COUNTY OF RAINS

Indigent Health Care Case Coordinator
167 E Quitman Street / P.O. Box 158
Emory, Texas 75440

Tel: (903) 473-5019 Fax: (903) 473-4298

Indigent Health Care Eligibility Requirements

ARE YOU ELIGIBLE FOR INDIGENT HEALTH CARE?

Rains County Indigent Health Care is the payer of last resort.

Rains County Indigent Health Care serves only those eligible county residents who are not eligible for health care services from Federal or State assistance programs.

If you are potentially eligible for health care assistance through any of the following programs, you must apply. Proof of application to the following programs must be provided.

Are you a Veteran of the Armed Forces?
Have you applied for Texas Benefits? **www.yourtexasbenefits.com**
Have you registered with Texas Workforce Commission? **(903) 885-7556**
Have you applied for Supplemental Security (SSI)? **888-306-3534 / www.ssabest.benefits.gov**
Would you qualify for Social Security Disability (SSDI)? **888-306-3534 / same as above**
Do you currently have Medicaid? **If the answer is yes, you do not qualify for Indigent Health Care**
If you are a female and have been denied Medicaid, access **www.Healthytexaswomen.org** for more details.

Eligible county resident's countable monthly income cannot exceed the Temporary Assistance to Needy Families (TANF) payment standard, approximately 21 percent of the federal poverty level.

If you have been denied services from the above list you must provide the denial letters.

If none of the above mentioned services pertain to you, then you will need to request an **Application for Health Care assistance.**

Once the **completed** application is received in our office, a decision about your eligibility will be made within 14 business days.

If you qualify for the Rains County Indigent Health Care program, only **Medically Necessary** services are provided.

RAINS COUNTY INDIGENT HEALTH CARE PROGRAM
ELIGIBILITY VERIFICATION

1. Texas Driver's License or Official ID
2. Current mail addressed to you at your residence
3. Paycheck stub for last two pay periods or Earnings Statement from employer(s)
4. Checking & Savings Account Statements
5. Auto registration for all vehicles *(copy of Title to show ownership)*
6. Self-employment Records
7. Proof of registration with the Texas Workforce *(unless documented as Disabled)*
8. Verification of Unemployment Compensation
9. Notice of AFDC, Food Stamps, TANF, Medicaid/Medicare Benefit or Denial
10. Social Security Notices – SSI, SSDI *(Award, Denial, Pending or Approval)*
11. Disability Insurance Letters *(Denial, Pending or Approval)*
12. Veterans Administration letter or checks
13. Worker's Compensation Approval or Denial
14. Proof that you or a member of the household that receives or pays child support and/or daycare.

PLEASE SUBMIT ITEMS ABOVE TO THE RCIHC OFFICE THE SAME DAY YOU SUBMIT YOUR COMPLETED APPLICATION.

A decision about your eligibility will be made no later than 14 business days after your application is **complete**.

If we do not receive the information we need and you do not contact us, we will assume that you do not want assistance.

Rains County Indigent Health Care Program
167 E Quitman Ste. 102
Emory, TX 75440

903-473-5019

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

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

Name (Last, First, Middle)/Nombre (Apellido, primer, segundo)			Home Telephone No./Teléfono de la casa	Other Telephone No./Otro número de teléfono
Have you ever used another name? If so, list other names you have used./¿Ha usado alguna vez otro nombre? Sí es el caso, enumere los nombres que ha usado. ☐Yes/Sí ☐No				
Mailing Address (Street or P.O. Box)/Dirección Postal (Calle o Apdo.)	Apt.# /Apto.#	City/Ciudad	State/Estado	ZIP
Home Address, if different from above. If it is rural, give directions. / Domicilio particular, si es diferente a la dirección de arriba. Si es rural, explique cómo llegar.				

1. **On the chart below, fill in the first line with information about yourself. Fill in the remaining lines for everyone who lives in the house with you, whether or not you consider them household members.** / En la tabla a continuación, llene la primera línea con información acerca de usted mismo. Llene las líneas restantes acerca de todos que viven en la casa con usted, los considere miembros de la unidad familiar o no.

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

The word "household" in Questions #2 - #16 refers to: you, your spouse, and anyone else that lives with you and with whom you have a legal relationship. You do not need to include information on people who live with you but are not part of your "household."
Las palabras "unidad familiar" en las preguntas #2- #16 se refiere a: usted, su esposo o esposa, y cualquier otra persona que vive con usted y con quien tiene una relación legal. No necesita incluir información de las personas quienes viven con usted que no son parte de su "unidad familiar."

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

County/Condado ______________________ **State**/Estado ______________

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

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

☐ **Own or paying for home** Soy dueño de mi casa o la estoy comprando
☐ **Live in a house provided by someone else** Vivo en una casa ajena
☐ **No permanent residence** No tengo residencia permanente
☐ **Live with someone else** Vivo con otra persona
☐ **Rent House/Apartment** Rento una casa o apartamento
☐ **Jail** Cárcel

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

Rent/Mortgage/Renta/hipoteca .... $ ____

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

Telephone/Teléfono .... $ ____

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

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

Other/Otro .... $ ____

Other/Otro .... $ ____

Other/Otro .... $ ____

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

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

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

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

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

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

8. **Have you – or has anyone in your household – applied for SSI or SSDI?**
¿Alguna vez usted o alguien de la unidad familiar solicitó beneficios de SSI o SSDI? .... ☐ Yes/Sí ☐ No
If Yes, who applied and when?
Si contesta "Sí," quién los solicitó y cuando? ____

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

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

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

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

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

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

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

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

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

16. **List all of your household's income below. Be sure to include the following: Government checks; money from training or work; money you collect from charging room and board; cash gifts, loans, or contributions from parents, relatives, friends, and others; sponsor's income; school grants or loans; child support and unemployment.**/Haga una lista de los ingresos de la unidad familiar a continuación. Asegúrese de anotar: Cheques del gobierno; ingresos de trabajo o de capacitación; dinero que recibe de cobros de cuarto y comida; regalos en efectivo, préstamos, o aportaciones de sus padres, familiares, amigos, y otras personas; los ingresos del patrocinador; becas o préstamos de la escuela; 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 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 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

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.

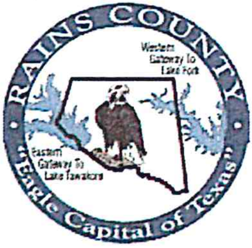
Otra Cobertura Para Gastos Médicos
Posibles Pruebas: Cartas de reclamación o de concesión, pólizas de seguros, papeles de la corte u otros documentos legales.

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.



RAINS COUNTY
INDIGENT HEALTH CARE PROGRAM

AUTHORIZATION FOR BACKGROUND CHECKS

Name: ____

SSN: __________________________

DOB: __________________________

Address: ____

City, State, Zip: ____

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

Applicant's Signature: ____

Date: ____

Subscribed and Sworn to (affirmed) before me this ____ day of _______________, 2020

Notary Signature: ____

NOTARY STAMP

Rains County Indigent Health Care Program
167 E. Quitman St. STE 102
Emory, Texas 75440

Rains 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 Indigent Health Care (IHC) staff has reason to believe that fraud may have occurred, the following procedures shall be followed:

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

2. Upon a finding of fraud, the client shall be administratively ineligible from IHC 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 + 12 months per subsequent offense

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

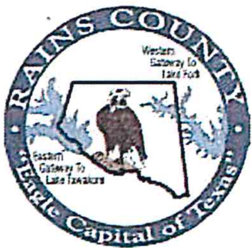
4. If the dispute remains unresolved, the IHC staff shall schedule an administrative hearing to allow the client to defend himself by confronting any adverse witness and by presenting his own argument and evidence. The IHC staff must disclose any evidence used to prove its case to the client so he has an opportunity to dispute it. The administrative hearing will be conducted by the Rains County Judge with the IHC Coordinator present. The administrative hearing shall be held at the office of the County Judge during normal business hours. The client shall be given 30 days written notice of the date of the administrative hearing. The burden of proof lies with the IHC program. If the client does not appear at the administrative hearing, the IHC Coordinator may proceed with presentation of her case only if proof of notice is present. The County Judge must make a decision within ninety days of the hearing.

5. The client shall have the right to appeal any unfavorable decision to the Rains County IHC Appeal Authority.

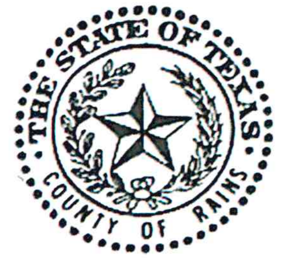
If after due process, a person is found to have intentionally misrepresented information in order to receive benefits, that person

- Shall reimburse Rains County for the cost of benefits they were ineligible to receive
- Shall be administratively ineligible for Rains County IHC benefits in accordance with Rains County IHC Policies and Procedures; and
- May be subject to prosecution under the Texas Penal code

______________________________ ____________________
SIGNATURE DATE



RAINS COUNTY INDIGENT HEALTH CARE PROGRAM
WORK REGISTRATION POLICY



Rains County has adopted the following as the Work Registration Policy for the Indigent Health Care Program. This policy is effective October 22, 2020

General Provisions:

I. Failure to register and actively seek employment through the Texas Workforce Commission constitutes a program violation of the Indigent Health Care Program (IHC).

II. Persons are exempt from having to register and seek employment if they meet one of the following criteria:
   a. Receive unemployment insurance benefits or have applied but not yet been notified of eligibility
   b. Physically or mentally unfit for employment (May require physician statement)
   c. Age 60 or older
   d. Participates in an outpatient substance abuse treatment and rehabilitation program who are not allowed to seek employment while in treatment
   e. Full time student participating in work study program (will need school schedule and work study information)
   f. Distance prohibits walking or transportation is NOT available
   g. Parent or other household member who personally provides care for a child under age 6 or a disabled person of any age living with the household

Consequences:

I. If a non-exempt applicant or CIHCP eligible resident fails without good cause to comply with work registration requirements he/she will be disqualified from the CIHCP benefits for a period of three (3) months.

II. Persons deemed not disabled by Social Security Administration guidelines at the hearing level may be required to seek employment

III. Terminating employment solely for the purpose of becoming eligible for IHC may cause disqualification from program for a period of six (6) months.

I hereby acknowledge that I have read and understand the above information stated in this document.

________________________________ ____________________

Signature Date

____

Printed Name

RAINS COUNTY INDIGENT HEALTH CARE PROGRAM
WORK REGISTRATION PROCEDURE

Work Registration Process - https://www.twc.texas.gov/jobseekers/applying-unemployment-benefits

- Clients not meeting an exemption shall be actively enrolled with the Texas Workforce Commission
- Clients must produce a TWC Registration Form documented with a signature of a TWC office personnel within (2) two months of their initial eligibility
- Clients shall actively seek employment; one (1) work search per week is required (not limited to one). Failure to do so will result in a denial for violation of the work registration policy and disqualification for three (3) months
- Clients must be enrolled and a minimum of one work search per calendar week is required before eligibility is granted. Clients must apply for jobs they are qualified for and accept any jobs they are offered
- Verification of work search may include but is not limited to documentation from website, employer, or Texas Workforce Commission
- Clients are responsible for providing verification of work searches for review of eligibility
- Clients deemed not disabled by Social Security Administration at the hearing level must comply with work policy
- Terminating employment solely for the purpose of becoming eligible for Indigent Health Care may cause disqualification for a period of six (6) months

RAINS COUNTY INDIGENT HEALTH CARE PROGRAM

Texas Workforce Commission Referral Form

Referring Agency

Rains County Indigent Health Program
Referring Agency

Emory, TX
City

Jordan Smith
Contact Name

903-473-5019
Contact Number

Referring Customer's Contact Information

____
First Name

____
Last Name

____
Mailing Address

____
City, State, Zip Code

____
Phone Number

____
Email (if available)

____
TWD Personnel Signature

Reason for Referral

Work Search Program – Rains County Indigent Health Program

- Client must bring in the TWD signed referral form within 2 months of becoming eligible for the RCIHP and provide proof of registration and two (2) active work searches or eligibility will be denied
- Client must complete at least one (1) work search per week
- Client is responsible for keeping track of their work searches and providing them once a month and at 6 month eligibility review

Notarized Letter of Residence

I______________________________DO HEREBY ATTEST THAT ___________________________________

Owners Name Residents Name

Is a current resident in my home/property located at ____

Residents Address

Signature____

Date____

NOTARY PUBLIC

Signature____

Date____

Witness my hand and official seal, this the___________day of____________________________,20_____.

____

Notary Public

My Commission Expires _______________________,20______.

RAINS County Indigent Health Care Program

STATEMENT OF SUPPORT

I/WE ________________________________ assist ________________________________
(Household providing support) (Applying individual/household)

by providing the following: (Answer **ALL** sections either *"Yes"* or *"No"*)

Yes No Cash (If yes, how much per month? $____________)

Yes No Payment of Medical Bills and/or Prescription needs

Yes No Payment of Utilities

Yes No Food and/or Clothing

Yes No Payment of Home Loan or Rent

Yes No Other (i.e. – cell phone, transportation, entertainment, personal hygiene, etc)

____

____

The above household **DOES / DOES NOT** live with me/us. He/She has lived with me/us since

____.
Month Day Year

Signature ____ Date ______________
(Household providing support)

Physical Address ____

City ______________ State ________ Zip ________ Telephone Number ______________

*CIHCP Staff witnessing the signing of this Support Statement*** ____________________

****Must be Notarized or Must have copy of Signatory's valid ID if NOT completed in front of a CIHCP Staff. See below.**

Before me, the undersigned authority, did personally appear ____________________________

________________________, who upon oath, swears that the foregoing statement is true and correct.

Signed this _________ day of _______, 20___ by me, the undersigned authority, in and for the county of

____________, State of Texas.

____
NOTARY PUBLIC

RAINS COUNTY INDIGENT HEALTH CARE PROGRAM
PHYSICIAN STATEMENT

Section I – TO BE COMPLETED BY COUNTY STAFF

Client Name:	Client Date of Birth
Client MR#:	

Section II – TO BE COMPLETED BY CLIENT

I authorize and request any physician, hospital, or institution that has medical records pertaining to the patient named above, to disclose information to the County Indigent Health Care Program in connection with the application for assistance.

Patient Signature: ______________________________ Date: ________________

Section III – TO BE COMPLETED BY PHYSICIAN

Section A

Diagnosis: ____
Prognosis: ____
Treatment: ____
Describe Treatment: ______________________________________

Diagnosis: ____
Prognosis: ____
Treatment: ____
Describe Treatment: ______________________________________

Section B

______ Patient is currently employed and can continue to work
______ Patient has been released to return to work Release Date: ________________

To what extent is the patient employable:

______ Full Time (no restrictions) _____ Full Time but restricted as described below
______ Able to work 20 hrs/wk _____ Can Not Work: disabling factor as described above

How long will the patient be disabled and unable to work full time?

______ Permanently (give onset date) ______________
______ Temporarily (give onset date) ______________ If temporary, number of months:
____

Physician's Printed Name	Physician Signature
Physician's Address	Date

Completed form should be returned to: **Rains County Indigent Health Care Program**
167 E Quitman St **PH: 903-473-5019**
Emory, TX 75440 **FAX: 903-473-4298**
Email: Jordan.smith@co.rains.tx.us