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

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.: _____

TEXAS
Health and Human Services

Form 3076
January 2020-E

County Indigent Health Care Program (CIHCP)

Case Record Information Release

Case Record Name:	Case Record No.

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:

☐ Specific Request (Specify in 1 and 2 below.)

1. Information Requested _____

2. Period covered (Dates) _____

☐ General Request (Any information available may be released.)

_____ _____
Signature – Applicant or Recipient Date

_____ _____
Signature – Spouse Date

_____ _____
Signature – Guardian, Power of Attorney, Parent of Minor Child Date

TEXAS
Health and Human Services

Form 3085
January 2020-E

County Indigent Health Care Program (CIHCP)

Statement of Self-Employment Income

Case Record Name	Case Record No.

See Page 2 for instructions and additional information.

1. Name of the person who has self-employment income: _____

2. Give the number of months covered by this income statement: _____

3. Describe what you did to earn this money:

4. List your business expenses and income. **Important: Attach receipts, invoices or other verifying papers.**

Date	Expenses	Amount
	Total Expenses	

Date	Income	Amount
	Total Income	
	Subtract Expenses –	
	Net Self-Employment Income	

The above information is true, correct and complete to the best of my knowledge. I understand that giving false information to the county could result in my being disqualified for fraud.

_____ _____
Signature Date

_____ _____
Signature of Person Helping Complete Form, if Applicable Date

TEXAS
Health and Human Services

Form H1134
November 2021-E

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

_____ **Signature of Person Giving Help**

_____ **Date**

Guadalupe Regional
FINANCIAL ASSISTANCE

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

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 approve 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