Galveston County Indigent Health Care Program (CIHCP)
INSTRUCTIONS/ *INSTRUCCIONES*

Your packet MUST include:
Su paquete DEBE incluir:

- ☐ Pre-Screening Form/ *Forma de pre-determinación*
- ☐ Information Release Form/ *Forma de Revelación de información*
- ☐ Application for Health Care Assistance/*Solicitud de Asistencia Medica*
- ☐ Required Documents from Checklist/*Documentos Requeridos de la Lista*

You must complete and sign all forms and you must provide all the required documentation, otherwise your application for assistance may be delayed or denied.

Es requerido que llene cada solicitud y firme todas las formas adjuntas al igual que proveer la documentación de la lista adjunta, de lo contrario su petición para asistencia podría ser atrasada o negada.

To submit your application, please mail forms and documents to:

Para someter su aplicación, favor de mandar las formas y documentos por correo a:

GCIHCP
P.O. Box 939
La Marque, TX 77568

Or drop off at/*O entregar en persona a:*

Coastal Health & Wellness
9850-C Emmett F Lowry Exp
Texas City, TX 77591

Please put your forms and documents in an envelope or folder so your Information won't be lost. If the clinic is closed, you are more than welcome to put it in the blue drop box outside of the location .

Favor de poner sus formas y documentos en un sobre o en una carpeta para que su información no se pierda. Si la clínica esta serrada, pueden dejar las cosas en la cajita afuera de la clínica que es azul.

If you need assistance with your application or have questions, please contact the CIHCP Office:
Si necesita asistencia con su aplicación o si tiene alguna pregunta, por favor llámenos a la oficina a:

Office/*Oficina*: (409) 949-3439

Email/*Correo Electrónico*: countyindigent@gchd.org

Galveston County Indigent Health Care Program (CIHCP)
Pre-screening Form / *Forma de pre-determinacion*

Date / Fecha: _____

Applicant's name / *Nombre del aplicante*: _____

Date of birth / *Fecha de Nacimiento*: _____

In order to expedite your case, Galveston County requires you to provide the following information:
Con elfin de agilizar su caso, el Condado de Galveston require que provea la siguiente informacion:

Residence: What County do you live in? */ Lugar donde vive: / En que condado vive?*

☐ Galveston County / Condado de Galveston

☐ Other county / Otro condado _____

Citizenship: What is your legal status? / *Cuidadania, Cual es su situacion legal?*

☐ United States Citizen (by birth or naturalization) / *Cuidadano de Los Estados Unidos (por Nacimiento o por naturalizacion)*

☐ Lawful Permanent Resident (LPR) / *Residente Permanente Legal (LPR)*

☐ Temporary Workers Visa / *Visa Temporal para Trabajadores*

☐ Special Visa / *Visa Especial*

☐ Other / *Otro*

Marital Status / *Estado Civil*

☐ Single / *Soltero*

☐ Married / *Casado*

☐ Divorced / *Divorciado*

☐ Widowed / *Viudo*

☐ Separated / *Separado*

☐ Common Law Marriage / *Union Libre*

The statements I have made, including my answers to all questions, are true and correct to the best of my knowledge. / L*as declaraciones que he hecho, incluyendo mis respuestas a todas las preguntas, son verdaderas y correctas dentro de mi conocimiento.*

_____ _____
Printed Name / Nombre en letra de molde Signature / Firma

OFFICE USE ONLY: Form Sent by _____

TEXAS Department of State Health 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

GALVESTON COUNTY HEALTH DISTRICT

☐ **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).

Including, but not limited to assest and personal search, enrollment in other state programs or insurances.

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

Galveston County Indigent Health Care Program (CIHCP)
Required Documentation Checklist

You MUST include the following with your application:

☐ **A copy of you and your spouse's official picture ID. One of the following:**

- ✓ Texas Driver's License
- ✓ Texas ID Card
- ✓ Permanent Resident Card (Green Card)
- ✓ U.S. Passport

☐ **A copy of proof of your citizenship or legal residency. One of the following:**

- ✓ Social Security Card
- ✓ Birth Certificate
- ✓ Documentation from the Dept. of Homeland Security
- ✓ Voters Registration Card
- ✓ U.S. Passport

☐ **Proof of current physical address in you and/or your spouse's name dated within the last 60 days. One of the following:**

- ✓ Utility or other bills
- ✓ Rent or mortgage payment
- ✓ Voting record
- ✓ Mail

☐ **Most recent income verification for whichever applies to you and/or members of your household.**

- ✓ Pay stubs (if paid weekly, 4; bi-weekly, 3; or monthly 2)
- ✓ Unemployment award letter
- ✓ Child support
- ✓ Social Security Disability
- ✓ Social Security Income
- ✓ Income/Business tax return (most recent)
- ✓ W-2forms
- ✓ Court orders (settlements, divorce, etc.)
- ✓ Cash gifts and loans
- ✓ RSDI payments
- ✓ Pensions
- ✓ VA payments
- ✓ Self-employment income
- ✓ Trust funds, stocks, bonds, etc.
- ✓ Worker's Compensation payments
- ✓ Any money received by a member of the household

☐ **Current bank statement(s) or bank print out(s), if you or your spouse have a checking or savings account. This includes personal and business as well as joint accounts. Also any: cashapp, venmo, paypal, direct express, etc.**

☐ **A copy of the Title(s) or Registration Form(s) on all the vehicles owned by you and/or your spouse. If you own any RV's, four-wheeler, boats, boat trailers, etc. will need to provide tittles and or registrations.**

☐ **Current payoff statement if you are still paying for any vehicle(s).**

☐ **If you or any other household member has Medicaid, include a copy of the Medicaid card.**

☐ **If you or any other household member has any form of medical insurance, include a copy of the insurance card.**

☐ **If you have any property, include information and value of the property. Property includes trailers, vacant lots, etc.**

☐ **If you and/or your spouse have applied for Social Security Income, include a copy of the approval/denial letter(s).**

If any other information is needed after your application and documents are reviewed, you will be provided 14 business days to provide the needed documentation. However, if you do not bring in the required documentation within the 14 business day deadline your case could be denied.

If you have any questions, please call: (409) 949-3439 or email: countyindigent@gchd.org

TEXAS
Health and Human Services

Form 3064
January 2020-E

County Indigent Health Care Program (CIHCP)

Application for Health Care Assistance

For Office Use Only				
Status ◯ Application ◯ 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?**
					◯ Yes ◯ No
					◯ Yes ◯ No
					◯ Yes ◯ No
					◯ Yes ◯ No
					◯ Yes ◯ No
					◯ Yes ◯ No
					◯ Yes ◯ 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			−
2			−
3			−
4			−

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 3604 _____ 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.: _____

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.