COMAL COUNTY

Comal County Indigent Healthcare
1297 Church Hill Drive Suite #101
New Braunfels, Texas 78130
830-221-1210
Fax: 830-625-5483

COMAL COUNTY INDIGENT HEALTHCARE PROGRAM APPLICATION

The Comal County Indigent Healthcare Program helps people pay for medical care on a short-term basis. Whether you are eligible depends on your income, what you own, where you live, the help you receive, and other items.

To submit an application, fill out the attached forms and submit them along with all documentation requested**. You must provide your own copies** of the documentation. If you have any questions, you may call us at (830) 221-1210. Applications may be picked up in our office from 8:00 AM – 4:00 PM, Monday through Thursday. Completed applications may be returned to us by mail or delivered in person.

Once a completed application is received, a decision regarding your eligibility will be made within 14 business days. Our office will notify you by mail of the decision. We ask that you wait to call our office regarding your application until the 14 business day period has passed. **If your application is submitted and it is incomplete, it will be returned to you by mail with a request for additional information.** We will not review incomplete applications for eligibility.

You may be asked to apply for assistance through other program(s) before our department can determine your eligibility status. If you are asked to apply for assistance through other program(s) or you have applied but are awaiting an answer, your application may be held until you are determined to be ineligible for the other assistance program(s).

After turning in a completed application, you must report any household changes within 14 business days of the change. Examples of changes that require reporting are: address, income, employment, resources, number of people living in the home, and any information from other assistance program(s).

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Indigent Program Required Documentation Checklist

You must provide your own copies. All pages/documentation must be completed.

You may be asked to provide more information during the application review process.

Name: _____ Date: _____/_____/_____

Application Pages 4-18 (note: some pages must be notarized)

Marital status

□ **Married** □ **Single (never married)** □ **Widowed** □ **Separated**

□ N/A □ **Divorced** (provide a copy of the Final Decree of Divorce – all pages)

□ N/A □ **Child Support Court Order**

Supporting Documents

□ N/A □ **All checking account statements** (Applicant/Spouse: Individual/Joint: for past 90 days)

□ N/A □ **All savings account statements** (Applicant/Spouse: Individual/Joint: for past 90 days)

□ N/A □ **Paycheck stubs or Employer Earnings Statements** (past 90 days □ Applicant □ Spouse)

□ N/A □ **Federal Income Tax Return** (current year, including if claimed as dependent(s) on another person's tax return)

□ N/A □ **Unemployment compensation award or denial letter** (□ Applicant □ Spouse)

□ N/A □ **Proof of registration from the Texas Workforce Commission** (if unemployed; 60 years of age and under)

□ N/A □ **Workers compensation award or denial letter** (□ Applicant □ Spouse)

□ N/A □ **Social Security award/denial letter OR proof of SSI filing** (if unemployed □ Applicant □ Spouse)

□ N/A □ **Verification of benefits** □ **Adult Medicaid** □ **TANF** □ **Food Stamps** (award/denial letter OR proof of filing)

□ N/A □ **Verification of benefits from Children's Medicaid** (for anyone in your immediate household)

□ N/A □ **Verification of Veterans Benefits** (□ Applicant □ Spouse)

□ N/A □ **Automobile registration/title** (if the vehicle(s) is in Applicant/Spouse name)

□ N/A □ **Current balance owed on vehicle(s)**, if vehicle(s) is not paid off (if vehicle(s) is in Applicant/Spouse name)

□ N/A □ **Verification of any Retirement Plans, Payments, or Funds** (if not in English, must be translated & notarized)

□ N/A □ **Verification of residence** □ Lease agreement □ Mortgage info. □ Tax assessor info.

□ N/A □ **Current mail** (addressed to you at your physical address, no older than 30 days from current application date)

□ N/A □ **Social Security Cards** (copies are needed for anyone listed on Page 4 Question #1)

□ N/A □ **Texas Drivers License or Texas Identification Card** (Applicant only - must show current address)

□ N/A □ **Passport** (complete copy)

□ N/A □ **Birth Certificate** (Applicant only - US-born citizens only)

□ N/A □ **Permanent Resident Card**

□ N/A □ **Refugee**

□ N/A □ **Certificate of Naturalization** (Applicant only)

□ N/A □ **Form I-864 Affidavit of Support** (copy of the ORIGINAL filed with INS for Permanent Resident applicants)

FOR OFFICE USE ONLY / PARA USO DE LA OFICINA				
Status ☐ Application ☐ Review	Date Form 100 is Requested/Issued	Date Identifiable Form100 is Received	Case Record Number	Appointment Date and Time, if applicable

APPLICATION FOR HEALTH CARE ASSISTANCE / SOLICITUD DE ASISTENCIA DE ATENCIÓN MÉDICA

Name (Last, First, Middle)/Nombre (Apellido, primer, segundo)	Home Telephone No./Teléfono de la casa	Other Telephone No./Otro número de teléfono

Have you ever used another name? If so, list other names you have used./¿Ha usado alguna vez otro nombre? Sí es el caso, enumere los nombres que ha usado.

☐ Yes/Sí ☐ No

Mailing Address (Street or P.O. Box)/Dirección Postal (Calle o Apdo.)	Apt.# /Apto.#	City/Ciudad	State/Estado	ZIP

Home Address, if different from above. If it is rural, give directions. / Domicilio particular, si es diferente a la dirección de arriba. Si es rural, explique cómo llegar.

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. / En la tabla a continuación, llene la primera línea con información acerca de usted mismo. Llene las líneas restantes acerca de todos que viven en la casa con usted, los considere miembros de la unidad familiar o no.

Name (Last, First, Middle) Nombre (Apellido, primero, segundo)	Social Security Number **(if available)** Número de Seguro Social (si lo tiene a su disposición)	Sex Sexo Male/ Female Hombre/ Mujer	Date of Birth Fecha de nacimiento	What Relation to you? ¿Parentesco con usted?	Are you a sponsored alien? ¿Es usted un extranjero patrocinado?
		--		MYSELF Yo mismo	--
		--			--
		--			--
		--			--
		--			--
		--			--

The word "household" in Questions #2 - #16 refers to: you, your spouse, and anyone else that 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."
Las palabras "unidad familiar" en las preguntas #2- #16 se refiere a: usted, su esposo o esposa, y cualquier otra persona que vive con usted y con quien tiene una relación legal. No necesita incluir información de las personas quienes viven con usted que no son parte de su "unidad familiar."

2. What is your household's county and state of residence (where you make your permanent home)?
¿En qué condado y en qué estado viven (tienen su hogar permanente) usted y las personas de la unidad familiar?

County/Condado _____ State/Estado _____

Do you plan to remain in this county and state?
¿Piensa quedarse en este condado y este estado?..... ☐ Yes/Sí ☐ No

3. Living Arrangements/Vivienda
Check all boxes that apply to your household./Marque todas las cajitas que se apliquen a su caso.

☐ Own or paying for home
Soy dueño de mi casa o la estoy comprando

☐ Live in a house provided by someone else
Vivo en una casa ajena

☐ No permanent residence
No tengo residencia permanente

☐ Live with someone else
Vivo con otra persona

☐ Rent House/Apartment
Rento una casa o apartamento

☐ Jail
Cárcel

4. **List your average monthly household expenses.**/Enumere los gastos mensuales de la unidad familiar.

Rent/Mortgage/Renta/hipoteca.....$ _____

Utilities (gas, water, electric)/Servicios públicos (gas, agua, luz) .....$ _____

Telephone/Teléfono .....$ _____

Transportation, such as gas, car payments, bus/Transportación, tal como gasolina, pagos del carro, autobús .....$ _____

Tax and Insurance on home per year/Impuesto y seguro anual de la casa .....$ _____

Other/Otro.....$ _____

Other/Otro.....$ _____

Other/Otro.....$ _____

Does anyone pay these household expenses for you?
¿Hay otra persona que paga estos gastos de la unidad familiar por usted? ..... ☐ **Yes**/Sí ☐ **No**

If Yes, who?/Si contesta "Sí," ¿ quién? _____

5. **Are you – or is anyone in your household – receiving** ☐ **TANF** ☐ **Food Stamp** ☐ **Medicaid benefits?**
¿Está usted o alguien de la unidad familiar recibiendo beneficios de TANF, estampillas para comida, y/o Medicaid? ..... ☐ **Yes**/Sí ☐ **No**

If Yes, who?/Si contesta "Sí," ¿ quién? _____

6. **Are you – or is anyone in your household – pregnant?**
¿Está usted o alguien de la unidad familiar embarazada?..... ☐ **Yes**/Sí ☐ **No** **If Yes, who?**
Si contesta "Sí," ¿ quién? _____

7. **Are you – or is anyone in your household – disabled?**
¿Está usted o alguien de la unidad familiar incapacitada?..... ☐ **Yes**/Sí ☐ **No** **If Yes, who?**
Si contesta "Sí," ¿ quién? _____

8. **Have you – or has anyone in your household – applied for SSI or SSDI?**
¿Alguna vez usted o alguien de la unidad familiar solicitó beneficios de SSI o SSDI?..... ☐ **Yes**/Sí ☐ **No**

If Yes, who applied and when?
Si contesta "Sí," quién los solicitó y cuando? _____

9. **Do you – or does anyone in your household – have unpaid health care bills from the last three months?**
¿Tiene usted o alguien de la unidad familiar cuentas médicas sin pagar de los últimos tres meses? ..... ☐ **Yes**/Sí ☐ **No**

If Yes, which months?
Si contesta "Sí," ¿Cuáles meses? _____

10. **Do you – or does anyone in your household – have health care coverage (Medicare, health insurance, V. A., Tricare, etc.)?**
¿Tiene usted o alguien de la unidad familiar la cobertura médica (Medicare, seguro médico, V. A., Tricare, etc.)? ..... ☐ **Yes**/Sí ☐ **No**

If Yes, who?/Si contesta "Sí," ¿ quién? _____

11. **How much money do you have? For example, on your person, in your home, in bank accounts, or other locations?**
¿Cuánto dinero tiene usted; por ejemplo, en el bolsillo, en la casa, en las cuentas bancarias, o en otros lugares? ..... **$**

12. **How many cars, trucks, or other vehicles do you – and anyone in your household -- have? List the year, make, and model in the chart below.**/¿Cuántos carros, camionetas u otros vehiculos tienen usted y las personas de la unidad familiar? Anote el año, la marca, y el modelo en la tabla a continuación. .....

	Year/Año	**Make and Model**/Marca y Modelo
1.		
2.		

	Year/Año	**Make and Model**/Marca y Modelo
3.		
4.		

13. **Do you – or does anyone in your household – own or pay for a home, lot, land, or other things?**
¿Tiene o paga usted o alguien de la unidad familiar una casa, un lote, un terreno, u otros bienes? ..... ☐ **Yes**/Sí ☐ **No**

14. **Did you – or did anyone in your household – sell, trade, or give away any cash or property during the last three months?**
Durante los últimos tres meses, ¿traspasó, vendió o regaló usted o alguien de la unidad familiar dinero o alguna propiedad?..... ☐ **Yes**/Sí ☐ **No**

15. **Have you – or has anyone in your household – worked in the last three months?**
¿Ha trabajado usted o alguien de la unidad familiar en los últimos tres meses?..... ☐ **Yes**/Sí ☐ **No** **If Yes, who?**
Si contesta "Si," ¿quien? _____

16. List all of your household's income below. Be sure to 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./Haga una lista de los ingresos de la unidad familiar a continuación. Asegúrese de anotar: Cheques del gobierno; ingresos de trabajo o de capacitación; dinero que recibe de cobros de cuarto y comida; regalos en efectivo, préstamos, o aportaciones de sus padres, familiares, amigos, y otras personas; los ingresos del patrocinador; becas o préstamos de la escuela; manutención de niños, o pagos por desempleo.

Name of person receiving money Nombre de la persona que recibe el dinero	Name of agency, person, or employer who provides the money Nombre del patrón, la persona o la agencia que paga el dinero	Amount received Cantidad recibida	How often received? (daily, weekly, every two weeks, twice a month, monthly?) ¿Con qué frecuencia lo recibe? (¿diariamente, por semana, cada quincena, dos veces al mes, una vez al mes?)
			--
			--
			--
			--

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 re-certification for assistance; and that I may request, orally or in writing, a fair hearing about actions affecting receipt or termination of health care assistance.

A mi leal saber y entender, las declaraciones que he hecho, y mis respuestas a todas las preguntas, son verdaderas y correctas.

Me comprometo a dar al personal que verifica la elegibilidad y al condado toda la información necesaria para comprobar mis declaraciones sobre la elegibilidad.

Me comprometo a avisar, dentro de los 14 días, de cualquier cambio de:

- Ingresos
- Recursos
- Número de personas que viven conmigo
- Dirección
- Solicitud de SSI, TANF, o Medicaid o la entrega de cualquiera de estas.

Me han dicho y comprendo que esta solicitud será considerada sin discriminación por raza, color, religión, credo, origen nacional, edad, sexo, discapacidad, ni afiliación política; que puedo pedir una revisión de la decisión que se haga acerca de mi solicitud de asistencia o recertificación para asistencia; y que puedo pedir, oralmente o por escrito, una audiencia imparcial sobre cualquier acción que afecte la entrega o la terminación de asistencia de atención médica.

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.

Comprendo que al firmar esta solicitud, doy al condado el derecho a recuperar de cualquier tercero el costo de los servicios médicos proporcionados por el condado. Me comprometo a dar al condado la información necesaria para identificar y localizar cualquier otro fuente de pagos por mis servicios médicos.

Me han dícho y comprendo que si dejo de cumplir con las obligaciones especificadas en ésta podría considerarse como una retención intencional de información y podría dar lugar a la recuperación de pérdidas por medio de la devolución de pagos o por medio de la presentación de cargos criminales en mi contra.

BEFORE YOU SIGN, BE SURE EACH ANSWER IS COMPLETE AND CORRECT.
ANTES DE FIRMAR, ASEGÚRESE DE QUE CADA RESPUESTA SEA COMPLETA Y CORRECTA.

Signature – Applicant / Firma – Solicitante	Date / Fecha	Signature – Spouse / Firma – Esposo o Esposa	Date / Fecha

If the applicant is married and his/her spouse is a household member, the spouse may also sign and date this Form 100 even if the spouse is a disqualified household member. Si el/la solicitante está casado/a y su esposo o esposa vive en la misma casa, el cónyuge también puede firmar que su esposo o esposa también firme esta Forma 100, aunque no tenga derecho de recibir asistencia.

Signature - Person Who Helped Complete This Application / Date Firma - Persona que ayudó a llenar esta solicitud / Fecha	Signature - Applicant's Representative / Date Firma – Representante del solicitante / Fecha	Signature – Witness (if signed with "X") / Date Firma – Testigo (si firma con "X") / Fecha

Address (Street, City, State, ZIP) and telephone number of anyone who helped complete this Form 100/Dirección (Calle, Ciudad, Estado, ZIP) y teléfono de la persona que ayudó a llenar esta Forma 100

COUNTY INDIGENT HEALTH CARE PROGRAM
CASE RECORD INFORMATION RELEASE
PROGRAMA DEL CONDADO DE ATENCIÓN MÉDICA AL INDIGENTE
REVELACIÓN DE INFORMACIÓN DE EXPEDIENTE DE CASO

Case Record Name/Nombre en el expediente de caso	**Case Record Number**/Número de expediente de caso

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 County Indigent Health Care Program 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.

Yo, por este medio, autorizo a las personas, organizaciones o establecimientos que tengan información o documentos sobre mí/nosotros o sobre mis/nuestras circunstancias para que den dicha información a un representante del Programa del Condado de Atención Médica al Indigente.

Yo, por este medio, doy permiso al Programa del Condado de Atención Médica al Indigente para que obtenga la información que pudiera incidir en mi/nuestro derecho a recibir asistencia.

Este formulario de revelación es válido por seis meses a partir de la fecha en que se firma.

Person or Agency to Whom Information Will Be Released/Persona o agencia a quien se revelará la información

☐ **Specific Request (Specify in 1 and 2 below.)**
Petición específica (especifique en 1 y 2 a continuación).

1. **Information Requested**/Información pedida: _____

_____

2. **Period Covered (Dates)**/Periodo cubierto (fechas): _____

_____

☐ **General Request (Any information available may be released.)**
Petición general (puede revelarse toda la información disponible).

_____

_____

Signature- Applicant or Recipient/Firma – Solicitante o beneficiado	**Date**/Fecha
Signature – Spouse/ Firma - Cónyuge	**Date**/Fecha
Signature – Guardian, Power of Attorney, Parent of Minor Child/ Firma - Tutor, poder notarial o padre/madre del menor	**Date**/Fecha

TEXAS
Health and Human
Services Commission

Date
Advisor
Office Address
Telephone No.

Assistance Statement Verification

Case Name	Case No.

The person named above states that you provide help to his/her household. To correctly evaluate the household's situation, the Texas Health and Human Services Commission needs information from you. Please answer the following questions explaining what help you provide and return the form in the postage paid envelope provided. Please return it as soon as possible, but no later than _____.

Does this person live with you? ☐ Yes ☐ No

Do you give anyone in the household cash? ☐ Yes ☐ No

If "Yes", who do you give money to? _____ How much? _____

How often do you give them money? _____ When did you begin providing this help? _____

Do you expect them to pay the money back? ☐ Yes ☐ No If "Yes", when? _____

Do you provide any assistance for the household that is not in cash? ☐ Yes ☐ No

If "Yes", what type? (check all that apply)

☐ shelter ☐ food ☐ personal items ☐ transportation ☐ other (please explain below):

_____

Do you pay any of their bills? ☐ Yes ☐ No

If "Yes", which bills? _____

If "Yes", who do you give the money to? _____

If paid by check or money order, who do you make it out to? _____

Do you plan to continue providing assistance to this household? ☐ Yes ☐ No

If "Yes", how long? _____ If "No", date of last assistance. _____

Comments: _____

_____

_____ _____ Name

Signature Date

Address	Telephone No.

COMAL COUNTY

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830-221-1210
Fax: 830-625-5483

This form is required to be completed and notarized.

Authorization for Background Checks

_____	_____-_____-_____	_____/_____/_____
Applicant (Print Name)	**Social Security Number**	**Date of Birth**
_____	_____-_____-_____	_____/_____/_____
Spouse (Print Name)	**Social Security Number**	**Date of Birth**

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

Applicant Signature **Date**

Spouse Signature **Date**

Subscribed and sworn to (affirmed) before me this _____ day of_____, _____
(Day) (Month) (Year)

at_____. Notary Public in and for the State of Texas.
(Place of Notary)

My commission expires on_____.
(MM/DD/YY)

_____
Notary Signature

(seal) Notary must sign and stamp this page.

Revised January 2016