



Brazoria County Indigent Health Care Department

432 East Mulberry Street Angleton, Texas 77515

Office: (979) 864-1884 Fax: (979) 864-1093

260 George St., Suite 200 Alvin, Tx 77511

Office: (281)585-3024 Fax: (281) 824-0174

How to apply for the Brazoria County Indigent Program

1. Fill out the application; do not leave any blanks.
2. Make copies of all documentation required and attach them to your application.
3. Mail or drop off your application with the required documentation attached, at the Health Department in **Angleton** (if you live in Brazoria, Clute, Damon, Danciger, Freeport, Guy, Jones Creek, Lake Jackson, Old Ocean, Oyster Creek, Pledger, Richwood, Surfside, Sweeny, or West Columbia) or in **Alvin** (if you live in Alvin, Friendswood, Liverpool, Manvel, Pearland, or Rosharon)

Note: The receptionist is not responsible for making copies.

WHAT HAPPENS NEXT?

- Your application and documentation will be screened by a caseworker.
- If there is any additional documentation needed to make a complete application, you will be notified by mail and asked to submit the additional information.
- Once your application is complete, we will complete the pre-screen process and notify you by phone or mail of a date and time of your appointment. (We reserve the right to request additional information at any time during the application or interview process.)
- Should your case be denied, you will be mailed a denial letter.

*******Assistance in completing the application will be provided if needed; please contact Jennifer Gutierrez at (979)864-1884 or Marissa Saenz at (281) 585-3024 for assistance*******



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APPLICATION REQUIREMENTS

The Brazoria County Indigent Health Care Program requires that all blank spaces on the application be completed at the time of submission. Applications that are incomplete or without the requested information will result in your application being denied or returned to you.

To expedite your application, please attach copies of information listed below that applies to you.

PROOF OF IDENTIFICATION for each applicant (& sponsor if applicable)

- Texas Driver's License / Texas ID Card
- Resident Alien Card & Passport
- Social Security Card
- Birth Certificate (if no other documentation available)
- Current identification from your home country

PROOF OF RESIDENCE

- TXDL or TXID with same address as on your application
- Voter's Registration Card with same address as on your application
- Current Utility Bill showing the same address as on your application (regardless of name on bill)

INCOME

- Four (4) most recent paycheck stubs (NOTE: if you have unpaid medical bills from the past 3 months, then we need all paycheck stubs for those months as well)
- If paid in cash, you must bring a statement from your employer verifying your income
- If self-employed, bring current records or self-employment form
- Current Social Security Award Letter for both spouses and any children receiving it
- Current Child Support Statements (actual checks or court-ordered child support)
- Divorce decree
- Current verification for Workmen's Compensation medical benefits OR denial of benefits
- Current proof of any fixed income, such as: widow's benefits, retirement, pension, dividend payments, unemployment, workmen's compensation, etc.
- If applicable, sponsor's income will also be considered as part of the application

RESOURCES

- Bank statements from checking or savings accounts
- Verification of stock, bond, or retirement accounts
- Automobile registration or title for all vehicles in the household **regardless** of whose name the vehicle is in
- If applicable, sponsor's resources would also be considered as part of the application

VERIFICATION OF OTHER ASSISTANCE

- Current award / denial letters for Medicaid, TANF, SSI, Housing and Food Stamps or any other assistance program (bring all that apply)
- Management Verification Form completed, signed, and notarized by everyone who helps to support you
- Any assistance within the last 3 months from your local Social Services or charity organizations



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All eligible Indigent Health Care clients are required to register for work with Texas Workforce Center.

You should go to Texas Workforce Center at the following locations:

- Lake Jackson - 491 This Way
- Phone: (979)297-6400

- Texas City – 3549 Palmer Hwy
- Phone: (409) 949-9055

When you submit the completed application, you should attach two forms of identification.

When you submit your completed application, please take this letter with you and ask them to date stamp it (or attach a printout) as verification that you have registered for work.

This letter (with Texas Workforce Center date stamp or printout) must then be returned to our office at your designated appointment. If not returned assistance will be withdrawn.

Received by TWC (date stamp) _____

Applicant Name: _____

FOR OFFICE USE ONLY / PARA USO DE LA OFICINA

Status <input type="checkbox"/> Application <input type="checkbox"/> Review	Date Form 100 is Requested/Issued	Date Identifiable Form100 is Received	Case Record Number	Appointment Date and Time, if applicable
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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? Si es el caso, enumere los nombres que ha usado. <input type="checkbox"/> Yes/Sí <input type="checkbox"/> 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.

- | | | |
|---|--|--|
| <input type="checkbox"/> Own or paying for home
Soy dueño de mi casa o la estoy comprando | <input type="checkbox"/> Live in a house provided by someone else
Vivo en una casa ajena | <input type="checkbox"/> No permanent residence
No tengo residencia permanente |
| <input type="checkbox"/> Live with someone else
Vivo con otra persona | <input type="checkbox"/> Rent House/Apartment
Rento una casa o apartamento | <input type="checkbox"/> 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 "Sí," ¿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.

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.

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.

Me han dicho 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 must 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, se requiere 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

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

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:

Where You Live and Plan To Continue Living

Possible Proof: Mail that you received at your address; school records; voting records; property tax, rent or mortgage receipts; Texas driver's license; other official identification.

What You Own and What It Is Worth

Possible Proof: Property tax appraisals, estimates from car dealers, ads selling similar items, statements from real estate agents, bank statements.

Your Income

Possible Proof: Pay check stubs, pay checks, W-2 tax forms or income tax returns, sales records, statements from employers, award letters, legal documents, statements from persons giving you money.

Other Health Care Coverage

Possible Proof: Award or claim letters, insurance policies, court documents, other legal papers.

Information on social security numbers should be given if this information is available. Information on sex (Male/Female) is voluntary. These types of 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, if you have answered all the questions on the application, and if you 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.

El Programa de Atención Médica para Indigentes del Condado (CIHCP) ayuda a la gente a pagar los servicios médicos que necesita. La elegibilidad para esta ayuda depende de los ingresos del solicitante, sus posesiones, el lugar donde vive, otra ayuda que recibe o que podría recibir, y otras consideraciones. Asegúrese de:

- 1.) Poner su nombre y dirección;
- 2.) Firmar y fechar la tercera página de la solicitud; y
- 3.) Contestar tantas preguntas que pueda sobre esta solicitud.

Entregue su solicitud, o échela al correo, hoy mismo aun si no ha podido contestar todas las preguntas.

SUS RESPONSABILIDADES

Puede que le pidan pruebas de lo que escriba en su solicitud o de lo que diga en su entrevista. Si necesita ayuda para obtener las pruebas, la persona que le haga la entrevista le puede ayudar. Estos son algunos ejemplos de información que puede que tenga que probar y de documentos que le puede servir de prueba:

El Lugar Donde Vive O Donde Tiene Su Hogar Permanente

Posibles Pruebas: Correo que recibió en esa dirección; expedientes de de la escuela; registros de votante; recibos de impuestos, renta o hipoteca; la licencia para manejar de Tejas; otra identificación oficial.

Las Posesiones Que Tiene Y Cuanto Vale Cada Una

Posibles Pruebas: El avalúo para impuestos sobre la propiedad, avalúos hechos por vendedores de carros, anuncios de la venta de artículos parecidos, declaraciones de agentes que venden propiedades, estado de cuentas del banco.

Los Ingresos Que Tiene

Posibles Pruebas: Talones del cheque de paga, cheque de paga, comprobante de salarios e impuestos (Forma W-2), declaración de impuesto federal, el historial de ventas, declaraciones de empleadores, carta de concesión, documentos legales, declaraciones de personas que le dan dinero.

Otra Cobertura Para Gastos Médicos

Posibles Pruebas: Cartas de reclamación o de concesión, pólizas de seguros, papeles de la corte u otros documentos legales.

Si tiene a su disposición los números de seguro social, debe darlos. La información sobre el sexo (Hombre/Mujer) es voluntaria. Esta información no afectará su elegibilidad.

Debe dar información sobre seguros médicos y de cualquier tercero que tenga la responsabilidad de pagar los servicios médicos pagados por el condado en beneficio de usted y miembros de la unidad familiar. Al firmar y presentar esta solicitud, usted se compromete a darle al condado el derecho de recuperar el costo de servicios de un tercero.

Pueden pedirle que solicite Medicaid, Asistencia Temporal a Familias Necesitadas (TANF), o Seguridad de Ingreso Suplemental (SSI). Si le han pedido que solicite beneficios de alguno de estos programas o si usted ya los solicitó y está esperando la respuesta, su solicitud de CIHCP puede ser detenida hasta que decidan que no es elegible para los programas mencionados. Si no es elegible para estos programas, si ha contestado todas las preguntas de la solicitud, y si ha dado todos los comprobantes que piden, ya pueden procesar su solicitud. Entonces, el CIHCP tiene un plazo de 14 días para determinar su elegibilidad.

Después de entregar su solicitud, usted debe reportar dentro de un plazo de 14 días cualquier cambio de dirección, ingreso, recursos, el número de personas que viven con usted, o si solicita o recibe Medicaid, TANF, o SSI.



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BEHAVIORAL GUIDELINES

- All Applicants and Qualified Clients are required to comply with all State and County policies and guidelines to receive services through the Brazoria County Indigent Health Care Program.
- All Applicants or Qualified Clients are required to comply with behavioral guidelines established by the State of Texas and apply to Brazoria County Primary Care Group and any specialist's offices they are referred to.
- All Applicants or Qualified Clients who are rude and display disruptive or abusive language 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 Health Care Program.
- All Qualified Clients are expected to comply with the medical regime proposed by the Brazoria County Primary Care Group, or by the Specialist Office to 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 visit. We cannot properly treat without testing results. Qualified Clients will be terminated from the program for repeated non-compliance.
- Clients will be terminated from the Indigent Health Care Program for illicit drug usage and continued alcohol abuse, if not currently and actively participating in a supervised rehab program.
- 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 Health Care Program for repeated failure to keep scheduled appointments.

I HAVE READ AND UNDERSTAND ALL OF THE ABOVE GUIDELINES AND UNDERSTAND THAT FAILURE TO COMPLY WITH THESE GUIDELINES COULD RESULT WITH SUSPENSION FROM THE PROGRAM:

Applicant Signature

Date

Printed Name of Applicant



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STATEMENT OF SERVICES

- **Clients are required to seek ALL non-emergency medical care from the Brazoria County UTMB Primary Group Office.** (If the Brazoria County UTMB Primary Care Group Office determines that your condition requires treatment from a specialist; he/she will issue a referral for you to see that specialist. Brazoria County CIHCP will not issue payment for any non-emergency services provided without a referral from the Brazoria Co. Primary Care Group).
- **Hospital emergency rooms are not to be used except in matters of true emergency.** If you seek routine medical attention, such as for a common cold, from an emergency room, you may be held responsible for the hospital bill and all related emergency room physician/lab bills.
- Brazoria County will pay for up to **three (3) prescriptions per month** and up to \$30,000 per year in hospital, doctor, lab, x-ray, and skilled nursing facility expenses **OR 30 days of hospitalization, whichever comes first.**
- **Clients can be held responsible for the balance of charges not paid by Brazoria County, including full payment for prescriptions exceeding 3 per month.**
- **Clients are responsible for informing providers of their eligibility** with the Brazoria County Indigent Health Care Program and for informing these providers of our billing address.
- Brazoria County Indigent Health Care is not responsible for any medical claims received after our deadline. (Either 95 days from the date of service OR 95 days from the date of your completed application). ***If a provider sends a bill to you, you must contact that provider and give them the above information so they can bill our office.**
- **Clients must notify our office within 14 days of any change of situation,** such as changes in: income, address, property (including vehicles), household members, application / receipt of SSI, TANF, or Medicaid.

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 of any medical services received after you became ineligible or you may be subject to prosecution under the Texas Penal Code.

I HAVE READ AND UNDERSTAND ALL CONDITIONS AS STATED ABOVE:

Applicant Signature

Date



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Dear Indigent Health Care Applicant:

Please be advised of the following:

BRAZORIA COUNTY INDIGENT HEALTH CARE PROGRAM

FRAUD POLICY

- I. If a person knowingly provides false information for the purpose of qualifying for indigent health care he or she are subject to Section 37.10 of the Texas Penal Code – Tampering with Government Record, Class ‘A’ Misdemeanor; and/or subject to Section 32.46 of the Texas Penal Code – Securing Execution of Document by Deception.
- II. If a person knowingly, within the previous 24 months, transferred a countable resource for less than fair market value to qualify for indigent health care, that person’s household is ineligible for two years beginning with the date the recourse was transferred and if a person fails to disclose such a transfer, that person would also be subject to the criminal sanctions set out in Section I.
- III. If a person fails to report a change in income, resources, residence, or household members, such failure makes the person ineligible for benefits. Any benefits paid to a person while they are ineligible shall be repaid.
- IV. If a person knowingly conceals a change of income, resources, or residence for the purpose of remaining eligible he or she is liable for any benefits received while ineligible; and subject to criminal sanctions listed in Section I; and subject to Section 31.03 and/or Section 31.04 of the Texas Penal Code, Theft and Theft of Services, respectively Class ‘C’ Misdemeanor to Second Degree Felony, depending on the value of the property or services taken.
- V. If a person knowingly alters an authorization document received from the indigent health care program for the purpose of changing the nature of health care authorized or the beneficiary of the health care authorized he or she is subject to Section 37.10 of the Texas Penal Code, Tampering with Governmental Record, Class ‘A’ Misdemeanor. If the alteration involves the dispensing of controlled substances the person is subject to criminal sanctions pursuant to the Dangerous Drugs Act, and the Controlled Substances Act.

The laws cited here are for illustrative purposes. Prosecution by the district attorney or other criminal authority need not be limited to the criminal authority provisions set forth above.

If you do not know the answer to a question you are asked please do not guess. If you do not know such answers please tell this office and we will be happy to assist you to the appropriate authority.

I have read the forgoing letter and understand its contents.

Signature

Date

Printed Name



Brazoria County Indigent Health Care Department

432 East Mulberry Street Angleton, Texas 77515

Office: (979) 864-1884 Fax: (979) 864-1093

260 George St., Suite 200 Alvin, Tx 77511

Office: (281) 585-3024 Fax: (281) 824-0174

AUTHORIZATION FOR BACKGROUND CHECK

APPLICANT: _____ SS: _____ D.O.B.: _____

SPOUSE: _____ SS: _____ D.O.B.: _____

ADDRESS: _____

I understand that as part of the application process for benefits from the Brazoria County Indigent Health Care Program I am required to provide certain written documents to the Health Department. I realize that my failure to provide such document will delay the receipt of benefits, if any, I might receive.

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

I, _____; hereby authorize any public agency including the Social Security Administration, Medicaid and Medicare to furnish Brazoria County or its agent, information related to assets or any other sources of income to me held in my name and/or criminal history. I hereby release Brazoria County and all of its agents and employees, the public agencies providing such information and all employees of public agencies furnishing information, and all liability resulting from the furnishing of this information to Brazoria County. I certify that the statements made by me on this form and on my application for health care services are true, complete, and correct to the best of my knowledge and belief, and are made in good faith. I understand that any false statements made herein or on my application for health services for Brazoria County will void further consideration for eligibility in Brazoria County's Indigent Health Care Program as it relates to my application for such health services. I know and understand the Brazoria County Indigent Health Care Program Fraud Policy.

I am aware that I must reapply for Indigent Health Care benefits every six months and that if I do not reapply I would lose any benefits I might have been receiving.

I have read all of the above and I understand it.

Signature of Applicant

Date

Signature of Applicant's Spouse

Date