Parker County Hospital District
Medical Assistance Program
817-458-3358

1501 Texas Dr. #200
Weatherford, TX 76086
Fax: 817-458-3257

PLEASE READ ENTIRE APPLICATION BEFORE COMPLETING

Should you have any questions please contact our office.

ANY PRESCREENING THAT THE APPLICANT RECEIVES WHILE IN THE HOSPITAL FROM ANY STAFF MEMBER OR SCREENING COMPANY DOES NOT PRE-QUALIFY THE PATIENT FOR THIS PROGRAM.

PATIENTS CAN ONLY BE MADE ELIGIBLE FOR SERVICES AFTER APPLICATION AND SCREENING ARE COMPLETED BY PCHD MEDICAL ASSISTANCE PROGRAM REPRESENTATIVES.

ONLY PCHD MEDICAL ASSISTANCE PROGRAM APPLICATIONS WILL BE ACCEPTED. NO APPLICATIONS TAKEN BY MAIL, EMAIL OR FAX UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE WITH STAFF. NO APPLICATIONS WILL BE TAKEN BEFORE YOUR SCHEDULED APPOINTMENT DATE.

**Please note:

It is a crime to give false or misleading information or fail to report changes as required by the program guidelines, which may affect the recipient's continued eligibility for MAP assistance.

You are hereby informed of this law and by signing this application you are acknowledging that you understand this law. It will be the policy of the Parker County Hospital District (PCHD) to refer all violations of the law for criminal prosecution as well as seek repayment of any funds due to PCHD.

Frequently Asked Questions

Current Household Composition:

The term household as used for this program shall include:

1. Person living alone.

2. Spouse of applicant including: common-law, persons cohabitating, estranged/separated spouses (even if they are not currently living together).

3. Children under the age of 18 in household

Income cannot exceed: 200% of the 2024 Federal Poverty Guidelines based on the number of people in your household.

Employment Information

All adult members of household must be employed a minimum of 20 hours per week, be actively enrolled at the Texas Workforce Commission, have an active application for Social Security Disability, have proof of current Social Security income and/or have a physician statement of inability to work the required minimum hours per week. **If you do not have proof of the above-listed employment conditions, your application will not be completed until you do.**

*Employment includes cash payments for services such as lawn maintenance, babysitting, dog walking, garage sales, scrap metal sales, etc.

Assets Information

Assets include but are not limited to: all bank accounts, IRA, 401K, mineral rights, cash, cash contributed by others, vehicles, real estate property, livestock, etc.

If an applicant sells, trades, or disposes of any household resource or asset to qualify for eligibility, it is considered fraud, and the applicant will be disqualified from MAP services.

PCHD Medical Assistance Program

FRAUD POLICY

This program makes every attempt to ensure that persons awarded eligibility meet all criteria outlined in the four main categories of resources available to the applicant, residency, income in the household and household composition. We are aware that fraud can still exist and takes place when applying for this program.

Fraud is the deliberate misrepresentation, omission or concealment of information or facts for the purpose of acquiring or continuing benefits through this program.

1. ALL cases where fraud is suspected will be investigated and evidence documented.
2. The MAP staff shall contact client who is suspected of fraud and send, via certified letter, informing them of allegations. The client has the right to dispute allegations with valid supporting documentation/verification.
3. If fraud is demonstrated and verified, the eligibility of the client will be withdrawn.
4. In the event fraud is evident, all of the following or any combination of the following will occur:

• Administrative disqualification:

First offense: 12 months from the date fraud is discovered

Second offense: 24 months from the date fraud is discovered

Third offense: 36 months + 12 months per subsequent offense

• Referral to Parker County Attorney/District Attorney for prosecution.

• Referral to Parker County Attorney/District Attorney for restitution.

5. The client shall have the right to appeal any unfavorable decision to the Parker County Hospital District Board.

_____

Signature of Applicant

_____

Date

Parker County Hospital District Medical Assistance Program

Non-covered Conditions/Diagnosis/Visits

Any visit to the assigned primary care provider that is not a covered condition as outlined in the Medical Assistance Program guidelines will be considered a cash pay visit and will not be paid for by the Program. These visits will need to be paid for by the patient at the time services are rendered.

***Examples of these conditions include, but are not limited to:**

Pain management

Fibromyalgia

Depression/anxiety/ADHD/any other mental health condition

Sleep Apnea; including sleep studies

Insomnia

Weight loss

Erectile dysfunction

Carpal Tunnel Syndrome

Routine gynecological exams

Birth Control

Routine podiatry

Routine ophthalmology (eye glass exams)

Routine dermatology (such as acne treatment)

No Durable Medical Equipment

Patient signature: _____

Date: _____

Emergency Room Usage

*_____ Emergency Room visits should consist of life-threatening injuries or illness. ER visits will not be covered in instances where: private insurance is available, vehicle insurance is available, suicide or other mental health occurrences, injuries sustained while engaging in illegal activity, minor/primary care related illness.

Abuse of ER facilities will result in the applicant's removal from the Program.

Back Pain Services

*_____ Back pain is a common medical complaint for many adults. With limited access to specialists that treat back/spine issues, this program must enforce limited services for anyone with back pain as their medical concern. There is a limit of two covered visits for any back issue, the first to establish care and have imaging ordered, the second to follow up on imaging and to determine whether physical therapy or a referral to a specialist is warranted. Beyond those two visits, any primary care visit for back pain management will be considered pain management and will not be covered. The patient must pay cash on the Campbell Clinic sliding scale fee.

By signing below, you acknowledge and understand non-covered conditions, back pain services and/or ER visits.

_____ _____

Signature **Date**

*initial at each line

Release of Information

Emergency Contact: _____

Relationship: _____

Phone: _____

Date added: _____

Date removed: _____

Authorization of Release of Medical Information:

I authorize my medical information to be released to the following people:

Name	Relationship	Phone	Date added	Date removed
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

I authorize the following people to pick up delivered medications or to pick up/drop off documentation required by the Program regarding eligibility.

Name	Relationship	Phone	Date added	Date removed
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

By signing this application, I acknowledge and understand the law of the Parker County Hospital District Medical Assistance Program. I further understand that it will be the policy of the Parker County Hospital District to refer all violations of the law for criminal prosecution as well as seek repayment of any funds due to the Parker County Hospital District.

• I agree to apply for and complete all applications for any other source of assistance for which I may qualify, such as Medicaid; HealthCare.gov (Obamacare); Healthy Texas Women's Medicaid; Social Security Disability; SSI; DARS; DADS; Crime Victim's Act, etc.

• I agree to apply for pharmaceutical assistance through Patient Assistance Programs when applicable.

• I agree to report any changes in income, household, address, assets, or resources which may affect my eligibility within seven (7) business days.

• I understand that the Program may re-evaluate my status and take appropriate action should any information of this application be found incorrect or upon any status change.

• I certify that I have read this application in its entirety and that the information listed is true and correct. I hereby authorize the verification of said information through my employer, tax return, and other sources.

Applicant Signature: _____

Date: _____

Spouse Signature (If applicable): _____

Date: _____

MAP Guidelines/Code of Conduct

Initial each line.

_____ MAP is NOT an insurance plan, nor does it represent itself to be. MAP is designed to assist qualified individuals with payment of outstanding medical costs and/or assist with payment of current medical needs. Any unpaid balances are the patient's responsibility.

_____ When a patient is approved for services from MAP, they are assigned a primary care provider (Campbell Clinic).

_____ There are specific specialty, hospital, radiology, and lab providers used by MAP patients. All referrals to specialty physicians, radiology or labs must be approved by the MAP office prior to being treated.

_____ Patients are not allowed to request a certain provider and are not allowed to request a change in providers for any reason.

_____ Hospital visits to out of county hospitals are not covered by this program. All hospital needs are provided by Medical City Weatherford, unless prior consent is given. In the event that an out of county hospital is utilized by the patient, any costs incurred become the financial responsibility of the patient and will not be paid by MAP. This does include emergency room visits, with the exception of life-threatening conditions such as a heart attack, stroke, auto accident where injuries have occurred or a Medical City required facility transfer. *

_____ MAP is aware of other hospital facilities available in Parker County, however as stated above, Medical City Weatherford is the only approved hospital for MAP patients.

_____ Patients on MAP are expected to maintain communication with all providers that they see. It is the patient's responsibility to ensure that providers are aware of their eligibility with this program.

_____ Any and all billing questions should be aimed toward the provider's office sending the bill. MAP does not have information regarding bills mailed to patients.

_____ Patients should address all questions regarding their health care needs directly to their physician's office. MAP is not a health care provider; MAP is simply a payment assistance program.

_____ Patients must adhere to the physician's office code of conduct and other guidelines. MAP has no governing authority over such rules; however, removal from MAP may occur should the primary physician's office remove the patient from their care.

_____ Patient must maintain a polite, non-confrontational attitude at all physician's offices, hospital facilities, labs or radiology offices, as well as the MAP office; swearing, yelling, demanding, intimidation, etc. are all unacceptable and will result in suspension or permanent removal from MAP.

***Please be advised that MAP is not denying medical treatment of any kind. It is the patient's right to seek treatment at any facility or with any provider that they choose; however payment for such instances is the sole responsibility of the patient.**

_____ _____ _____

Patient Signature **Patient Printed Name** **Date**

Document Request List

Last four (4) paystubs for every household member

Most recent IRS tax return, include 1040, W2's and other worksheets used to file return

Self-employment records: profit/loss and YTD gross

Last six (6) months banking statements for each account in the household

Social Security award letter and or proof of application

Child Support statement

SNAP/TANF/ Medicaid award letter or proof of application

HealthCare.gov application acceptance or denial letter

Housing award letter

Other charity/assistance award letter

Proof of Texas Workforce Commission registration

Most recent Property Tax report

Proof of residency: utility bill; lease agreement; vehicle insurance verification

Notarized contribution/living arrangement form (if included with packet; this may be requested later)

Driver license/social security card- shown at time of visit

Please bring all documents to your scheduled appointment. We will be unable to complete the application process until all documentation has been provided.

You will have ten (10) business days to return all required documents, or your case will be closed.

Parker County Hospital District

Medical Assistance Program

All applicants should be aware that there are limited physicians available to this program, therefore, there will be times when a patient may need to see a specialist that is unavailable.

This is beyond the control of the Medical Assistance Program and should be kept in mind if a referral is ever denied or unable to be processed.

All patients have the option to pay cash for services as they see fit.

Patient printed and signed name:

Printed Name: _____

Signature: _____

Date: _____

PCHD Medical Assistance Program

DECLARATION OF NO INCOME

I, _____, have personal knowledge that _____

(Person giving statement) (Applicant)

currently has no income of any kind.

Please check below all that apply to applicant's current status:

_____ The applicant listed above is currently living in my home.

_____ I am assisting the applicant listed above with basic needs and a place to live.

_____ The applicant is not married or cohabitating with any one at this time.

****THIS FORM MUST BE NOTARIZED IF NOT SIGNED IN FRONT OF MEDICAL ASSISTANCE PROGRAM STAFF****

By signing below, you are certifying that the statements are true based upon your personal knowledge. Falsified information could disqualify the applicant from receiving assistance from our charity program.

_____ _____

(Signature of person giving statement) (Date)

_____ _____ _____

(Printed name) (Relationship to applicant) (Phone number)

_____

(Signature of MAP staff member)

Before me, the undersigned authority, did personally appear _____, who upon oath, swears 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 **Date**

My commission expires: _____

PCHD Medical Assistance Program

STATEMENT OF SUPPORT/LIVING ARRANGEMENT

I/WE _____ assist _____ by providing the following:

(Household providing support) (Applicant)

(Check ***ALL*** sections, indicating *yes* or *no*)

_____ yes _____ no **CASH** If so, how much? _____

_____ yes _____ no **MEDICAL COSTS/PRESCRIPTIONS** If so, how much? _____

_____ yes _____ no **PAYMENT OF UTILITIES** Approximate monthly costs? _____

_____ yes _____ no **FOOD/CLOTHING/PERSONAL ITEMS** If so, how much? _____

_____ yes _____ no **OTHER (CELL PHONE/TRANSPORTATION/ENTERTAINMENT, ETC)** If so, how much? _____

_____ yes _____ no **The applicant DOES NOT live with me/us.**

_____ yes _____ no **The applicant DOES live with me. He/she has lived with me/us since:**

_____

MONTH DAY YEAR

*******THIS FORM MUST BE NOTARIZED IF NOT SIGNED IN FRONT OF MEDICAL ASSISTANCE PROGRAM STAFF*******

Signature _____ Date _____

(Household providing support)

Address

_____

Telephone Number _____

***Staff witnessing signature _____

Before me, the undersigned authority, did personally appear _____, who upon oath, swears 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 **Date**

My commission expires: _____

TEXAS
Health and Human Services

Form 3064
January 2020-E

County Indigent Health Care Program (CIHCP)

Application for Health Care Assistance

For Office Use Only				
Status ◯ Application ◯ Review	Date Form 3064 Requested/Issued	Date Identifiable Form 3064 Received	Case Record No.	Appointment Date and Time, if applicable

Name (Last, First, Middle)	Home Area Code and Phone No.	Other Area Code and Phone No.

Have you ever used another name? If so, list other names you have used.
◯ Yes ◯ No

Mailing Address (Street or P.O. Box)	Apt. No.	City	State	ZIP Code

Home Address, if different from above. If it is rural, give directions.

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.

Name (Last, First, Middle)	**Social Security No.** (if available)	**Sex** (Male/ Female)	**Date of Birth**	**Relation to You**	**Are you a sponsored alien?**
					◯ Yes ◯ No
					◯ Yes ◯ No
					◯ Yes ◯ No
					◯ Yes ◯ No
					◯ Yes ◯ No
					◯ Yes ◯ No
					◯ Yes ◯ No

Note: The word “household” in Questions 2 through 16 refers to you, your spouse and anyone else who 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.”

2. What is your household's county and state of residence (where you make your permanent home)?

County: _____ State: _____ Do you plan to remain in this county and state? ◯ Yes ◯ No

3. Living Arrangements – Check all boxes that apply to your household.

☐ Own or paying for home ☐ Live in a house provided by someone else ☐ No permanent residence
☐ Live with someone else ☐ Rent house or apartment ☐ Jail

4. List your average monthly household expenses.

Rent/Mortgage	$
Utilities (gas, water, electric)	$
Phone	$
Transportation (such as gas, car payments, bus)	$
Tax and Insurance on Home Per Year	$
Other:	$
Other:	$
Other:	$

Does anyone pay these household expenses for you? ◯ Yes ◯ No If Yes, who pays? _____

5. Are you or is anyone in your household receiving any of the following? ◯ Yes ◯ No

☐ Temporary Assistance for Needy Families (TANF) ☐ Food Stamps ☐ Medicaid Benefits

If Yes, who? _____

6. Are you or is anyone in your household pregnant? ◯ Yes ◯ No If Yes, who? _____

7. Are you or is anyone in your household disabled? ◯ Yes ◯ No If Yes, who? _____

8. Have you or has anyone in your household applied for Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI)?

◯ Yes ◯ No If Yes, who applied and when? _____

9. Do you or does anyone in your household have unpaid health care bills from the last three months? ◯ Yes ◯ No

If Yes, which months? _____

10. Do you or does anyone in your household have health care coverage (Medicare, health insurance, Veterans Affairs, Tricare, etc.)?

◯ Yes ◯ No If Yes, who? _____

11. How much money do you have in your wallet, in your home, in bank accounts or other locations? _____

12. How many cars, trucks or other vehicles do you and anyone in your household have? List the year, make and model below. _____

	Year	Make and Model	+
1			−

13. Do you or does anyone in your household own or pay for a home, lot, land or other things? ◯ Yes ◯ No

14. Did you or did anyone in your household sell, trade, or give away any cash or property during the last three months? ◯ Yes ◯ No

15. Have you or has anyone in your household worked in the last three months? ◯ Yes ◯ No If Yes, who? _____

16. List all of your household's income below. 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.

Name of Person Receiving Money	Name of Agency, Person or Employer Providing Money	Amount Received	How Often Received?

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 recertification for assistance; and that I may request, orally or in writing, a fair hearing about actions affecting receipt or termination of health care assistance.

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.

Before you sign, be sure each answer is complete and correct. If the applicant is married and the spouse is a household member, the spouse may also sign and date this form, even if the spouse is a disqualified household member.

Signature — Applicant _____ Date _____ Signature — Spouse _____ Date _____

Signature — Person Helping Complete Form 3604 _____ Signature — Applicant's Representative _____ Signature — Witness (if applicant signed with "X") _____

Address of Person Helping Complete Form 3064 (Street, City, State, ZIP Code): _____ Area Code and Phone No.: _____

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 listed below.

Where You Live and Plan to Continue Living – Mail that you received at your address; school records; voting records; property taxes, rent or mortgage receipts; Texas driver license; and other official identification.

What You Own and What it is Worth – Property tax appraisals; estimates from car dealers; ads selling similar items; statements from real estate agents; and bank statements.

Your Income – Paycheck stubs; paychecks; W-2 tax forms or income tax returns; sales records; statements from employers; award letters; legal documents; and statements from persons giving you money.

Other Health Care Coverage – Award or claim letters; insurance policies; court documents; and other legal papers.
Information regarding Social Security numbers should be given if this information is available. Information regarding sex (male/female) is voluntary. This 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 and if you have answered all the questions on the application and 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.