

Name: \_\_\_\_\_

Appt: \_\_\_\_\_

## INDIGENT CARE PROGRAM/FINANCIAL ASSISTANCE PROGRAM

Attached is an application for possible financial assistance. To be considered eligible for financial assistance or to maintain your current eligibility, please complete the application in pen, with the necessary documentation. Your application will be denied if not all documentation requested is received. Eligibility will be determined within 14 days of receipt of a completed application and documentation from the patient.

Income	
<input type="checkbox"/>	• Current Bank Statement.
<input type="checkbox"/>	• Last three (3) paystubs. (If cash payment, letter from employer or cash logs)
<input type="checkbox"/>	• If self-employed, last three (3) months of Profit and Loss statements
<input type="checkbox"/>	• If unemployed, proof that patient has applied for Social Security Disability
<input type="checkbox"/>	• Social Security Award Letter or Social Security Disability Award Letter
<input type="checkbox"/>	• Pension Benefit
<input type="checkbox"/>	• Child support
<input type="checkbox"/>	• Veterans Administration benefit
Residence & Transportation	
<input type="checkbox"/>	• Current Utility Statement (gas, electric or water).
<input type="checkbox"/>	• Residing outside of Seguin, proof of Guadalupe County residency such as: <i>(vehicle registration, voter identification, or property tax statement)</i>
Identification & Benefits	
<input type="checkbox"/>	• Texas Driver's License or Texas ID. (must have the applicants current address)
<input type="checkbox"/>	• Social Security Card.
<input type="checkbox"/>	• If someone is providing assistance to the applicant, the 5th page of the application must be signed ( <b>Assistance Statement Verification. Form H1134/07-2004</b> )
<input type="checkbox"/>	• Food Stamp Award Letter

### **Important:**

Please complete your name, address, sign and date application.

### **Indigent Health Care is for Guadalupe County Residents and for adults 18 years and older ONLY**

As a condition of your eligibility, Guadalupe County Indigent Health Program requires your cooperation in identifying potential payment sources. If you are out of county, please apply for Indigent Health Care thru your county. If applicable and you are not employed at time of application, you will be asked if you have applied for Medicaid, Supplemental Social Security Income or the Texas Workforce Commission, proof of such is required. Your application may be pended until you are determined ineligible for the other programs. Thank you for your cooperation in the process of your application.

You must give information about health care insurance and any third party financially liable for health care services paid by the county for yourself and members of the 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 by any third party.

If you have answered all the questions on the application including signatures and provided all documents, your application can be processed.

**Guadalupe County Indigent Health Care Program**  
**Attn: Paola Pacheco (Financial Counselor)**  
**1215 E. Court St. - Seguin, TX. 78155**

**Please call Patient Account Service Offices at**  
**(830) 401-7875 to set up an appointment**  
**Email:ppacheco@grmedcenter.com**





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		-
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? \_\_\_\_\_





County Indigent Health Care Program (CIHCP)  
**Case Record Information Release**

Case Record Name:	Case Record No.
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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 CIHCP 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.

Person or Agency to Whom Information will be Released:
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Specific Request (Specify in 1 and 2 below.)

1. Information Requested \_\_\_\_\_

2. Period covered (Dates) \_\_\_\_\_

General Request (Any information available may be released.)

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\_\_\_\_\_  
Signature – Applicant or Recipient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature – Spouse

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature – Guardian, Power of Attorney, Parent of Minor Child

\_\_\_\_\_  
Date





### Help Statement Verification

#### Part I – Case Information

Case Name	Case No.	Agency Area Code and Phone No.
Name of Person Giving Help		Name of Person Giving Help Area Code and Phone No.
Address of Person Giving Help		

#### Part II – Help Provided

The person named above states that you provide help to their household. To correctly evaluate the household's situation, the Texas Health and Human Services Commission needs information from you. Answer the following questions explaining what help you provide and return the form in the postage paid envelope provided. Return it as soon as possible, but no later than \_\_\_\_\_.

Does this person live with you?  Yes  No

Do you give cash to this person or to anyone in this household?  Yes  No

If "Yes", who receives the cash? \_\_\_\_\_

How much cash do you give them? \_\_\_\_\_

How often do you give them cash? \_\_\_\_\_

When did you begin giving this help? \_\_\_\_\_

Do you expect the money to be repaid?  Yes  No

If "Yes", when? \_\_\_\_\_

Do you give help to the household that is not cash?  Yes  No

If "Yes", check all that apply:  Shelter  Food  Personal Items  Transportation  Other (explain below)

Do you pay any of the Household bills?  Yes  No

If "Yes", what bill(s) do you pay? \_\_\_\_\_

Who gets the payment? \_\_\_\_\_

Do you plan to continue giving help to this household?  Yes  No

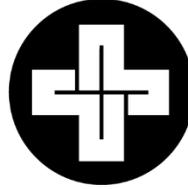
If "Yes", please specify for how long. \_\_\_\_\_

If "No", date you no longer give help. \_\_\_\_\_

Comments

#### Part III – Signatures

_____ <b>Signature of Person Giving Help</b>	_____ <b>Date</b>
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Guadalupe County Indigent Healthcare  
1215 E. Court St., Seguin, TX 78155  
Phone: (830) 401-7550 Fax: (830) 401-7460

## **Guadalupe County Indigent Healthcare Fraud Policy**

**Definition:**

Fraud is the deliberate misrepresentation of some material fact for the purpose of acquiring benefits.

**Policy:**

Guadalupe Regional Medical Center (GRMC) staff shall investigate cases of suspected fraud by collecting and documenting evidence. Upon a finding of fraud, the patient will be administratively ineligible from the Guadalupe Indigent Healthcare Program. The patient who is suspected of fraud will be contacted via certified letter informing the patient of the withdrawal of eligibility and current allegations. The patient may submit applicable supporting documents/verifications to be considered if he/she disputes the allegations. The patient will have the right to appeal any unfavorable decision.

If, after due process, a patient is found to have intentionally misrepresented information in order to receive benefits the patient will reimburse Guadalupe Indigent Healthcare Program for the cost of benefits the patient was ineligible to receive. The individual will be administratively ineligible for Guadalupe Indigent Healthcare Program benefits and may be subject to prosecution under the Texas Penal Code.

By signing this, I agree to the policy and I have been given an opportunity to ask questions.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Spouse's Signature

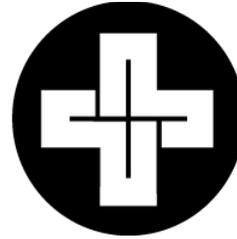
\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

# Guadalupe Regional

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**PRESCRIPTION ASSISTANCE PROGRAM**



If I elect to apply for Guadalupe Regional Medical Center's (GRMC) Prescription Assistance Program in addition to the Indigent Healthcare Program:

(Select one)

- I give my permission for the information I provide in my Indigent Healthcare Assistance Application to be shared with GRMC's Prescription Assistance Program.
- Please do not provide GRMC's Prescription Assistance Program with any of my information. I will provide them with documentation myself if I apply for the program.

Two separate applications are required for the Indigent Healthcare Program and GRMC's Prescription Assistance Program. If you give your permission, information contained in your Indigent Healthcare Program Application will be shared with GRMC's Prescription Assistance Program. Please note that approval for one program does not guarantee approval for the other program. Additional documentation may be requested from you by GRMC's Prescription Assistance Program after information from the Indigent Healthcare Program is provided.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Spouse's Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date