Comanche County Medical Center

CCMC

To Whom It May Concern:

Enclosed you will find a finical assistance application to determine if you are eligible for help with your medical bills through the Financial Assistance Program offered by Comanche County Medical Center. Please supply the information requested below, along with completed application that has been enclosed. Be sure to complete the form in its entirety and return all completed documentation. Without the requested information, we are unable to determine your eligibility and account balances will become your responsibility and could be reviewed for collections in not resolved. **If you have a Primary Insurance the Deductibles or Copays, will not be covered by the Financial Assistance Program.**

Requested Documents: (In addition to completed financial assistance application)

- Valid Texas Drivers Licenses or Other Official Identification
- Proof of Residency (If address on ID is not Correct)
- If not a Resident of Comanche Co, **Denial Letter from County of Residence**.
- Automobile Registration
- Checking Account Statement (Current Month)
- Savings Account Statement (Current Month)
- Proof of Income (Provide 1 Complete Month) or Self Employment Form.
- Federal Income Tax – If you are unable to provide Proof of Income.
- Social Security Award Letter or Check
- Disability Insurance
- Denial Letter from Medicaid (Screen Shots from website are not accepted as denial)

TO APPLY FOR MEDICAID, GO TO
Yourtexasbenefits.com or Call
2-1-1 – help information / Phone 325-673-8211
Local Medicaid Office Brownwood, Texas
Phone 325-646-0541

Please send requested information to the address:

Comanche County Medical Center
ATT: Brenda Allen / Financial Assistance Coordinator
10201 Hwy 16 N
Comanche, TX 76442
ballen@cmanchecmc.com

Should you have any questions or concerns, please feel free to contact our Customer Service Representative at 254-879-4900 x 4453 or x4452, or ask for Brenda Allen, between the hours of 8-5 Monday through Friday.

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			−

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.

TEXAS
Health and Human Services

Form 3065
February 2020-E

County Indigent Health Care Program (CIHCP)
Worksheet

Date Identifiable Form 3064, Application for Health Care Assistance, Received in Office	Case Record No.	Type of Determination ◯ Application ◯ Review
Case Record Name (Last, First, Middle)	Case Record Action ◯ Approved ◯ Continued ◯ Denied	Eligibility Effective Date
		Prior Eligibility Effective Dates

Signature — Eligibility Determiner _____ Date _____

Eligibility Items

1. Form 3064, Application for Health Care Assistance

A. Is Form 3064 appropriately signed and dated by the applicant? ..... ◯ Yes ◯ No

B. Is Form 3064 appropriately signed and dated by the spouse, if the applicant is married and the spouse lives in the house? ..... ◯ Yes ◯ No ◯ N/A

C. Is information complete and consistent? ..... ◯ Yes ◯ No

Documentation:

2. Household

A. Who is applying for CIHCP?

B. Does legal responsibility for support exist between the applicant(s) listed in 2.A. and any other person living in the house? ..... ◯ Yes ◯ No

If Yes, between whom?

C. Does any individual listed in 2.A. or 2.B. receive Medicaid? ..... ◯ Yes ◯ No

If Yes, who?

Disqualify the Medicaid recipient(s) listed in 2.C. and use Step 2 of the Budget Calculation on Page 3, if applicable.

D. Is any individual listed in 2.A. or 2.B. potentially eligible to receive Medicaid? ..... ◯ Yes ◯ No

If Yes, who?

Use the Medicaid screening tool at www.yourtexasbenefits.com and refer to the CIHCP Handbook for application processing.

E. Who are the members of the CIHCP household? (Verify household if questionable.)

In the following questions 3. through 10., "CIHCP household member" refers to each individual listed in 2.E. above.

Documentation:

3. Residence

A. Is each CIHCP household member a county resident? (Verify residence if questionable.) ..... ◯ Yes ◯ No

B. Does each CIHCP household member plan to remain in the county?..... ◯ Yes ◯ No

Documentation:

4. Resources (Exempt all resources of the Medicaid recipients listed in 2.C.)

A. Does any CIHCP household member own the following? ..... ◯ Yes ◯ No

Resource	Yes	No	Countable Value
1. Cash on Hand	◯	◯	
2. Certificates of Deposit	◯	◯	
3. Checking Accounts	◯	◯	
4. Insurance Settlements	◯	◯	
5. Lawsuit Settlements	◯	◯	
6. Livestock	◯	◯	
7. Lump Sum Payments	◯	◯	
8. Notes, Bonds or Stocks	◯	◯	
9. Prepaid Burial Insurance	◯	◯	
10. Real Estate (excluding homestead)	◯	◯	
11. Retirement (including IRAs)	◯	◯	
12. Savings Accounts	◯	◯	
13. Vehicles	◯	◯	
14. Alien Sponsor's Resources	◯	◯	
15. Other Resources	◯	◯	
16. Total Countable Resources (This amount is not rounded.)			

B. Has any CIHCP household member transferred a countable resource in the three months before application? ◯ Yes ◯ No

(Document regarding countable resources for the application month and the three months prior. Verify resources if questionable or if the countable value is close to the resource limit.)

Documentation:

5. Income (Exempt all income of the Medicaid recipients listed in 2.C.)

A. Does any CIHCP household member have terminated income in the application month or three months prior? ..... ◯ Yes ◯ No

B. Does any CIHCP household member have any other countable income in the application month or three months prior? ◯ Yes ◯ No

(Document and verify all countable income, including terminated income, for the application month and three months prior.)

Documentation:

6. Budget Calculation

A. Determine the household's monthly total countable income.

Type of Income	Name of Member(s) with Income		
Earned Income (1. through 7.)	[Name]	[Name]	
1. Monthly Gross Earned Income			
2. Standard Work-Related Expense	–	–	
3. Subtotal (Line 1 Minus Line 2.)	=	=	
4. Calculate 1/3 of Line 3.	–	–	
5. Subtotal (Line 3. Minus Line 4.)	=	=	
6. Child/Incapacitated Adult Care	–	–	
7. Countable Earned Income	=	=	
Unearned Income (8. through 17.)			
8. Alien Sponsor's Income			
9. Cash Gifts, Contributions, Prizes			
10. Child Support Payments			
11. Interest and Dividend Payments			
12. Retirement Benefit Payments			
13. Social Security Benefit Payments			
14. Unemployment Benefit Payments			
15. Veterans Affairs Benefit Payments			
16. Workers' Compensation Payments			
17. Other Unearned Income			
(Add Line 7. Plus Lines 8. through 17.)			
18. Total Countable Income	**+**	**+**	**=**

Documentation:

B. Complete 6.B. if anyone in the CIHCP household is making child support payments, alimony payments, other payments to persons they can claim as tax dependents or are legally obligated to support and who reside outside the CIHCP home, or if a household member was disqualified due to receiving Medicaid (refer to Page 1, 2.C.). If none of these exist, then proceed to 6.C.

1. Total countable income from 6.A., Line 18.	
2. Deduction for the support of the Medicaid recipients listed in 2.C. (See CIHCP Handbook, Section 2440, Verifying Income.)	–
3. Deduction for the actual amount of household member's payments made to dependents outside the household group, including child support, alimony, and other payments made to persons they can claim as tax dependents or are legally obligated to support.	–
4. Net Countable Income (Line 1. minus Lines 2. and 3.)	

C. Compare the CIHCP household's Net Countable Income to the CIHCP Monthly Income Standard.

1. Net Countable Income (from 6.A., Line 18. or from 6.B., Line 4.) with cents rounded down.	
2. CIHCP Monthly Income Standard for the CIHCP household (See CIHCP Handbook, Section 2450, Documenting Income.)	

If the Line 1. amount is equal to or less than the Line 2. amount, the CIHCP household is income eligible.
If the Line 1. amount is greater than the Line 2. amount, the CIHCP household is not income eligible.

7. Eligibility

A. Is the household eligible for CIHCP? ..... ◯ Yes ◯ No

B. Is any CIHCP household member eligible in any of the three months before the month in which the identifiable application was filed? (Question 7B is for applications. Mark N/A if this is a review.) ..... ◯ Yes ◯ No ◯ N/A

If Yes, list the name(s) and the eligible prior month(s).

Documentation:

(If the household is eligible for CIHCP, complete Items 8., 9. and 10.)

8. Other Sources of Health Care Coverage

Does any CIHCP household member have private health insurance, Veterans Affairs (VA) health care coverage, Workers' Compensation health care coverage, Texas Rehabilitation Commission (TRC) health care coverage, or any other source of health care coverage? ..... ◯ Yes ◯ No

If Yes, document regarding other source(s).

(Receipt of any other source of non-Medicaid health care coverage does not deny an applicant or recipient from CIHCP. It may indicate another payment source.)

9. Supplemental Security Income (SSI) Status

A. Has any CIHCP household member applied for SSI or Retirement, Survivors and Disability Insurance (RSDI) with the Social Security Administration? ..... ◯ Yes ◯ No ◯ N/A

If yes, who?

B. Is any CIHCP household member an SSI or RSDI appellant with the Social Security Administration? ..... ◯ Yes ◯ No ◯ N/A

If yes, who?

The Benefit Eligibility Screening Tool (BEST) screens for potential eligibility for benefits from any of the programs that Social Security administers. BEST may be accessed at http://best.ssa.gov.

10. Case Review

This case is due for its next six-month review [Insert Date] .