Comanche County Medical Center *Health System*

PLEASE READ, BEFORE TURNING IN APPLICATION:

Enclosed you will find a financial 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 Health System. 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 if 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 or Any Document with Auto VIN #
- Checking Account Statement (Current Month)
- Savings Account Statement (Current Month)
- Proof of Income (3 Complete Months), Self-Employment Form or Support Letter
- 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@comanchecmc.com

Should you have any questions or concerns, please feel free to contact our Customer Service Representative at 254-879-4900 x 4452, or ask for Brenda Allen, between the hours of 8-5 Monday through Friday.

Comanche County Medical Center *Health System*

DOCTORS MEDICAL CENTER:

G. TODD DAVIS, DO	SPECIALTY- FAMILYMEDICINE
SYDNEY DEAL, MD	SPECIALTY- FAMILYMEDICINE
STEPHEN H. DICKEY, DO	SPECIALTY- FAMILY PRACTICE
GUYLE DONHAM, DO	SPECIALTY- FAMILY MEDICINE
KENDA LUKER, PA-C	SPECIALTY- FAMILY MEDICINE
WESLEY MAYR PA-C	SPECIALTY- FAMILY MEDICINE
DWAYNE MILLER, MD	SPECIALTY- FAMILY MEDICINE
HELEN ONG, MD	SPECIALTY- PEDIATRICS
ANNELLE ONISHI, MD	SPECIALTY- FAMILY PRACTICE
JOEL WISE, PA-C	SPECIALTY- WOUND CARE
ROBYN MCGINNIS, FNP	SPECIALITY - FAMILY MEDICINE

RISING STAR HEALTH CLINIC:

MICHAEL BRENNAN, PA-C	SPECIALTY- FAMILYMEDICINE
SARA EAKER, PA-C	SPECIALTY- FAMILY MEDICINE

DUBLIN FAMILY MEDICINE CLINIC:

JOHN HODGES, MDD	SPECIALTY- INTERNAL MEDICINE
JASON GROSECLOSE, FNP	SPECIALTY- FAMILY MEDICINE
AMY YOUNG, FNP	SPECIALTY- FAMILY MEDICINE
ELIZABETH YOUNG, FNP	SPECIALTY- FAMILY MEDICINE

CORNERSTONE FAMILY MEDICINE:

MERCY DAVIS, FNP	SPECIALTY- FAMILY MEDICINE
MOLLY GRAY, DO	SPECIALTY- OSTEOPATHIC
GINA YOUNG-HARPER, FNP	SPECIALTY- FAMILY MEDICINE

COMANCHE PIR Infusion Clinic:

RACHEL HILLIARD, FNP	SPECIALTY- FAMILY MEDICINE
JENNIFER JOHNSON, FNP	SPECIALTY- FAMILY MEDICINE

SLIDING FEE SCALE BASED ON 2025 FEDERAL POVERTY GUIDELINES

All self pay patient to receive a 35% discount on hospital services. 10% discount on clinic services

FAP - Will not cover any Primary Insurance deductibles or copays.

Family Size	100% FPG	125% FPG	150% FPG	175% FPG	200% FPG	250% FPG	300% FPG
	Less Than $	Less Than $	Less Than $	Less Than $	Less Than $	Less Than $	Less Than $
1	$15,650	$19,563	$23,475	$27,388	$31,300	$39,125	$45,950
2	$21,150	$26,438	$31,725	$37,013	$42,300	$52,875	$63,450
3	$26,650	$33,313	$39,975	$46,638	$53,300	$66,625	$79,950
4	$32,150	$40,188	$48,225	$56,263	$64,300	$80,375	$96,450
5	$37,650	$47,063	$56,475	$65,888	$75,300	$94,125	$112,950
6	$43,150	$53,938	$64,725	$75,513	$86,300	$107,875	$129,450
7	$48,650	$60,813	$72,975	$85,138	$97,300	$121,625	$145,950
8	$54,150	$67,688	$81,225	$94,763	$108,300	$135,375	$162,450
Each addition family member	$5,500	$6,875	$8,250	$9,625	$11,000	$13,750	$16,500

Hospital Expected Payment	$0	$0	$0	80% MCR Rate	100% MCR Rate	100% MCR Rate	100% MCR Rate
				Co-Pay	Co-Pay	Co-Pay	Co-Pay
Clinic Expected Payment	$10.00	$15.00	$20.00	$25.00	$30.00	$35.00	$40.00

ADDITIONAL INSTRUCTIONS:

For any non-emergent patient, attempts should be made to collect as much of the dedctible and Copay at registration. If the patient has a very large deductible and/or Copay amount due, the patient can fill out a financial assistance application. Once the application is returned with ALL the requested information, the application must be reviewed by the CFO or FAP Admin Team to determine if a charity discount can be offered.

Medicare deductibles and Co Insurance amouints due from the patient must go through the collection process to be written off to Medicare Bad Debt.

Medicaid approved patients will not be eligible for the Financial Assistance Program (FAP)

Patients that have a double insurance will not be eligible for the Financial Assistance Program (FAP)

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.