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:
<ol> <li>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. <u>LIST ALL PERSONS</u></li> </ol>

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)

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



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	1
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 <u>No</u> If "yes", amount <u>\$</u> Date received: Are the medical services required due to an occupational disease? Yes <u>No</u> 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.

YES	NO	NAME OF COMPANY
	YES	YES NO

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	C

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## **EARNED INCOME**

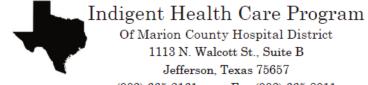
- 8) Is the patient 65 years of age or older? YES \_\_\_\_\_ NO \_\_\_\_\_
- 9) Is any member of the HOUSEHOLD working full time or part time and earning any money? YES NO If "yes", complete items one (1) and/or two (2), below:

	EMPLOYED PERSON:
	Social Security Number:
	Type of work:
	Employer:
	EMPLOYED PERSON:
	Social Security Number:
	Type of work:
	Employer:
2.	<u>SELF-EMPLOYED</u> :
	Social Security Number:
	Type of work:
l0) HOUSE	EHOLD INCOME last three (3) months
\$	

\$

## 11) **PROOF OF INCOME**:

- Copies of work stubs
- W-2 .
- Copy of filed income tax •
- Other: ٠



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## <u>\*INCOME – OTHER</u>

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**.)

<u>YES</u>	<u>NO</u>	<u>AMOUNT</u>	BY WHOM RECEIVED	HOW OFTEN
	Supplemental Security Income	e \$		
	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 ow	vn home? YesNo
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?

Total m	arket value S	
		 e \$
		me and address)
Does any	one else ow	n a legal interest in this property: Yes No
If "yes",	what interest	st do they own?
If you ar	e <u>renting a p</u>	lace to live, how much rent do you pay? \$
	vou rent fro	m?
•	j = = 1 = 110	
Who do		Phone:

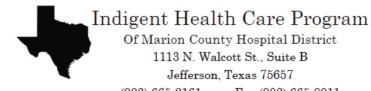
15) Does anyone in the household own any of the items listed below? Check "Yes" or "No" for EACH item. If "yes", complete the column for that item.

#### <u>YES NO</u>

C.

#### AMOUNT BY WHOM OWNED

Savings Account (	Present Amount) \$	
Checking Account	·	
Money not in Bank	x (How Much?) \$	
Savings Bonds (Pr	esent Cash Value) \$	
Stocks and bonds(I	Present Cash Value) \$	
Life insurance (Av	ailable Cash Value) \$	
Livestock	\$	
Farming Equipmer	nt \$	
Mineral rights	\$	
Other (Describe)	\$	



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## **MOTOR VEHICLES:**

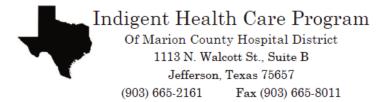
(1)	Make, model and year:
	Value: \$
	Equity (amount paid on vehicle) \$
	Balance due on vehicle \$
(2)	Make, model and year:
	Value: \$
	Equity (amount paid on vehicle) \$
	Balance due on vehicle \$

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?



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



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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.

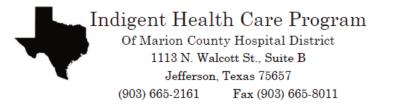
Signed:

Applicant

Relationship, if other than application

Applicant's Social Security Number

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



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:		