Indigent Health Care Program
Of Marion County Hospital District
1113 N. Walcott St., Suite B
Jefferson, Texas 75657
(903) 665-2161 Fax (903) 665-8011

APPLICATION FOR MEDICAL ASSISTANCE

(For Office Use Only)

DATE APPLICATION PICKED UP: ____________________
DATE APPLICATION RETURNED: ____________________
DATE OF INTERVIEW: ____________________

NAME OF PATIENT: ____________________

PATIENT'S PHYSICAL ADDRESS: ____________________

____

PATIENT'S MAILING ADDRESS: ____________________

____

PHONE NUMBER: ____________ MOBILE: ____________

MARITAL STATUS: (circle one) Single Married Widower Divorced Separated

MARRIED: Name of Spouse: ____________________

DIVORCED: Date: ____________ SEPARATED: Date: ____________

1) Payment for medical assistance is being requested on my behalf. My name, age, birth date, sex and Social Security number are shown on line 1 below. **LIST ALL PERSONS LIVING IN THE HOUSEHOLD**.

NAME	M/F	AGE	D.O.B	Relationship to Patient	SSN#:
1.					
2.					
3.					
4.					
5.					

(If you have more than 5 people in your household, please continue on back of page)

NOTE: Any children living with you that are NOT your biological children/grandchildren will require proof of legal Guardianship.

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2) Does the patient or any other person living in the home receiving Food Stamps, Old Age Assistance (OAA), Aid to the Blind, Aid to the Disabled, or Aid to the Families with Dependent Children?
Yes ______ No _____If "yes", give name of person and type of assistance:
____
____
Amount of Food Stamps: $___________________

3) Is the patient a Veteran? Yes ______ No ______
If "yes", does the patient qualify for and/or receive medical benefits?
Yes _____ No ________

4) Is the patient a citizen of the United States? Yes ______ No ______
5) What is the Nature of your Medical Need? _______________________________________
____

6) Are there medical services required due to an accident? Yes ______ No ______
If "yes", complete the following:
Nature of accident____
Was another party responsible for the accident? Yes ___________ No ______________
Has legal action been taken or planned against the other party? Yes ______ No _______
Name and address of patient's attorney: _______________________________________
____
Has a settlement been received? Yes ______ No ______
If "yes", amount $________________ Date received:_____________________________
Are the medical services required due to an occupational disease? Yes _____ No _____
Nature of disease:____

7) Does the patient have or is he/she included in any of the following types of insurance? Answer "yes" or "no" to each of the following. If "yes", give name of insurance company.

TYPE OF INSURANCE	YES	NO	NAME OF COMPANY
Hospital	____	____	__________________________________
Physicians	____	____	__________________________________
Nursing Care	____	____	__________________________________
Accident	____	____	__________________________________
Medicate Part A	____	____	__________________________________
Medicare Part B	____	____	__________________________________

EARNED INCOME

8) Is the patient 65 years of age or older? YES ______ NO ______

9) Is any member of the **HOUSEHOLD** working full time or part time and earning any money? YES ______ NO ______

If "yes", complete items one (1) and/or two (2), below:

EMPLOYED PERSON: ______________________________

Social Security Number: ______________________________

Type of work: ______________________________

Employer: ______________________________

EMPLOYED PERSON: ______________________________

Social Security Number: ______________________________

Type of work: ______________________________

Employer: ______________________________

2. **SELF-EMPLOYED**: ______________________________

Social Security Number: ______________________________

Type of work: ______________________________

10) **HOUSEHOLD INCOME** last three (3) months

$______________________________

Patient's income last three (3) months

$______________________________

11) **PROOF OF INCOME**:

- Copies of work stubs
- W-2
- Copy of filed income tax
- Other:

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***INCOME – OTHER**

12) Does any member of **the household** have any income other than earned income? Answer "yes" or "no" for each item on this page. If "yes", enter the amount of income in the proper column and enter how often it is received, such as weekly, monthly, yearly. (Show the total amount of income **before any deductions**.)

YES	NO		AMOUNT	BY WHOM RECEIVED	HOW OFTEN
___	___	Supplemental Security Income	$_________	____________________	____________
___	___	Social Security	$_________	____________________	____________
___	___	Veterans Benefits	$_________	____________________	____________
___	___	Military Benefits	$_________	____________________	____________
___	___	Unemployment	$_________	____________________	____________
___	___	Royalties	$_________	____________________	____________
___	___	Worker's Compensation	$_________	____________________	____________
___	___	Child Support Payments	$_________	____________________	____________
___	___	Rental Income	$_________	____________________	____________
___	___	Farm Income	$_________	____________________	____________
___	___	TANF (Temp Assistance for Needy Families)	$_________	____________________	____________
___	___	Cash Contributions	$_________	____________________	____________
___	___	Other	$_________	____________________	____________

*Income-A type of payment that is a regular and predictable gain for the benefit of a household

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CAPITAL RESOURCES

13) Does anyone in the household own his/her own home? Yes______ No ____

If "yes", complete the following:

Value of home $_____________ Balance owed on mortgage $______________

Name of mortgage holder: ____

Name of lots __________________ or acres ______________________________

14) Does anyone in the household own or are they buying any real estate other than the home?

Yes ______ No ______If "yes", fill in ALL blanks:

Number of lots and/or acres ____

Total market value $____

Balance on mortgage $____

Mortgage holder (name and address) _____________________________________

____

Does anyone else own a legal interest in this property: Yes ______ No ______

If "yes", what interest do they own?___________________________________

C. If you are <u>renting a place to live</u>, how much rent do you pay? $________________

Who do you rent from? ____

Address: _________________________________ Phone: _________________

If you do not rent, but just stay with someone, give name and address:

____

Relationship: ____

15) Does anyone in the household own any of the items listed below?
Check "Yes" or "No" for EACH item. If "yes", complete the column for that item.

YES	**NO**		**AMOUNT**	**BY WHOM OWNED**
_____	_____	Savings Account (Present Amount)	$_______	____________________
_____	_____	Checking Account (Present Amount)	$_______	____________________
_____	_____	Money not in Bank (How Much?)	$_______	____________________
_____	_____	Savings Bonds (Present Cash Value)	$_______	____________________
_____	_____	Stocks and bonds(Present Cash Value)	$_______	____________________
_____	_____	Life insurance (Available Cash Value)	$_______	____________________
_____	_____	Livestock	$_______	____________________
_____	_____	Farming Equipment	$______	____________________
_____	_____	Mineral rights	$______	____________________
_____	_____	Other (Describe)____________	$______	____________________

MOTOR VEHICLES:

(1) Make, model and year: ____

Value: $____

Equity (amount paid on vehicle) $ ______________________________________

Balance due on vehicle $____

(2) Make, model and year: ____

Value: $____

Equity (amount paid on vehicle) $______________________________________

Balance due on vehicle $____

16) Has the patient, or any other member of the household, given away, sold, or deeded during the last three (3) months, any item or items of value such as land, minerals, buildings, money, bonds, bank accounts, etc.?

Yes ______ No ________ If "yes", complete the following:

Description:____
____

Value $____

Date of Transfer: ____

To Whom Transferred? ____

What was received in return? ____

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I certify that I have read this application, or the application has been read to me, that I fully understand the application and all particulars. I understand further that a false statement or false representation made by me for the purpose of obtaining medical care makes me subject to prosecution for perjury.

I agree to notify the **Marion County Hospital District** immediately if at any time while receiving hospital care I sell, convey, or encumber any property I now own, or if I become possessed of any property or income other than what is stated in this application.

I understand that by signing this application, I am giving the Hospital District the right to recover the cost of health care service provided by the Hospital District from any third party. I agree to give the Hospital District the right to recover the cost of health care services provided by the Hospital District from any third party. I agree to give the Hospital District 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 willful withholding of information and can result in the recovery of any loss by repayment, or by filing criminal charges against me.

I understand that I have the right to a fair hearing or an appeal on a decision I consider improper, and that I will be notified of the decision of the Board of Directors of the Marion County Hospital District (working days being Monday through Friday, excluding holidays).

I understand that this request is to be considered an application for medical services as of the date that this form is received in the office of the Marion County Hospital District and acknowledged in the space provided. Until that time, it is considered an **<u>INTENT TO APPLY</u>** for medical services.

______________________________ ___________________________________

Signature Mailing Address

______________________________ ___________________________________

____

INDIGENT HEALTH CARE COORDINATOR/ELIGIBILITY REPRESENTATIVE

Indigent Health Care Program
Of Marion County Hospital District
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TO: TEXAS STATE DEPARTMENT OF HUMAN SERVICES
4105 Victory Drive
Marshall, Texas 75670
Phone (903) 938-7751

DATE: ______________________

I, ____, authorize
Name (print or type)
and request the TEXAS DEPARTMENT OF HUMAN SERVICES and its representatives, employees, and/or agents to furnish to the MARION COUNTY HOSPITAL DISTRICT, its representatives, employees and/or agents, ALL information concerning my application, and the disposition thereon, for MEDICAID and ALL OTHER related programs administered by said TDHS, including copies of applications and dispositions thereof.

The purpose or reason for this request for disclosure and release of my application for MEDICAID and other programs administered by said TDHS is to verify information which I have given to the MARION COUNTY HOSPITAL DISTRICT in an application for Indigent Health Care as a resident of Marion County, Texas.

Signed: ____
Applicant

____
Relationship, if other than application

____
Applicant's Social Security Number

____
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AUTHORIZATION TO RELEASE INFORMATION

TO: SOCIAL SECURITY ADMINISTRATION
1509 Sedberry Street
Marshall, Texas 75670
Phone (903) 935-8351

DATE: ______________________

I, ____, authorize
Name (print or type)

the SOCIAL SECURITY ADMINISTRATION and its representatives, employees, and/or agents to furnish the MARION COUNTY HOSPITAL DISTRICT INDIGENT HEALTH CARE PROGRAM, its representatives, employees and/or agents, ALL information concerning my application, and the disposition thereon, for DISABILITY and ALL OTHER related programs administered by said SOCIAL SECURITY ADMINISTRATION, including copies of applications and dispositions thereof.

The purpose or reason for this request for disclosure and release of any application for DISABILITY and other programs administered by said SOCIAL SECURITY ADMINISRATION is to verify information which I have given to the MARION COUNTY HOSPITAL DISTRICT as an application for Indigent Health Care as a resident of Marion County, Texas.

Signed: ____
Applicant

____
Relationship, if other than application

____
Applicant's Social Security Number

____
Applicant's Date of Birth (mm/dd/yy)

____
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AUTHORIZATION TO RELEASE INFORMATION FOR MEDICAL RECORDS

I, ____, hereby authorize
Name (print or type)

____
Hospital

____
And/or

____
Doctor

____
Address

____
who attended me while I was a patient in said HOSPITAL and/or OFFICE VISIT during the approximate period from ________________________ to ____________________ and to release information from my Medical Records, including history, physical examination, diagnosis, laboratory and x-ray findings, a synopsis of treatment, etc., to the MARION COUNTY HOSPITAL DISTRICT as may be necessary for reimbursement to the HOSPITAL and/or PHYSICIAN for services rendered to me during this time.

The purpose or reason for this request for disclosure and release of my Medical Records is to verify information which I have given to the MARION COUNTY HOSPITAL DISTRICT in an application for INDIGENT HEALTH CARE as a resident of Marion County, Texas.

Signed: ____
Applicant

____
Relationship, if other than application

____
Applicant's Social Security Number

____
Applicant's Date of Birth (mm/dd/yy)

____
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AUTHORIZATION TO RELEASE INFORMATION/EMPLOYMENT RECORDS

I, ____, authorize
Applicant

____
Employer

____
Address of Employer
to release information concerning employment and income.

The purpose or reason for this request and release of my employment record and income is to verify information which I have given to the MARION COUNTY HOSPITAL DISTRICT in an application for INDIGENT HEALH CARE as a resident of Marion County, Texas.

Signed: ____
Employee

____
Relationship, if other than application

____
Applicant's Social Security Number

____

Applicant's Date of Birth (mm/dd/yy)
____

____
INDIGENT HEALTH CARE COORDINATOR/ELIGIBILITY REPRESENTATIVE

BELOW DOTTED LINE TO BE FILLED OUT BY EMPLOYER

Employee's date of employment from ____________________ to_______________________

Employee's earnings for the last three (3) months: $____________________

Employee's hourly rate: $______________. Hours worked per week: ___________________

Signed: ____

Title: ____

Date: ____