BIG BEND HEALTH

Documentation Requirements

*****In order to process your application, please bring the following documents as applicable to you and your household*****

Proof of Identification – Must provide ***one*** of the following:

- ❑ Driver's Licenses or State ID Card
- ❑ Government issued ID
- ❑ Passport
- ❑ Resident Card

Proof of Residence – must provide a ***minimum of two*** of the following:

- ❑ Property deed or tax statement
- ❑ Current utility bill with home address
- ❑ Voter registration card
- ❑ DL/ID with current address
- ❑ Lease agreement
- ❑ Landlord verification form

State benefits received – Must provide ***all*** award and/or denial letters for each household member:

- ❑ Medicare
- ❑ Medicaid
- ❑ SNAP
- ❑ TANF Assistance
- ❑ CHIP

Proof of assets and resources – Must provide resource documentation for ***all*** household members:

- ❑ Last 3 months of bank account statements (savings, checking, money markets, cash app, venmo, zelle,pay pal,etc.)
- ❑ Title or Registration of vehicles, boats, RVs under household members
- ❑ Vehicle loan information showing current balance owed on vehicle
- ❑ Statements for CDs, IRAs, or other investment accounts
- ❑ Real Estate information for all property owned

Proof of all Household Income – Must provide income documentation for ***all*** household members

- ❑ 4 weeks of most recent, consecutive paystubs
- ❑ Self-employment (provide income tax returns or business records)
- ❑ Statement of Self-employment Income Form 3085
- ❑ Child Support – court orders or statement
- ❑ Unemployment award letter
- ❑ Current award letter for SSI, RSDI, VA, SSA, TANF
- ❑ Worker's Compensation
- ❑ Employer Verification Form 3084
- ❑ Pension/Retirement documents
- ❑ Proof of loans, gifts, or other contributions
- ❑ Any other income received by any household member
- ❑ Zero Income Certification

Social Security Number

- ❑ Provide for each household member

Application Materials

- ❑ Completed, signed, and dated Application
- ❑ Completed Supplemental Application
- ❑ Information Release Form
- ❑ Fraud Policy Form
- ❑ Behavioral Guidelines
- ❑ PHI Disclosure Form

Other Information (list here):

- ❑ Affidavit of Marital Status
- ❑
- ❑
- ❑
- ❑

If any other information is required after your application and documentation is reviewed, you will be provided 14 days to submit the needed documentation. Failure to provide adequate documentation to prove program eligibility could result in denial of services. Anyone who knowingly misrepresents the truth in the completion of the program application will result in denial of services and /or criminal persecution.

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.

Big Bend Health
Supplemental Application

Client Name:					County:	
Email address:		Phone number:			Citizenship:	
Marital Status:	☐ Single	☐ Married	☐ Separated	☐ Divorced	☐ Widowed	☐ Common Law
Employment status:	☐ Employed	☐ Full Time	☐ Part Time	☐ Temporary	Primary Language:	
	☐ Unemployed					
Student Status:	☐ University/College, list name and place:					

How did you hear about the Presidio-Brewster County Indigent Health Program?		
Provide details on any current medical conditions, list all on-going medical issues:		
Is your medical condition a result of:	Yes	No
Workplace accident		
Motor vehicle accident		
Assault		
If yes, please explain:		
Are you currently seeing a doctor? Do you have a primary care physician? If yes, please list doctor(s):		
Are you currently taking any prescription medications? Please list all medications:		
Do you have any immediate medical needs?		

What benefits do you receive?

☐ Medicare Part A	☐ TANF
☐ Medicare Part B	☐ WIC
☐ Medicare Part D	☐ TX Medicaid Women's Health Program
☐ SNAP	☐ Housing assistance
☐ Other:	☐ Other:

Do you have any of the following assets/resources?			
Asset/Resource	Yes	No	$ Value
Cash on Hand			$
Checking Account			$
Savings Account			$
Certificates of Deposit			$
Stocks or Bonds			$
Real Estate (excluding homestead)			$
Retirement accounts			$
Livestock			$
Insurance or lawsuit settlements			$
Boat/RV/ATV			$
Vehicle(s):			$
Cash app, Venmo, Zelle, Pay Pal,etc.			$
Other assets:			$

Do you have income from any of the following sources?				
Income source	Yes	No	$ Amount	Frequency
Employment wages, salaries, commissions			$	
Tip Income			$	
Self-employment income			$	
Unemployment benefits			$	
Social Security benefits			$	
Workers compensation benefits			$	
Cash gifts			$	
Child support			$	
Dividends or royalties			$	
Interest			$	
Pensions			$	
Alien sponsor income			$	
Other income:			$	
Other income:			$	
Other income:			$	

Social Security	Yes	No
Do you receive Social Security/SSI (Supplemental Security Income)		
Are you in the process of applying for Social Security/SSI benefits?		
What is the status of your application? ☐ New Application ☐ Appeal ☐ Reconsideration ☐ Hearing Request		

Do you need transportation assistance to medical appointments?	Yes	No
Is there anything else the Patient Advocate should know about you or your household? Do you have other needs?		

I verify that the information provided in this application is true and correct.

Applicant Signature _____ Date _____

BIG BEND HEALTH

CONSENT TO OBTAIN AND RELEASE INFORMATION

Applicant: _____ SSN: _____

Spouse: _____ SSN: _____

I am a member of a household applying for health care assistance from Big Bend Health. I understand that in order to determine this household's eligibility or continued eligibility, it is necessary for Big Bend Health to verify all earnings and other information.

I authorize Big Bend Regional Hospital District/Big Bend Health to run a credit history and personal data search report for the purpose of making a preliminary determination of whether I meet the eligibility requirements for the Indigent Health Care Program. I also understand that any approval will be conditional based on the information reviewed in my report.

I authorize any relative, lawyer, employer, landlord, banker, postal savings official, insurance company, fraternal order, government agency, Texas Department of Health and Human Services, Social Security Administration, charitable organization, or other person or entity having information about me or my circumstances to furnish such information to a representative of Big Bend Health for the purpose of making a determination of whether I meet the eligibility requirements for the Indigent Health Care Program.

I agree to sign a written authorization permitting my physician(s) and other health care providers and health care entities to release my health information to Big Bend health for the purpose of making a determination of whether I meet the eligibility requirements for the Indigent Health Care Program.

I authorize the Big Bend Regional Hospital District to release information in my application to the persons and entities named above for the purpose of verifying all earnings and other information and to make a determination of my eligibility for the Indigent Health Care Program.

I understand that anyone who knowingly lies or misrepresents the truth or arranges for someone to knowingly lie or misrepresent the truth in the completion of this application and determination of eligibility is committing a crime, which can be punished under Federal law, State law, or both.

_____ _____

Signature of Applicant Date

_____ _____

Signature of Applicant's Spouse Date

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

_____
Last First Middle

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

_____

CITY _____ **STATE** _____ **ZIP** _____

PHONE (_____)_____ **ALT. PHONE** (_____)_____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____)_____ Fax (_____)_____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name Big Bend Regional Hospital District
Address P.O. Box 1019
City Alpine State TX Zip Code 79831
Phone (432) 837-7051 Fax (432) 837-3261

REASON FOR DISCLOSURE
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☒ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☒ **All health information**
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Other_____

Your initials are required to release the following information:

_____Mental Health Records (excluding psychotherapy notes)
_____Drug, Alcohol, or Substance Abuse Records
_____Genetic Information (including Genetic Test Results)
_____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X_____ _____
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X_____ _____
Signature of Minor Individual **DATE**

IMPORTANT INFORMATION ABOUT THE AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

The Attorney General of Texas has adopted a standard Authorization to Disclose Protected Health Information in accordance with Texas Health & Safety Code § 181.154(d). This form is intended for use in complying with the requirements of the Health Insurance Portability and Accountability Act and Privacy Standards (HIPAA) and the Texas Medical Privacy Act (Texas Health & Safety Code, Chapter 181). **Covered Entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.**

Covered entities, as that term is defined by HIPAA and Texas Health & Safety Code § 181.001, must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. (Tex. Health & Safety Code §§ 181.154(b),(c), § 241.153; 45 C.F.R. §§ 164.502(a)(1); 164.506, and 164.508).

The authorization provided by use of the form means that the organization, entity or person authorized can disclose, communicate, or send the named individual's protected health information to the organization, entity or person identified on the form, including through the use of any electronic means.

Definitions - In the form, the terms "treatment," "healthcare operations," "psychotherapy notes," and "protected health information" are as defined in HIPAA (45 CFR 164.501). "Legally authorized representative" as used in the form includes any person authorized to act on behalf of another individual. (Tex. Occ. Code § 151.002(6); Tex. Health & Safety Code §§ 166.164, 241.151; and Tex. Probate Code § 3(aa)).

Health Information to be Released - If "All Health Information" is selected for release, health information includes, but is not limited to, all records and other information regarding health history, treatment, hospitalization, tests, and outpatient care, and also educational records that may contain health information. As indicated on the form, specific authorization is required for the release of information about certain sensitive conditions, including:

- Mental health records (excluding "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501).
- Drug, alcohol, or substance abuse records.
- Records or tests relating to HIV/AIDS.
- Genetic (inherited) diseases or tests (except as may be prohibited by 45 C.F.R. § 164.502).

Note on Release of Health Records - This form is not required for the permissible disclosure of an individual's protected health information to the individual or the individual's legally authorized representative. (45 C.F.R. §§ 164.502(a)(1)(i), 164.524; Tex. Health & Safety Code § 181.102). If requesting a copy of the individual's health records with this form, state and federal law allows such access, unless such access is determined by the physician or mental health provider to be harmful to the individual's physical, mental or emotional health. (Tex. Health & Safety Code §§ 181.102, 611.0045(b); Tex. Occ. Code § 159.006(a); 45 C.F.R. § 164.502(a)(1)). If a healthcare provider is specified in the "Who Can Receive and Use The Health Information" section of this form, then permission to receive protected health information also includes physicians, other health care providers (such as nurses and medical staff) who are involved in the individual's medical care at that entity's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purposes permitted by law for that specified covered entity or person. If a covered entity other than a healthcare provider is specified, then permission to receive protected health information also includes that organization's staff or agents and subcontractors who carry out activities and purposes permitted by this form for that organization. Individuals may be entitled to restrict certain disclosures of protected health information related to services paid for in full by the individual (45 C.F.R. § 164.522(a)(1)(vi)).

Authorizations for Sale or Marketing Purposes - If this authorization is being made for sale or marketing purposes and the covered entity will receive direct or indirect remuneration from a third party in connection with the use or disclosure of the individual's information for marketing, the authorization must clearly indicate to the individual that such remuneration is involved. (Tex. Health & Safety Code §181.152, .153; 45 C.F.R. § 164.508(a)(3), (4)).

Limitations of this form - This authorization form shall not be used for the disclosure of any health information as it relates to: (1) health benefits plan enrollment and/or related enrollment determinations (45 C.F.R. § 164.508(b)(4)(ii), .508(c)(2)(ii); (2) psychotherapy notes (45 C.F.R. § 164.508(b)(3)(ii); or for research purposes (45 C.F.R. § 164.508(b)(3)(i)). **Use of this form does not exempt any entity from compliance with applicable federal or state laws or regulations regarding access, use or disclosure of health information or other sensitive personal information (e.g., 42 CFR Part 2, restricting use of information pertaining to drug/alcohol abuse and treatment), and does not entitle an entity or its employees, agents or assigns to any limitation of liability for acts or omissions in connection with the access, use, or disclosure of health information obtained through use of the form.**

Charges - Some covered entities may charge a retrieval/processing fee and for copies of medical records. (Tex. Health & Safety Code § 241.154).

Right to Receive Copy - The individual and/or the individual's legally authorized representative has a right to receive a copy of this authorization.

BIG BEND HEATLH

BEHAVORIAL GUIDELINES

- ALL applicants and qualified clients are required to comply with all State and County policies and guidelines to receive services through Big Bend Health programs.
- ALL applicants and qualified clients are required to comply with behavioral guidelines established by the State of Texas and apply to your Primary Care Physicians office and any specialist's offices they are referred to.
- ALL applicants and qualified clients who are rude and display disruptive or abusive languages 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 Healthcare Program.
- ALL qualified clients are expected to comply with the medical regime proposed by the assigned Primary Care Physician's office or by the Specialist Office of 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 physician's visit. We cannot properly treat without testing results. Qualified clients will be terminated from the program for repeated non-compliance.
- 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 Healthcare Program for repeated failure to keep scheduled appointments.
- No qualified clients shall receive any medications without periodic primary care physician evaluation (six months evaluation).
- Clients will be terminated from the Indigent Healthcare Program for illicit drug usage and continued alcohol abuse, if not currently and actively participating in a supervised rehab program.

I HAVE READ AND UNDERSTAND ALL OF THE ABOVE GUIDELINES:

PAUTAS DE COMPORTAMIENTO

- Todos los solicitantes y clientes calificados deben cumplir con todas las pólizas y pautas estatales del condado para recibir servicios a través de los programas de Big Bend Health
- Todos los solicitantes y clientes calificados están obligados a cumplir con las pautas de comportamiento establecidas por el Estado de Texas y aplicar a su oficina de Primary Care Physicians y a las oficinas de cualquier especialista a los que se les hace referencia.
- No se verán a los solicitantes y clientes calificados que sean groseros y muestren lenguajes y comportamientos disruptivos o abusivos. Nuestra voluntad personal estará protegida de situaciones peligrosas; las confrontaciones físicas o combativas son motive para la terminación inmediata del Programa de atención Medica Indigente.
- Se espera que todos los clientes calificados cumplan con el régimen medico propuesto por la Oficina del Médico de Atención Primaria asignada o por la Oficina de Especialistas de quien fueron referidos. Las pruebas adicionales referidas, como el laboratorio, los procedimientos de radiología u otras derivaciones especializadas, deben completarse una semana después de la visita de su médico de atención primaria. No Podemos tartar adecuadamente sin los resultados de las pruebas. Los clientes calificados serán despedidos del programa por incumplimiento repetido.
- Ningún cliente calificado recibirá ningún medicamento sin evaluación periódica del médico de atención primaria (evaluación de seis meses).
- Los clientes serán despedidos del Programa de Cuidado de salud de Indigente por el uso ilícito de drogas y el abuso continuo de alcohol, si no participa actualmente y activamente en un programa de rehabilitación supervisado.
- Se espera que todos los clientes calificados notifiquen a todos los médicos, atención primaria o especialistas con lo menos 24 horas de anticipacion a la cancelación de una cita, si el cliente no puede cumplir la cita. El cliente será despedido del Programa de atención Medica de Indigente por fallas repetidas en a la realización de citas programadas.

HE LEIDO Y ENTIENDO TODAS LAS PAUTAS ANTERIORES:

_____ _____

Applicant's Signature/*Firme de Solicitante* Date/*Fecha*

_____

Printed Name of Applicant/*Nombre en molde del Solicitante*

BIG BEND HEALTH

Fraud Policy

I, _____ attest that the statements I have made in my application and interviews, including my answers to all questions, are true and correct to the best of my knowledge and belief.

I agree to give staff and the Big Bend Regional Hospital District any information necessary to prove statements about my eligibility.

I agree to report any of the following changes within 14 days:

- Address
- Household Members
- Property
- Income
- Application for/or receipt of SSI, TANF, or Medicaid/

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 criminal charges against me.

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 health care services you receive after you become ineligible and/or you may be subject to prosecution under the Texas Penal Code.

Póliza de Fraude

Yo,_____ atestiguo de que las declaraciones que hice en mi solicitud y entrevista, incluyendo mis respuestas a todas las preguntas, son ciertas y correctas al mayor de mi conocimiento y creencia.

Acepto dar información al personal de elegibilidad y al Big Bend Regional Hospital District cualquier información necesaria para probar declaraciones sobre mi elegibilidad.

Estoy de acuerdo en avisar cualquier de los siguientes cambios:

- *Dirección*
- *Los miembros del hogar*
- *Propiedades*
- *Ingresos*
- *Solicitud de SSI, TANF o Medicaid*

He sido informado/a y entiendo que al no cumplir con las obligaciones establecidas será considerado retención de información intencional y puede resultar en la recuperación de cualquier perdida mediante pago o presentando cargos civiles y penales contra mi.

Si ocurre un cambio que lo haga inelegible y usted no reporta el cambio como es requerido, usted puede ser considerado/a responsable de cualquier atención medica resivida después de ser inteligible y puede ser subjeto/a a procesamiento bajo el Código Penal de Texas.

_____ _____

Applicant Signature/*Firma de Solicitante* Date/*Fecha*

BIG BEND HEALTH

Client Orientation Form

Client name:_____ Client #:_____

I have been thoroughly explained and understand the program services covered and my responsibilities as a client. Topics covered during the orientation included:

- Medical Benefits and Coverages
- Primary Care Physicians
- Emergency visits and EMS
- Client Responsibilities
- Immunizations
- Prescription and RX Grant
- Dental Coverages
- Vision Care
- Transportation
- Durable medical Equipment

I also acknowledge that the benefit client cap amount of $30,000.00 is available per fiscal year, beginning October 1st through September 30th.

_____ _____

Applicant signature Date

_____ _____

Presentation given by Date

AUTHORIZATION TO RECEIVE TEXT MESSAGES

Would you like to stay updated with important information from Big Bend Health?

We are pleased to offer you the option to receive text message reminders about your account. This service is optional, and you will continue to receive notices by mail regardless of your choice to opt in for text messages.

Your privacy and security are our top priorities. Before proceeding, please note that text messages are not confidential. Anyone with access to your cell phone may view these messages. Additionally, your service provider, as well as Big Bend Health, may have access to these messages. Standard text message rates may apply, depending on your service provider.

We will only send you text messages with your explicit consent. By agreeing to this Consent for text messaging agreement, you authorize Big Bend Health to send you text messages regarding appointments, renewals, other information regarding your account and notices about event/activities we promote. You can opt out of this service at any time by texting STOP to any message. You can request a copy of our terms of service and privacy policies at any time.

I understand this service is optional, and I can stop it at any time. I would like to receive text messages from Big Bend Health.

_____Yes _____ No

Printed name:

Date of birth:

Signature:

Date:

Cell phone number:

Alpine Office
105 W. Holland Avenue
P.O. Box 1019
Alpine, Texas 79831
(432) 837-7051
(432) 837-3261-Fax

Big Bend Regional Hospital District

Presidio Office
602 W. O'Reilly Street
P.O. Box 3044
Presidio, Texas 79845
(432) 229-2151
(432) 229-2161-Fax

Date/Fecha_____

I, _____,
Applicant's Name
authorize

_____
Name of Bank or Credit Union
to forward the requested bank statements to **Big Bend Regional Hospital District**, for the purpose of determining my eligibility for programs of Big Bend Health.

Yo, _____,
Nombre de Solicitante
autorizo

_____
Nombre del banco
para enviar los extractos bancarios solicitados a **Big Bend Regional Hospital District**, a los fines de determinar mi elegibilidad para programas de Big Bend Health.

Bank statements for the following months are requested for the following bank accounts:

Account Number/Numero de Cuenta	Month/Year	Month/Year	Month/Year
Checking #			
Saving #			
Other #			

_____
Applicant Signature / Firma de Solicitantes

_____
Date / Fecha