



Brazoria County Indigent Health Care Department

434 East Mulberry Street Angleton, Texas 77515

Office: (979) 864-1884 Fax: (979) 864-3922

260 George St., Suite 200 Alvin, Tx 77511

Office: (281)585-3024 Fax: (281) 824-0174

How to apply for the Brazoria County Indigent Program

1. Fill out the application; do not leave any blanks.
2. Make copies of all documentation required and attach them to your application.
3. Mail or drop off your application with the required documentation attached, at the Health Department in **Angleton** (if you live in Brazoria, Clute, Damon, Danciger, Freeport, Guy, Jones Creek, Lake Jackson, Old Ocean, Oyster Creek, Pledger, Richwood, Surfside, Sweeny, or West Columbia) or in **Alvin** (if you live in Alvin, Friendswood, Liverpool, Manvel, Pearland, or Rosharon)

Note: The receptionist is not responsible for making copies.

WHAT HAPPENS NEXT?

- Your application and documentation will be screened by a caseworker.
- If there is any additional documentation needed to make a complete application, you will be notified by mail and asked to submit the additional information.
- Once your application is complete, we will complete the pre-screen process and notify you by phone or mail of a date and time of your appointment. (We reserve the right to request additional information at any time during the application or interview process.)
- Should your case be denied, you will be mailed a denial letter.

******* Assistance in completing the application will be provided if needed; please contact Jennifer Gutierrez at (979)864-1884 or Amalia Ramos (281) 585-3024 for assistance*******



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APPLICATION REQUIREMENTS

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

To expedite your application, please attach copies of information listed below that applies to you.

PROOF OF IDENTIFICATION for each applicant (& sponsor if applicable)

- Texas Driver's License / Texas ID Card
- Resident Alien Card & Passport
- Social Security Card
- Birth Certificate (if no other documentation available)
- Current identification from your home country

PROOF OF RESIDENCE

- TXDL or TXID with same address as on your application
- Voter's Registration Card with same address as on your application
- Current Utility Bill showing the same address as on your application (regardless of name on bill)

INCOME

- Four (4) most recent paycheck stubs (NOTE: if you have unpaid medical bills from the past 3 months, then we need all 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 both spouses and any children receiving it
- Current Child Support Statements (actual checks or court-ordered child support)
- Divorce decree
- Current verification for Workmen's Compensation medical benefits OR denial of benefits
- Current proof of any fixed income, such as: widow's benefits, retirement, pension, dividend payments, unemployment, workmen's compensation, etc.
- If applicable, sponsor's income will also be considered as part of the application

RESOURCES

- Bank statements from checking or savings accounts
- Verification of stock, bond, or retirement accounts
- Automobile registration or title for all vehicles in the household **regardless** of whose name the vehicle is in
- If applicable, sponsor's resources would also be considered as part of the application

VERIFICATION OF OTHER ASSISTANCE

- Current award / denial letters for Medicaid, TANF, SSI, Housing and Food Stamps or any other assistance program (bring all that apply)
- Management Verification Form completed, signed, and notarized by everyone who helps to support you
- Any assistance within the last 3 months from your local Social Services or charity organizations



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All eligible Indigent Health Care clients are required to register for work with Texas Workforce Center.

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

- Lake Jackson – 206 Hwy 332 W
• Phone: (979)297-6400
- Pearland – 5730 Broadway St., Suite 122
• Phone: (832) 409-0049
- Texas City – 3549 Palmer Hwy
• Phone: (409) 949-9055

When you submit the completed application, you should attach two forms of identification.

When you submit your completed application, please take this letter with you and ask them to date stamp it (or attach a printout) as verification that you have registered for work.

This letter (with Texas Workforce Center date stamp or printout) must then be returned to our office at your designated appointment. If not returned assistance will be withdrawn.

Received by TWC (date stamp) _____

Applicant Name: _____



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.



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BEHAVIORAL GUIDELINES

- All Applicants and Qualified Clients are required to comply with all State and County policies and guidelines to receive services through the Brazoria County Indigent Health Care Program.
- All Applicants or Qualified Clients are required to comply with behavioral guidelines established by the State of Texas and apply to Brazoria County Primary Care Group and any specialist's offices they are referred to.
- 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 the Brazoria County Primary Care Group, or by the Specialist Office to whom they were referred. Referred additional testing, such as lab, radiology procedures or other specialist referrals, should be completed within one week of their last Primary Care visit. We cannot properly treat without testing results. Qualified Clients will be terminated from the program for repeated non-compliance.
- Clients will be terminated from the Indigent Health Care Program for illicit drug usage and continued alcohol abuse, if not currently and actively participating in a supervised rehab program.
- All Qualified Clients are expected to give all physicians, Primary Care or Specialists, at least 24 hours advance notice to cancellation of an appointment, if the client is unable to keep the appointment. The Client will be terminated from the Indigent Health Care Program for repeated failure to keep scheduled appointments.

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 Signature

Date

Printed Name of Applicant



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STATEMENT OF SERVICES

- **Clients are required to seek ALL non-emergency medical care from the Brazoria County UTMB Primary Group Office.** (If the Brazoria County UTMB Primary Care Group Office determines that your condition requires treatment from a specialist; he/she will issue a referral for you to see that specialist. Brazoria County CIHCP will not issue payment for any non-emergency services provided without a referral from the Brazoria Co. Primary Care Group).
- **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.
- Brazoria 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 expenses **OR 30 days of hospitalization, whichever comes first.**
- **Clients can be held responsible for the balance of charges not paid by Brazoria County, including full payment for prescriptions exceeding 3 per month.**
- **Clients are responsible for informing providers of their eligibility** with the Brazoria County Indigent Health Care Program and for informing these providers of our billing address.
- Brazoria 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 they can bill our office.**
- **Clients must notify our office within 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.

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 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:

Applicant Signature

Date



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Dear Indigent Health Care Applicant:

Please be advised of the following:

BRAZORIA COUNTY INDIGENT HEALTH CARE PROGRAM

FRAUD POLICY

- I. If a person knowingly provides false information for the purpose of qualifying for indigent health care he or she are 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 years beginning with the date the recourse was transferred and if a person fails to disclose such a transfer, that person would also be subject to the criminal sanctions set out in Section I.
- III. If a person fails to report a change in income, resources, residence, or household members, such failure makes the person ineligible for benefits. Any benefits paid to a person while they are ineligible shall be repaid.
- IV. If a person knowingly conceals a change of 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 Penal Code, Theft and Theft of Services, respectively Class ‘C’ Misdemeanor to Second Degree Felony, depending on the value of the property or services taken.
- V. 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. Prosecution by the district attorney or other criminal authority need not be limited to the criminal authority provisions set forth above.

If you do not know the answer to a question you are asked please do not guess. If you do not know such answers please tell this office and we will be happy to assist you to the appropriate authority.

I have read the forgoing letter and understand its contents.

Signature

Date

Printed Name



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AUTHORIZATION FOR BACKGROUND CHECK

APPLICANT: _____ SS: _____ D.O.B.: _____

SPOUSE: _____ SS: _____ D.O.B.: _____

ADDRESS: _____

I understand that as part of the application process for benefits from the Brazoria County Indigent Health Care Program I am required to provide certain written documents to the Health Department. I realize that my failure to provide such document will delay the receipt of benefits, if any, I might receive.

I hereby give my permission to the Brazoria County Indigent Health Care Program to obtain a 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, _____; hereby authorize any public agency including the Social Security Administration, Medicaid and Medicare to furnish Brazoria 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 Brazoria 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 Brazoria 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 health services for Brazoria County will void further consideration for eligibility in Brazoria County's Indigent Health Care Program as it relates to my application for such health services. I know and understand the Brazoria County Indigent Health Care Program Fraud Policy.

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

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

Signature of Applicant

Date

Signature of Applicant's Spouse

Date