COLLIN COUNTY

Collin County Indigent Healthcare Program
825 N. McDonald Street
Suite 110
McKinney, Texas 75069
www.collincountytx.gov
Phone: 972-548-4702
Fax: 972-547-7268

COLLIN COUNTY INDIGENT HEALTHCARE PROGRAM APPLICATION

The Collin 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, 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 (972) 548-4702. 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).

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.

COLLIN COUNTY

Collin County Indigent Healthcare Program
825 N. McDonald Street, Suite 110
McKinney, Texas 75069
www.collincountytx.gov
Phone: 972-548-4702
Fax: 972-547-7268

Indigent Program Required Documentation Checklist

You may be asked to provide additional information during the application review process. You must provide your own copies.

Name: _____ Date: _____/_____/_____

Application All pages (4-22) must be completed (note: some pages must be notarized)

Marital status

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

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

Supporting Documents

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

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

□ 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 □ **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** □ **Food Stamps** □ **TANF** (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 □ Tax assessor statement

□ N/A □ **Social Security Card(s)** (□ Applicant □ Spouse)

□ N/A □ **Texas Driver's 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 □ **Certificate of Naturalization** (Applicant only)

□ N/A □ **Permanent Resident Card**

□ N/A □ **Refugee/Asylee**

□ N/A □ **Child Support Court Order**

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?
		Male		MYSELF Yo mismo	No
		Male			No
		Male			No
		Male			No
		Male			No
		Male			No

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

COLLIN COUNTY

Collin County Indigent Healthcare Program
825 N. McDonald Street
Suite 110
McKinney, Texas 75069
www.collincountytx.gov
Phone: 972-548-4702
Fax: 972-547-7268

This form is required to be completed. Please print all information

Medical Questionnaire

What is your **primary** health concern at this time? _____

_____

Please list **all** other ongoing health issues or diagnoses:

_____

_____

Were you referred to our office by another facility? ☐ Yes ☐ No
If yes, what facility? _____

Do you have any unpaid medical bills within the past 95 days? ☐ Yes ☐ No
If yes, please complete the following information:

_____ _____ _____
Facility (Hospital) Admit Date Discharge Date

_____
Reason for visit

Are you currently a LifePath Systems (MHMR) client? ☐ Yes ☐ No
Are you currently receiving assistance through DARS? ☐ Yes ☐ No
Do you have a primary care physician? ☐ Yes ☐ No

Please list **all** medications you are currently taking (if you need extra space please use the back of this form)

Medication	**Reason for medication**	**Daily Dosage**
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____

Emergency Contact: Please provide the name, address and telephone of a relative, or friend, that we may contact in case of an emergency. Name: _____

_____
Address Telephone Relationship to Applicant

_____ _____
Applicant Signature **Date**

Revised September 2019

COLLIN COUNTY

Collin County Indigent Healthcare Program
825 N. McDonald Street
Suite 110
McKinney, Texas 75069
www.collincountytx.gov
Phone: 972-548-4702
Fax: 972-547-7268

This form is required to be completed and notarized even if you are supporting yourself.

Affidavit of Income and Support/Affidavit of Self Support

☐ Check this box if you are supporting yourself. Sign and date below in front of notary.

This affidavit is made by me, _____, for the purpose
(Person supporting the applicant/Self)

of assuring the Collin County Indigent Healthcare Program that _____
(Applicant's name)

____ lives with me at _____.
(Address, City, State, Zip code)

____ does not live with me and lives at _____.
(Address, City, State, Zip code)

1. I help support this person and affirm that he/she:

   ____ does not have an income **_____ does have an income**.

2. I affirm that I currently support the applicant ☐ financially and/or ☐ provide the applicant with a place to live. I affirm that a Collin County Indigent Healthcare Program (CCIHCP) representative has explained this Affidavit of Income and Support form to me and that I have been given the opportunity to ask questions about this form. I understand that if a change occurs that makes the applicant ineligible for CCIHCP services and I fail to report the changes as required, I may be held responsible for payment of any medical services that the applicant received after becoming ineligible and/or I may be subject to prosecution under the Texas Penal Code.
3. I swear (affirm) that the contents of this affidavit signed by me are true and correct.

Signature of person providing support/Self	**Date**	**Relationship to Applicant/Self**

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 April 2019

COLLIN COUNTY

Collin County Indigent Healthcare Program
825 N. McDonald Street
Suite 110
McKinney, Texas 75069
www.collincountytx.gov
Phone: 972-548-4702
Fax: 972-547-7268

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 Collin County Indigent Healthcare Program to obtain a background check from the Texas Workforce Commission, Department of Motor Vehicles Registration, LexisNexis Accurint and any other sources that may need to be contacted to determine my eligibility for the Collin 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 April 2019

COLLIN COUNTY

Collin County Indigent Healthcare Program
825 N. McDonald Street
Suite 110
McKinney, Texas 75069
www.collincountytx.gov
Phone: 972-548-4702
Fax: 972-547-7268

This form is required to be completed.

Authorization for Release of Information

Applicant Name: _____

I hereby give permission to the Collin County Indigent Healthcare Program to contact any source to verify the statements I have made in my application. I understand that a background check company and the Texas Workforce Commission will be contacted. I will cooperate fully with Collin County Indigent Healthcare Program personnel to obtain any information necessary to verify statements about my eligibility. I understand that random home visits will be conducted.

_____ **(Print name of Authorized Representative)** is my representative and I give the Collin County Indigent Healthcare Program permission to speak to them in person or on the phone at any time regarding my eligibility or benefits under the Collin County Indigent Healthcare Program.

I have been told and I understand that my failure to meet the obligations set forth or the unlawful use of ID cards, pharmacy cards, etc. can result in the recovery of any loss by repayment, or by the filing of criminal or civil charges against me.

I give permission for my legal counsel or the Social Security Administration to release information regarding my application or appeal for SSI Disability benefits.

I also give permission for any providers treating me to release my medical records to the Collin County Indigent Healthcare Program for the purpose of determining proper referrals and/or determining whether or not the services provided meet the criteria for payment by the Collin County Indigent Healthcare Program.

Acknowledgment of Receipt of Notice of Privacy Practices

I understand that as part of the provision of healthcare services, Collin County creates and maintains health records and other information describing, among other things, my health and medical history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I have read and understand that document. I consent to the use and disclosure, by Collin County Health Care Services and its agents (including Collin County Indigent Healthcare Program), of my medical and health information and/or protected health information as is stated in the Notice of Privacy Practices. I understand that Collin County reserves the right to change its Notice and practices with regard to the use and disclosure of health information. I understand that I have the right to request restrictions as to how my health information may be used or disclosed for treatment, payment, or healthcare operations, but that Collin County is not required to agree to the requested restrictions.

This authorization is effective for the duration that the applicant remains in the program.

_____ _____

Applicant Signature **Date**

COLLIN COUNTY

Collin County Indigent Healthcare Program
825 N. McDonald Street
Suite 110
McKinney, Texas 75069
www.collincountytx.gov
Phone: 972-548-4702
Fax: 972-547-7268

This form is required to be completed.

Verification Statement

This form is to be completed by any person or persons who are providing any assistance to you.

☐ **Check this box if no one is currently assisting you. Sign and date below.**

Applicant Name: _____

Have you given cash to the above-named person within the past 95 days? ☐ **Yes** ☐ **No**

- If yes, please note the dates and amounts, however small, in the spaces below. You may use the back of this form if you need more space.

Date	Amount	Date	Amount

Have you paid any bills directly for the above-named person? ☐ **Yes** ☐ **No**

- If yes, please list below. You may use the back of this form if you need more space.

Date	Name of person or company paid

Is the above-named person currently living with you? ☐ **Yes** ☐ **No**

Are you currently providing room and board for the above-named person? ☐ **Yes** ☐ **No**

I understand that providing any false information can result in a fine or imprisonment. I certify that the above information is correct to the best of my knowledge.

_____
Print Name (person providing the assistance or Applicant, if no one is assisting you)

_____
Address **City** **State** **Zip Code**

(_____)_____ _____
Phone Number **Relationship to Applicant or Self**

_____
Signature **Date**

Revised November 2010

COLLIN COUNTY

Collin County Indigent Healthcare Program
825 N. McDonald Street
Suite 110
McKinney, Texas 75069
www.collincountytx.gov
Phone: 972-548-4702
Fax: 972-547-7268

This form is required to be completed.

Collin County Indigent Health Care Fraud Policy

Definition

Fraud is the deliberate misrepresentation of some material fact for the purpose of acquiring benefits.

Procedure

When the Collin County Indigent Healthcare Program (CCIHP) staff has reason to believe that fraud may have occurred, the following procedures shall be followed:

1. The CCIHP staff shall investigate all cases of suspected fraud and shall collect and document evidence.

2. Upon a finding of fraud, the applicant/client shall be administratively ineligible from CCIHP as follows:
   First offense: 24 months from the date fraud was discovered
   Second offense: 36 months from the date fraud was discovered
   Third offense: 24 months from the date fraud was discovered + 12 months per subsequent offense

3. The CCIHP staff shall contact the applicant/client who is suspected of fraud by sending a certified letter informing the applicant/client of the withdrawal of eligibility and explaining the allegations. If the applicant/client disputes the allegations, the applicant/client will be allowed to submit applicable supporting documents/verifications for further consideration.

4. If the dispute remains unresolved, the CCIHP staff shall schedule an administrative hearing to allow the applicant/client to defend themselves by confronting any adverse witness and by presenting their own argument and evidence. The CCIHP staff must disclose any evidence used to prove its case to the client so they have an opportunity to dispute it. The administrative hearing will be conducted by the CCIHP Coordinator with the CCIHP Eligibility Clerk or designee present. The administrative hearing shall be held at the offices of the CCIHP during normal business hours. The applicant/client shall be given 30 days written notice of the date of the administrative hearing. The burden of proof lies with CCIHP. If the applicant/client does not appear at the administrative hearing, the CCIHP Eligibility Clerk or designee may proceed with presentation of the CCIHP's case only if proof of notice is present. The CCIHP Coordinator must make a decision within ninety (90) days of the hearing.

5. The applicant/client shall have the right to appeal any unfavorable decision to the CCIHP Appeal Authority.

Consequence of Fraud

If, after due process, a person is found to have intentionally misrepresented information in order to receive benefits, that person:

- shall reimburse Collin County for the cost of benefits the applicant/client was ineligible to receive;
- shall be administratively ineligible for CCIHP benefits in accordance with CCIHP Policies and Procedures; and
- may be subject to prosecution under the Texas Penal Code.

_____ _____

Signature **Date**

COLLIN COUNTY

Collin County Indigent Healthcare Program
825 N. McDonald Street
Suite 110
McKinney, Texas 75069
www.collincountytx.gov
Phone: 972-548-4702
Fax: 972-547-7268

This form is required to be completed and notarized.

Applicant - Affidavit of Assets, Income and Resources

This affidavit is made by me _____ for the purpose of
(Applicant - Print Name)

informing the Collin County Indigent Healthcare Program that **I do have access** to the assets, income or resources listed below, either in the United States or any foreign countries.

Please check the items that you do have access to:

- ☐ Ownership of any property in the U.S.
- ☐ Ownership of any property in foreign countries
- ☐ Businesses in the U.S. or foreign countries
- ☐ Retirement plans/payments; US/foreign countries
- ☐ Vehicles (Autos, Motorcycles, ATV, Golf Carts, etc.)
- ☐ U.S. bank accounts (checking, savings, IRA, etc.)
- ☐ Foreign bank accounts (checking, savings, IRA, etc.)
- ☐ Medical benefits in the U.S. or foreign countries

I understand that if I fail to report any of the above information, I will be held responsible for payment of any medical services that I may have received under the Collin County Indigent Healthcare Program, and I will be subject to prosecution under the Texas Penal Code.

I swear (affirm) that the contents of this affidavit signed by me are true and correct.

Applicant (Print Name)	**Applicant 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 September 2019

COLLIN COUNTY

Collin County Indigent Healthcare Program
825 N. McDonald Street
Suite 110
McKinney, Texas 75069
www.collincountytx.gov
Phone: 972-548-4702
Fax: 972-547-7268

This form is required to be completed.

Applicant - Employment Verification Form

If you are not currently employed:

☐ I have not been employed for _____ (months/years) because _____

_____

Last place of employment: _____

☐ Check this box if applicant has **NEVER** worked in the USA and sign and date the bottom of this form

If you are currently employed:

_____ _____
Company Name (Please Print) Supervisor (Please Print)

_____ _____
Company Address Telephone

Employee (Applicant) Information:

☐ Full time ☐ Part time Pay Period: ☐ Weekly ☐ Bi-Weekly ☐ Monthly

_____/_____/_____ _____ _____
Hire Date Hourly wage Hours worked weekly

☐ **Check this box if you are Self Employed and/or own your own business:**

_____
Occupation/Trade Name of Business Start Date

_____ _____
Supervisor Signature Date

_____ _____
Employee/Applicant Signature (REQUIRED) Date (REQUIRED)

Revised September 2019

COLLIN COUNTY HEALTH CARE SERVICES

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

If you have any questions about this Notice please contact: Candy Blair by calling 972-548-5532.

We are required by law to maintain the privacy of protected health information and to provide patients with notice of our legal duties and privacy practices with respect to protected health information. This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by either mailing the revised Notice to an address you provide or by delivering a revised Notice to you at our office.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Uses and Disclosures of Protected Health Information for Treatment, Payment and Health Care Operations

We are permitted to use and disclose your protected health information for treatment, payment and health care operations as described in this Section 1. Your protected health information may be used and disclosed by us and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to facilitate payment of your health care bills and to support our operations.

Following are examples of the types of uses and disclosures of your protected health care information that we are permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians and health care providers who may be treating you: i.e. your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at our request, becomes involved in your care by providing assistance with your health care diagnosis or treatment.

Payment: Your protected health information may be used, as needed, to obtain payment for your health care services. This may include certain activities that a payor (whether a governmental entity or private insurance or other health plan) may undertake before it approves or pays for the health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. Your protected health information may be used, as needed, to obtain reimbursement from a sponsor who signed an I-864 affidavit of support on your behalf.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of our office. These activities include, but are not limited to: quality assessment activities; employee review activities; training of medical students, other practitioners, or non-health care professionals; accreditation; certification; licensing; credentialing; and conducting or arranging for other business activities. For example, we may use and disclose your protected health information when training and reviewing our staff. We may use or disclose your protected health information, as necessary, to contact you to remind you of upcoming appointments.

If you are a job applicant, existing employee, or a family member of an employee covered by the County's health insurance, we will share your protected health information with the Collin County Human Resources Department, and/or supervising department as part of routine business operations. Some examples of situations where your information would be shared are: post-offer/pre-employment health screening outcomes, wellness screening outcomes, random drug screening outcomes, and Department of Transportation physical outcomes.

We will share your protected health information with third party "business associates" that perform various activities (e.g., auditing, legal) for us. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information. This requirement will not apply if the business associate is a "health care component" designated by our governing body.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services we offer that may be of interest to you. You may contact our Privacy Official to request that these materials not be sent to you.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation.

Other Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that we have taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted Uses and Disclosures to Which You May Agree or Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then we may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are not present or unable to agree or object to such a disclosure because of your incapacity or an emergency circumstance, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. If required by law, you will be notified of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Abuse or Neglect: We may disclose your protected health information to a public health authority or other government authority that is authorized by law to receive reports of child abuse or neglect. In addition, if we believe that you have been a victim of abuse, neglect or domestic violence we may disclose your protected health information to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug

APPLICANT NAME:_____ APPLICANT SIGNATURE:_____ DATE:_____

Administration to report adverse events, product defects or problems, biological product deviations; to track products; to enable product recalls; to make repairs or replacements; or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), and in response to a subpoena, discovery request or other lawful process as permitted by law. We may disclose protected health information in the course of any legal proceedings which seek reimbursement from a sponsor who signed an I-864 affidavit of support on your behalf.

Law Enforcement: We may disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. Such disclosures include (1) the reporting of certain physical injuries; (2) responding to legal processes; (3) providing limited information for identification and location purposes, (4) providing law enforcement officials with information pertaining to victims of a crime; (5) reporting deaths possibly resulting from criminal conduct; (6) reporting a crime that occurs on our premises; and (7) reporting criminal activity outside our premises that results in emergency medical services.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out his/her duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Serious Threat to Health or Safety: Consistent with applicable federal and state laws, we may disclose your protected health information if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or certain other individuals.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and we created or received your protected health information in the course of providing care to you.

Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Sponsored Immigrant (I-864 Affidavit of Support): Your protected health information may be disclosed as part of a request for reimbursement from a person who sponsored your admissibility into the United States by signing an I-864 on your behalf. Additionally, your protected health information may be disclosed in public legal proceedings if we pursue legal proceedings against a sponsor who signed an I-864 affidavit of support on your behalf.

Project Access-Collin County, Inc.: Your protected health information may be disclosed in order to provide continuity of care through Collin County's participation in the Project Access—Collin County, Inc. program.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Title 45, Code of Federal Regulations, Parts 160 and 164.

2. YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

We are not required to agree to a restriction that you may request. If we believe it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If we agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. Additionally, if you are a sponsored immigrant and we need to use your protected health information in order to seek reimbursement from the person who sponsored you with an I-864 affidavit of support, your protected health information will not be restricted when communicating with your sponsor or pursuing legal action against your sponsor. With this in mind, please discuss any restriction you wish to request with your health care provider. You may request a restriction by completing a "Restriction of use and Disclosures Request Form," which you may obtain from our Privacy Official.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Official.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that we use for making decisions about you. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to any law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. Please contact our Privacy Official if you have questions about access to your medical record.

You may have the right to have us amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. Requests for amendment must be in writing and must provide a reason to support each requested amendment. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Official if you have questions about amending your protected health information.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, for notification purposes, and for other purposes, as permitted by law. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003 and during the six years prior to your request. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying the person named below of your complaint. We will not retaliate against you for filing a complaint.

For further information about the complaint process, or to file a complaint, contact:
Candy Blair, 825 N McDonald 130, McKinney, TX 75069
Phone 972-548-5532 , Fax 972-548-5550

For further information about filing a complaint with the Secretary of Health and Human Servers, or to file a complaint, contact:

U.S. Dept. of Health & Human Services, Office for Civil Rights
Medical Privacy, Complaint Division
200 Independence Avenue, SW
HHH Building, Room 509H
Washington, D.C. 20201
Phone: 866-627-7748 , TTY: 886-788-4989

This notice was published and becomes effective on April 14, 2003.
[NOTICE OF PRIVACY PRACTICES—HEALTH CARE PROVIDERS (2/22/2012); EFFECTIVE 4/14/2003]

APPLICANT NAME:_____ APPLICANT SIGNATURE:_____ DATE:_____

Collin County Indigent Health Care Public Notice
September 1, 2019 - August 31, 2020

All residents over the age of 18 who reside in Collin County and who fall within 100% of Federal Poverty Level Income, resource, residency, citizenship and household composition criteria established in the Collin County Indigent Care Program and who have no other equivalent public or private health care benefits, may be eligible for medically necessary health care benefits as mandated by the State of Texas pursuant to the programs and services offered by Collin County Indigent Program.

Potentially eligible residents may include:

- US Citizens
- Permanent Residents
- Individuals whose household composition makes them ineligible for Medicaid through the State of Texas
- Individuals who countable gross income minus work deductions does not exceed the minimum Federal Poverty Income Level (FPIL) of 100%
- Individuals whose resource standards approximate the State of Texas' TANF standards

Eligibility determination will be made within 14 (fourteen) business days after the date a completed application and all required documentation is received by Collin County Indigent Program office.

A complete application will include but may not be limited to the following types of verification:

- Identification for each member of the applying household
- Proof of marital status
- Resources identification, to include automobile registration or title, property tax statement, savings account/CD statements, etc.
- If applicant is a sponsored immigrant, a copy of the I-864 affidavit of support, name and address of the sponsor, proof of resources provided to applicant from the sponsor, the date the sponsored immigrant became a permanent resident, alien registration number, address, and date of birth
- Income and resources of all sponsors (and the sponsor's spouse if applicable) who executed an affidavit of support on behalf of a sponsored alien will be used to determine applicant's eligibility
- Proof of income or lack of income to include verification of support by friends, family or other sources, pay stubs, food stamp printout, self-employment records, etc.
- Proof of County residency
- Proof of registration with Texas Workforce Commission (some exemptions may apply)

Applicants must provide all requested information and documentation in order to determine eligibility or applicant will be denied eligibility for assistance. Background checks will be completed. Applicants have the right to appeal adverse decisions regarding eligibility.

Additional information applicable to sponsored immigrants: Collin County considers the benefits given to applicants to be a means-tested public benefit. Therefore, Collin County reserves the right to seek reimbursement from a Sponsor who signed an I-864 or any Affidavit of Support on behalf of an immigrant who receives any benefits from Collin County. Collin County shall use all legal rights available to seek reimbursement from the Sponsor.

Collin County Indigent Program
825 N. McDonald Street, Suite 110
McKinney, Texas 75069
Phone: (972) 548-4702

Applications can be mailed directly to you by calling the phone number listed above. Additionally, applications can be found on the Collin County website at www.co.collin.tx.us by clicking on the County Directory and choosing Health Care Services and refer to Indigent Program Application under Links and Resources.

Collin County Indigent Program does not discriminate on the basis of age, race, or gender in administering the Indigent Health Care Program.

Applicant (print name)	Applicant signature	Date