



KAUFMAN COUNTY INDIGENT HEALTH CARE PROGRAM
REQUEST FOR INFORMATION
PROGRAMA DE ATENCION MEDICA PARA INDIGENTES DEL CONDADO
SOLICITUD DE INFORMACION

[Empty rectangular box for applicant information]

Date/Fecha Case Record No./Num de Caso
Office Address and Telephone No./Oficina y Telefono
Kaufman County IHC
100 N Washington Courthouse Annex
KAUFMAN, TX 75142
Phone: 469-376-4544
Fax: 469-595-0496

Your application for assistance is not complete. To determine your eligibility, we need the following additional information./Su solicitud de asistencia no esta completa. Para determinar su elegibilidad, necesitamos la siguiente informacion.

ONLY THE CHECKED BOXES APPLY TO YOU./SOLAMENTE LAS CASILLAS MARCADAS SE APLICAN A SU CASO.

- Mail Addressed to You or Another Household Member
Texas Driver's License or Other Official Identification
Voter Registration Card
Automobile Registration
Notice of TANF, SNAP (Food Stamps), or Medicaid Benefits
Checking Account Statement
Savings Account Statement
Paychecks or Paycheck Stubs
Earnings Statement from Employer
Other Items (see below)
Federal Income Tax Return
Self-Employment Bookkeeping, Sales, Expenditure Records
Social Security Award Letter, Check, or Denial Notice
Disability Insurance Award Letter or Check
Unemployment Compensation Award Letter or Check
Veterans Administration Award Letter or Check
Worker's Compensation Award Letter or Check
Verification of Application for Social Security or SSI
Verification of Application for Other Assistance Programs

MUST PROVIDE TWO STATEMENT FROM 2 PEOPLE NOT RELATED TO YOU OR LIVES WITH YOU WHO CAN VERIFY HOW YOU LIVE ON A DAY TO DAY BASIS. HOW BILLS PAID, FOOD PROVIDED, NECESSITIES PROVIDED, ETC. STATEMENTS MUST BE SIGNED AND DATED WITH ADDRESS AND PHONE NUMBER OF PERSON WRITING STATEMENT. COPY OF REGISTRATION FORM FROM TEXAS WORKFORCE COMMISSION.

PLEASE RETURN THE ITEMS CHECKED ABOVE BY:

HAGA EL FAVOR DE ENVIAR LOS DOCUMENTOS ENUMERADOS PARA EL:

[Empty rectangular box for return date]

A decision about your eligibility will be made no later than 14 days after your application is complete, including all requested information. If we do not receive the information we need and you do not contact me, I will assume that you do not want assistance. Call me if you have any questions./Se tomara una decision en cuanto a su elegibilidad a mas tardar 14 dias despues de que tengamos su solicitud completa, incluyendo todas informacion pedidas. Si no recibimos la informacion que necesitamos y usted no se comunica conmigo, supondre que usted no quiere asistencia. Si tiene alguna pregunta, hableme.

Signature/Firma: Desiree Pool



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
					<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.

<input type="checkbox"/> Own or paying for home	<input type="checkbox"/> Live in a house provided by someone else	<input type="checkbox"/> No permanent residence
<input type="checkbox"/> Live with someone else	<input type="checkbox"/> Rent house or apartment	<input type="checkbox"/> 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.

**Kaufman County**

**Indigent Health Care**

**Assistance Verification Statement**

We need to verify the amount of assistance you provide to \_\_\_\_\_  
and how that assistance is given.

I, \_\_\_\_\_ provide assistance to \_\_\_\_\_ by:

Please check:

\_\_\_\_\_ give money to the potential client

Date: _____	Amount: _____	Date: _____	Amount: _____
Date: _____	Amount: _____	Date: _____	Amount: _____
Date: _____	Amount: _____	Date: _____	Amount: _____

\_\_\_\_\_ pay bills directly to vendors.

Name of person or company: _____	Date: _____	Amount: _____
Name of person or company: _____	Date: _____	Amount: _____
Name of person or company: _____	Date: _____	Amount: _____

\_\_\_\_\_ have been providing food, shelter, transportation, personal items, and/or household needs, etc.  
***If checked, what was provided and for which months***

_____	_____
_____	_____
_____	_____

Do you plan to continue this support? \_\_\_\_\_  
How long? \_\_\_\_\_

I certify that the above information is correct.

Your signature \_\_\_\_\_  
Print your name \_\_\_\_\_  
Your address \_\_\_\_\_  
Telephone number \_\_\_\_\_  
Relationship to potential client \_\_\_\_\_  
Date \_\_\_\_\_

Please return this form to:

Kaufman County IHC  
100 N. Washington St.  
Courthouse Annex  
Kaufman, TX 75142



Desiree Pool  
Indigent Health Care

100 N. Washington  
Kaufman, TX 75142

Kaufman County Indigent Health Care Program  
Authorization for Background Checks

Name

\_\_\_\_\_

Social Security Number

\_\_\_\_\_

Date of Birth

\_\_\_\_\_

I hereby give permission to the Kaufman County Indigent Health Care Program to obtain a background check from Texas Workforce Commission, Department of Motor Vehicle Registration, Credit Bureau and any other sources that may need to be contacted to determine my eligibility for the Indigent Program.

Printed Name

Date

\_\_\_\_\_

Signature

\_\_\_\_\_

Subscribed and Sworn to (affirmed) before me this \_\_\_\_ day of \_\_\_\_\_, at \_\_\_\_\_. Notary Public in and for the State of Texas. My Commission expires on \_\_\_\_\_.

Notary Signature

\_\_\_\_\_

(seal)

## **Kaufman County Indigent Health Care Fraud Policy**

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### **Definition**

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

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### **Procedure**

When the Indigent Health Care (IHC) staff has reason to believe that fraud may have occurred, the following procedures shall be followed:

1. The IHC staff shall investigate all cases of suspected fraud and shall collect and document evidence.
2. Upon a finding of fraud, the client shall be administratively ineligible from IHC as follows:

First Offense	24 months from the date fraud was discovered client becomes ineligible for program
Second Offense	36 months from the date fraud was discovered client becomes ineligible for program
Third Offense	24 months + 12 months per subsequent offense
3. The IHC staff shall contact the client who is suspected of fraud by sending a certified letter informing him of the withdrawal of eligibility and explaining the allegations. If the client disputes the allegations, the client will be allowed to submit applicable supporting documents / verifications for further consideration.
4. If the dispute remains unresolved, the IHC staff shall schedule an administrative hearing to allow the client to defend himself by confronting any adverse witness and by presenting his own argument and evidence. The IHC staff must disclose any evidence used to prove its case to the client so he has an opportunity to dispute it. The administrative hearing will be conducted by the Director of the Indigent Health Care Program with the IHC designee present. The administrative hearing shall be held at the office of the Indigent Health Care Program in Kaufman during normal business hours. The client shall be given 30 days written notice of the date of the hearing. If the client does not appear at the administrative hearing, the IHC designee may proceed with presentation of the case only if proof of notice is present. The Director of the Indigent Health Care Program must make a decision within ninety days of the hearing. The client shall have the right to appeal any unfavorable decision to the Kaufman County IHC Appeals Court.

### **Consequence of Fraud**

If, after due process, a person is found to have intentionally misrepresented information in order to receive benefits, that person:

- ◆ Shall reimburse Kaufman County for the cost of benefits they did receive;
- ◆ Shall be administratively ineligible for Kaufman County IHC benefits in accordance with Kaufman County IHC Policies and Procedures; and
- ◆ May be subject to prosecution under the Texas Penal Code.



Desiree Pool  
Indigent Health Care

100 N. Washington  
Kaufman, TX 75142

## **Acknowledgement of Kaufman County Fraud Policy**

I hereby understand that by signing this form I acknowledge that I have received a copy of the Kaufman County Indigent Health Care Fraud Policy.

**Name:**

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**Date:**

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**Signature:**

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KAUFMAN COUNTY  
INDIGENT HEALTH CARE  
100 N. WASHINGTON  
COURTHOUSE ANNEX  
KAUFMAN, TX 75142  
PHONE # 469-376-4544  
FAX# 469-595-0496/ Email:  
indigenthealth@kaufmancounty.net



**ELIGIBILITY CRITERIA:**

**Residence-** The applicant must live in Kaufman County and must intend to stay.

**Household-** A CHCP household is a person living alone or two or more persons living together where legal responsibility for support exists, excluding disqualified person. A disqualified person is one who receives or is categorically eligible to receive Medicaid.

**Resources-** A household is eligible if the total countable household resources do not exceed \$3000.00 when a person is aged or disabled and who meets relationship requirements lives in home or \$2000.00 for all other households

**Medical Need-** Must have a medical necessity

**Income-** A household is eligible if its monthly net income does not exceed 21% of the Federal Poverty Guidelines (FPG).

<b>CHCP Monthly Income Standards 2024</b>	
# of Individuals in CHCP Household	21% FPG
1	\$264
2	\$358
3	\$452
4	\$546
5	\$640

**BASIC HEALTH CARE SERVICES for medical necessity needs:**

**Physician-** services include services ordered and performed by a physician that are within the scope of practice of their profession as defined by state law.

**Annual Physical Examinations-** are examinations provided once per calendar year by a physician or a physician assistant. Associated testing can be covered with a physician referral.

**Medical screening-** services include blood pressure, blood sugar, and cholesterol screening.

**Laboratory and X-rays-** services are professional and technical services ordered and provided under the personal supervision of a physician in a setting other than a hospital (inpatient or outpatient)

**Cancer Patients KCHC will only cover X-rays/such as MRI's, CT's, and other types of scans) and blood work up.**

**Prescriptions-** this service includes up to three prescriptions drug per month. New and refilled prescriptions count equally toward this three prescription drugs per month total. Drugs must be prescribed by a physician or other practitioner with the scope of practice under law.

**Rural Health Clinic-** services must be provided in a freestanding or hospital-based rural health clinic by a physician, a physician assistant, and advanced practice nurse.

**Inpatient hospital-** services must be medically necessary and provided in a acute care hospital to hospital inpatients, by or under the direction of a physician, and for the care and treatment of patients.

**Outpatient Hospital-** services must be medically necessary and provided in an acute care hospital to hospital outpatients, by or under the direction of a physician. Outpatient hospital services include hospital-based ambulatory surgical center (HASC) services.