Office Use Only:

Requested By: _____

HAMILTON COUNTY HOSPITAL DISTRICT
REQUEST FOR DETERMINATION OF ELGIBILITY
FOR PATIENT PAYMENT PROGRAM/HAMILTON HOSPITAL INDIGENT PROGRAM

I hereby request that Hamilton Healthcare System make a determination of my eligibility for the Patient Payment Program or Hamilton Hospital Indigent Program. I understand that proof of residency and proof of household income must be provided before my application can be processed. (**Proof of residency:** Driver's license, state issued ID, utility bill. **Proof of income:** copy of check/check stub, or written verification from employer of gross monthly income and period of time employed, tax return, or bank statements.) **Note: Your application will not be processed unless all the requested information is attached and the form is completed in full.** ***If we do not receive your proof of income within 15 days of receipt of application, your request for financial assistance WILL NOT BE APPROVED.***

If No Income You need to provide a Medicaid Denial or SSI Denial

HAMILTON HOSPITAL INDIGENT/PATIENT PAYMENT PROGRAM AGREEMENT

Please note that eligibility is for a six month period unless you have change in your situation. You have 14 days to notify us of any changes in your situation. It is required you present the Indigent or Patient Payment Program card each time services are rendered if approved. If not, you will be expected to pay for services at that time. You will need to reapply for the program every 5 months to continue to be eligible.

Patient Payment Program:
Please note that this program only covers services rendered at and by the Hamilton Healthcare System (Family Practice Rural Health Clinic, Hico Clinic, Goldthwaite Clinic, and Hamilton General Hospital only.) The hospital district is NOT RESPONSIBLE for payment to any outside entities. Any outside services rendered at the hospital or clinics are the responsibility of the patient. You will be responsible for any labs sent out to Kings Daughter's Hospital, Scott and White radiology bills, and Family Practice Associates bills for inpatient and surgery visits. Dr. Larry Bragg General Surgeon physician fees are not covered. You are also responsible for all payment to outside physicians seen at the Family Practice Rural Health Clinic. Do not present your card if approved to outside entities for payment of their services.

While on the program please make appointments to Family Practice Rural Health Clinic, Hico Clinic, or Goldthwaite Clinic for all non-emergent visits. Overuse/Abuse of ER services is reason to be removed from the assistance program and all ER visits are monitored. If there is ever a question of whether or not to use ER please call the clinic for guidance from the nursing staff. ***You will be removed from the program for any abuse/misuse/providing fraudulent information/or failing to provide information.***

Hamilton Hospital Indigent Program:

Please note that this program only covers services rendered at Family Rural Health Clinic and Hamilton General Hospital. The hospital district is NOT RESPONSIBLE for payment to any outside entities. Any outside services rendered at the hospital or clinics are the responsibility of the patient. You will be responsible for any labs sent out to Kings Daughter's Hospital, Scott and White radiology bills. You are also responsible for all payment to outside physicians seen at the Family Practice Rural Health Clinic. Dr. Larry Bragg General Surgeon physician fees are not covered. Do not present your card if approved to outside entities for payment of their services.

While on the program please make appointments to Family Practice Rural Health Clinic, for all non-emergent visits. Overuse/Abuse of ER services is reason to be removed from the assistance program and all ER visits are monitored. If there is ever a question of whether or not to use ER please call the clinic for guidance from the nursing staff. ***You will be removed from the program for any abuse/misuse/providing fraudulent information/or failing to provide information.***

Please note also that the Hamilton Healthcare System Patient Payment Program/Hamilton Hospital Indigent Program is a payer of last resort meaning you must seek any available federal, state, or local programs before charity care will cover. Patient Payment Program/Indigent does not cover well women exams or family planning as this is available thru Planned Parenthood and other state funded clinics. Females/males seeking STD screening and/ or treatment, pregnancy testing, or female related problems must seek services available at local family planning clinics (Waco- 254-759-5750, San Saba 512-556-8570, or Lampasas 512-556-8570). Patients seeking ongoing mental health medication management must apply for services thru Central Counties MHMR 254-386-8179.

Patient Payment Program/ Hamilton Hospital Indigent Program only covers current bills and you will still be responsible for all balances due prior to approval date.

Please sign that you grant permission for Hamilton Healthcare System to obtain and/or release your information that may have a bearing on your eligibility for the Patient Payment Program/ Hamilton Hospital Indigent Program or for other human service agencies and organizations to which you may be referred to.

_____

Name & Date (Applicant)

_____

Name & Date (Spouse

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?
				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.

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

I agree to give eligibility staff and the county any information necessary to prove statements about my eligibility.

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

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**

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.

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.

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 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 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 require 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

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.

SOLICITUD DE ASISTENCIA DE ATENCIÓN MÉDICA

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.) Conteste 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 articulos 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 salaries 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 Necesitadad (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 dias para determinar su elegibilidad.

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