yes No If Yes, who? _____

16. List all of your household's income below. Include the following: government checks; money from training or work; money you collect from charging room and board; cash gifts, loans or contributions from parents, relatives, friends and others; sponsor's income; school grants or loans; child support; and unemployment.

Name of Person Receiving Money	Name of Agency, Person or Employer Providing Money	Amount Received	How Often Received?

The statements I have made, including my answers to all questions, are true and correct to the best of my knowledge and belief. I agree to give eligibility staff and the county any information necessary to prove statements about my eligibility. I agree to report any of the following changes within 14 days:

- Income
- Resources
- Number of people who live with me
- Address
- Application for or receipt of SSI, TANF or Medicaid

I have been told and understand that this application will be considered without regard to race, color, religion, creed, national origin, age, sex, disability or political belief; that I may request a review of the decision made on my application or recertification for assistance; and that I may request, orally or in writing, a fair hearing about actions affecting receipt or termination of health care assistance.

I understand that by signing this application, I am giving the county the right to recover the cost of health care services provided by the county from any third party.

I agree to give the county any information it needs to identify and locate all other sources of payment for health care services.

I have been told and understand that my failure to meet the obligations set forth may be considered intentional withholding of information and can result in the recovery of any loss by repayment or by filing civil or criminal charges against me.

Before you sign, be sure each answer is complete and correct. If the applicant is married and the spouse is a household member, the spouse may also sign and date this form, even if the spouse is a disqualified household member.

Signature — Applicant _____ Date _____ Signature — Spouse _____ Date _____

Signature — Person Helping Complete Form 3064 _____ Signature — Applicant's Representative _____ Signature — Witness (if applicant signed with "X") _____

Address of Person Helping Complete Form 3064 (Street, City, State, ZIP Code): _____ Area Code and Phone No.: _____

**INDIGENT/CHARITY HEALTH
CARE PROGRAM
CONSENT TO RELEASE
INFORMATION**

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 Indigent/Charity Health Care Program.

I hereby grant permission for the Indigent/Charity 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.

**PROGRAMA DE ATENCION
MÉDICA AL
INDIGENTE/CHARITY
CONSENTIMIENTO PARA
LANZAR LA INFORMACIÓN**

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

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

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

**Signature-Applicant or
Recipient/Firma-Solicitante o
beneficiado**

Date/Fecha