

CHAPTER 61

Health and Safety Code

HEALTH AND SAFETY CODE

TITLE 2. HEALTH

SUBTITLE C. PROGRAMS PROVIDING HEALTH CARE BENEFITS AND SERVICES

CHAPTER 61. INDIGENT HEALTH CARE AND TREATMENT ACT

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 61.001. SHORT TITLE. This chapter may be cited as the Indigent Health Care and Treatment Act.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.

Sec. 61.002. DEFINITIONS. In this chapter:

(1) Repealed by Acts 2015, 84th Leg., R.S., Ch. 1, Sec. 3.1639(21), eff. April 2, 2015.

(2) "Eligible county resident" means an eligible resident of a county who does not reside in the service area of a public hospital or hospital district.

(3) "Eligible resident" means a person who meets the income and resources requirements established by this chapter or by the governmental entity, public hospital, or hospital district in whose jurisdiction the person resides.

(4) "Emergency services" has the meaning assigned by Chapter 773.

(5) "General revenue levy" means:

(A) the property taxes imposed by a county that are not dedicated to:

(i) the construction and maintenance of farm-to-market roads under Article VIII, Section 1-a, Texas Constitution;

(ii) flood control under Article VIII, Section 1-a, Texas Constitution;

(iii) the further maintenance of the public roads under Article VIII, Section 9, Texas Constitution; or

(iv) the payment of principal or interest on county debt; and

(B) the sales and use tax revenue to be received by the county during the calendar year in which the state fiscal year begins under Chapter 323, Tax Code, as determined under Section 26.041(d), Tax Code.

(6) "Governmental entity" includes a county, municipality, or other political subdivision of the state, but does not include a hospital district or hospital authority.

(7) "Hospital district" means a hospital district created under the authority of Article IX, Sections 4-11, of the Texas Constitution.

(8) "Mandated provider" means a person who provides health care services, is selected by a county, public hospital, or hospital district, and agrees to provide health care services to eligible residents, including the primary teaching hospital of a state medical school located in a county which does not have a public hospital or hospital district, and the faculty members practicing in both the inpatient and outpatient care facilities affiliated with the teaching hospital.

(9) "Medicaid" means the medical assistance program provided under Chapter 32, Human Resources Code.

(10) "Public hospital" means a hospital owned, operated, or leased by a governmental entity, except as provided by Section 61.051.

(11) "Service area" means the geographic region in which a governmental entity, public hospital, or hospital district has a legal obligation to provide health care services.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.
Amended by Acts 1991, 72nd Leg., ch. 14, Sec. 14, eff. Sept. 1, 1991; Acts 1995, 74th Leg., ch. 76, Sec. 8.119, eff. Sept. 1, 1995; Acts 1999, 76th Leg., ch. 1377, Sec. 1.01, eff. Sept. 1, 1999.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1295 (H.B. 2315), Sec. 1, eff. June 17, 2011.

Acts 2011, 82nd Leg., R.S., Ch. 1341 (S.B. 1233), Sec. 16, eff. June 17, 2011.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.1639(21), eff. April 2, 2015.

Sec. 61.003. RESIDENCE. (a) For purposes of this chapter, a person is presumed to be a resident of the governmental entity in which the person's home or fixed place of habitation to which the person intends to return after a temporary absence is located. However, if a person's home or fixed place of habitation is located in a hospital district, the person is presumed to be a resident of that hospital district.

(b) If a person does not have a residence, the person is a resident of the governmental entity or hospital district in which the person intends to reside.

(c) Intent to reside may be evidenced by any relevant information, including:

(1) mail addressed to the person or to the person's spouse or children if the spouse or children live with the person;

(2) voting records;

(3) automobile registration;

(4) Texas driver's license or other official identification;

(5) enrollment of children in a public or private school; or

(6) payment of property tax.

(d) A person is not considered a resident of a governmental entity or hospital district if the person attempted to establish residence solely to obtain health care assistance.

(e) The burden of proving intent to reside is on the person requesting assistance.

(f) For purposes of this chapter, a person who is an inmate or resident of a state supported living center, as defined by Section 531.002, or institution operated by the Texas Department of Criminal Justice, Department of Aging and Disability Services, Department of State Health Services, Texas Juvenile Justice Department, Texas School for the Blind and Visually Impaired, Texas School for the Deaf, or any other state agency or who is an inmate, patient, or resident of a school or institution operated by a federal agency is not considered a resident of a hospital district or of any governmental entity except the state or federal government.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 87 (S.B. 1969), Sec. 25.091, eff. September 1, 2009.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0175, eff. April 2, 2015.

Sec. 61.004. RESIDENCE OR ELIGIBILITY DISPUTE. (a) If a provider of assistance and a governmental entity or hospital district cannot agree on a person's residence or whether a person is eligible for assistance under this chapter, the provider or the governmental entity or hospital district may submit the matter to the department.

(b) The provider of assistance and the governmental entity or hospital district shall submit all relevant information to the department in accordance with the application, documentation, and verification procedures established by department rule under Section 61.006.

(c) If the department determines that another governmental entity or hospital district may be involved in the dispute, the department shall notify the governmental entity or hospital district and allow the governmental entity or hospital district to respond.

(d) From the information submitted, the department shall determine the person's residence or whether the person is eligible for assistance under this chapter, as appropriate, and shall notify each governmental entity or hospital district and the provider of assistance of the decision and the reasons for the decision.

(e) If a governmental entity, hospital district, or provider of assistance does not agree with the department's decision, the governmental entity, hospital district, or provider of assistance may file an appeal with the department. The appeal must be filed not later than the 30th day after the date on which the governmental entity, hospital district, or provider of assistance receives notice of the decision.

(f) The department shall issue a final decision not later than the 45th day after the date on which the appeal is filed.

(g) A governmental entity, hospital district, or provider of assistance may appeal the final order of the department under Chapter 2001, Government Code, using the substantial evidence rule on appeal.

(h) Service may not be denied pending an administrative or judicial review of residence.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.
Amended by Acts 1995, 74th Leg., ch. 76, Sec. 5.95(49), eff. Sept. 1, 1995; Acts 1999, 76th Leg., ch. 1377, Sec. 1.02, eff. Sept. 1, 1999.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0176, eff. April 2, 2015.

Sec. 61.0045. INFORMATION NECESSARY TO DETERMINE ELIGIBILITY. (a) Any provider, including a mandated provider, public hospital, or hospital district, that delivers health care services to a patient who the provider suspects is an eligible resident of the service area of a county, hospital district, or public hospital under this chapter may require the patient to:

(1) provide any information necessary to establish that the patient is an eligible resident of the service area of the county, hospital district, or public hospital; and

(2) authorize the release of any information relating to the patient, including medical information and information obtained under Subdivision (1), to permit the provider to submit a claim to the county, hospital district, or public hospital that is liable for payment for the services as described by Section 61.033 or 61.060.

(b) A county, hospital district, or public hospital that receives information obtained under Subsection (a) shall use the information to determine whether the patient to whom services were provided is an eligible resident of the service area of the county, hospital district, or public hospital and, if so, shall pay the claim made by the provider to the extent that the county, hospital district, or public hospital is liable under Section 61.033 or 61.060.

(c) The application, documentation, and verification procedures established by the department for counties under Section 61.006 may include a standard format for obtaining information under Subsection (a) to facilitate eligibility and residence determinations.

Added by Acts 1999, 76th Leg., ch. 1377, Sec. 1.03, eff. Sept. 1, 1999.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 916 (H.B. 2963), Sec. 1, eff. September 1, 2009.

Sec. 61.005. CONTRIBUTION TOWARD COST OF ASSISTANCE. (a) A county, public hospital, or hospital district may request an eligible resident receiving health care assistance under this chapter to contribute a nominal amount toward the cost of the assistance.

(b) The county, public hospital, or hospital district may not deny or reduce assistance to an eligible resident who cannot or refuses to contribute.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.

Sec. 61.006. STANDARDS AND PROCEDURES. (a) The department shall establish minimum eligibility standards and application, documentation, and verification procedures for counties to use in determining eligibility under this chapter.

(b) The minimum eligibility standards must incorporate a net income eligibility level equal to 21 percent of the federal poverty level based on the federal Office of Management and Budget poverty index.

(b-1) Expired.

(b-2) Repealed by Acts 2001, 77th Leg., ch. 1128, Sec. 7, eff. Sept. 1, 2001.

(c) The department shall also define the services and establish the payment standards for the categories of services listed in Sections [61.028\(a\)](#) and [61.0285](#) in accordance with commission rules relating to the Temporary Assistance for Needy Families-Medicaid program.

(d) The department shall establish application, documentation, and verification procedures that are consistent with the analogous procedures used to determine eligibility in the Temporary Assistance for Needy Families-Medicaid program. Except as provided by Section [61.008\(a\)\(6\)](#), the department may not adopt a standard or procedure that is more restrictive than the Temporary Assistance for Needy Families-Medicaid program or procedures.

(e) The department shall ensure that each person who meets the basic income and resources requirements for Temporary Assistance for Needy Families program payments but who is categorically ineligible for Temporary Assistance for Needy Families will be eligible for assistance under Subchapter B. Except as provided by Section [61.023\(b\)](#), the executive

commissioner by rule shall also provide that a person who receives or is eligible to receive Temporary Assistance for Needy Families, Supplemental Security Income, or Medicaid benefits is not eligible for assistance under Subchapter B even if the person has exhausted a part or all of that person's benefits.

(f) The department shall notify each county and public hospital of any change to department rules that affect the provision of services under this chapter.

(g) Notwithstanding Subsection (a), (b), or (c) or any other provision of law, the department shall permit payment to a licensed dentist for services provided under Sections [61.028\(a\)\(4\)](#) and (6) if the dentist can provide those services within the scope of the dentist's license.

(h) Notwithstanding Subsection (a), (b), or (c), the department shall permit payment to a licensed podiatrist for services provided under Sections [61.028\(a\)\(4\)](#) and (6), if the podiatrist can provide the services within the scope of the podiatrist's license.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.
Amended by Acts 1989, 71st Leg., ch. 1100, Sec. 5.09(a), eff. Sept. 1, 1989; Acts 1991, 72nd Leg., ch. 14, Sec. 15, eff. Sept. 1, 1991; Acts 1995, 74th Leg., ch. 76, Sec. 8.120, eff. Sept. 1, 1995; Acts 1999, 76th Leg., ch. 1377, Sec. 1.04, eff. Sept. 1, 1999; Acts 2001, 77th Leg., ch. 1128, Sec. 1, 7 eff. Sept. 1, 2001.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 173 (S.B. [420](#)), Sec. 1, eff. May 28, 2011.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. [219](#)), Sec. 3.0177, eff. April 2, 2015.

Sec. 61.007. INFORMATION PROVIDED BY APPLICANT. The executive commissioner by rule shall require each applicant to provide at least the following information:

- (1) the applicant's full name and address;
- (2) the applicant's social security number, if available;
- (3) the number of persons in the applicant's household, excluding persons receiving Temporary Assistance for Needy Families, Supplemental Security Income, or Medicaid benefits;
- (4) the applicant's county of residence;
- (5) the existence of insurance coverage or other hospital or health care benefits for which the applicant is eligible;
- (6) any transfer of title to real property that the applicant has made in the preceding 24 months;
- (7) the applicant's annual household income, excluding the income of any household member receiving Temporary Assistance for Needy Families, Supplemental Security Income, or Medicaid benefits; and
- (8) the amount of the applicant's liquid assets and the equity value of the applicant's car and real property.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.
Amended by Acts 1999, 76th Leg., ch. 1377, Sec. 1.04, eff. Sept. 1, 1999.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. [219](#)), Sec. 3.0178, eff. April 2, 2015.

Sec. 61.008. ELIGIBILITY RULES. (a) The executive commissioner by rule shall provide that in determining eligibility:

- (1) a county may not consider the value of the applicant's homestead;
- (2) a county must consider the equity value of a car that is in excess of the amount exempted under department guidelines as a resource;

(3) a county must subtract the work-related and child care expense allowance allowed under department guidelines;

(4) a county must consider as a resource real property other than a homestead and, except as provided by Subsection (b), must count that property in determining eligibility;

(5) if an applicant transferred title to real property for less than market value to become eligible for assistance under this chapter, the county may not credit toward eligibility for state assistance an expenditure for that applicant made during a two-year period beginning on the date on which the property is transferred; and

(6) if an applicant is a sponsored alien, a county may include in the income and resources of the applicant:

(A) the income and resources of a person who executed an affidavit of support on behalf of the applicant; and

(B) the income and resources of the spouse of a person who executed an affidavit of support on behalf of the applicant, if applicable.

(b) A county may disregard the applicant's real property if the applicant agrees to an enforceable obligation to reimburse the county for all or part of the benefits received under this chapter. The county and the applicant may negotiate the terms of the obligation.

(c) In this section, "sponsored alien" means a person who has been lawfully admitted to the United States for permanent residence under the Immigration and Nationality Act (8 U.S.C. Section 1101 et seq.) and who, as a condition of admission, was sponsored by a person who executed an affidavit of support on behalf of the person.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 173 (S.B. 420), Sec. 2, eff. May 28, 2011.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0179, eff. April 2, 2015.

Sec. 61.009. REPORTING REQUIREMENTS. (a) The department shall establish uniform reporting requirements for governmental entities that own, operate, or lease public hospitals providing assistance under this chapter and for counties.

(b) The reports must include information relating to:

- (1) expenditures for and nature of hospital and health care provided to eligible residents;
- (2) eligibility standards and procedures established by counties and governmental entities that own, operate, or lease public hospitals; and
- (3) relevant characteristics of eligible residents.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.
Amended by Acts 1995, 74th Leg., ch. 76, Sec. 8.121, eff. Sept. 1, 1995.

Sec. 61.010. DEDICATED TAX REVENUES. If the governing body of a governmental entity adopts a property tax rate that exceeds the rate calculated under Section 26.04, Tax Code, by more than eight percent, and if a portion of the tax rate was designated to provide revenue for indigent health care services required by this chapter, the revenue produced by the portion of the tax rate designated for that purpose may be spent only to provide indigent health care services.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.

Sec. 61.011. SERVICES BY STATE HOSPITAL OR CLINIC. A state hospital or clinic shall be entitled to payment for services rendered to an eligible resident under the provisions of this chapter applicable to other providers. The executive

commissioner may adopt rules as necessary to implement this section.

Added by Acts 1999, 76th Leg., ch. 1377, Sec. 1.05, eff. Sept. 1, 1999.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0180, eff. April 2, 2015.

Sec. 61.012. REIMBURSEMENT FOR SERVICES. (a) In this section, "sponsored alien" means a person who has been lawfully admitted to the United States for permanent residence under the Immigration and Nationality Act (8 U.S.C. Section 1101 et seq.) and who, as a condition of admission, was sponsored by a person who executed an affidavit of support on behalf of the person.

(b) A public hospital or hospital district that provides health care services to a sponsored alien under this chapter may recover from a person who executed an affidavit of support on behalf of the alien the costs of the health care services provided to the alien.

(c) A public hospital or hospital district described by Subsection (b) must notify a sponsored alien and a person who executed an affidavit of support on behalf of the alien, at the time the alien applies for health care services, that a person who executed an affidavit of support on behalf of a sponsored alien is liable for the cost of health care services provided to the alien.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 1.16(a), eff. September 28, 2011.

SUBCHAPTER B. COUNTY RESPONSIBILITY FOR PERSONS NOT RESIDING IN AN AREA SERVED BY A PUBLIC HOSPITAL OR HOSPITAL DISTRICT

Sec. 61.021. APPLICATION OF SUBCHAPTER. This subchapter applies to health care services and assistance provided to a

person who does not reside in the service area of a public hospital or hospital district.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.

Sec. 61.022. COUNTY OBLIGATION. (a) A county shall provide health care assistance as prescribed by this subchapter to each of its eligible county residents.

(b) The county is the payor of last resort and shall provide assistance only if other adequate public or private sources of payment are not available.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.

Sec. 61.0221. AUTHORITY RELATING TO OTHER ASSISTANCE PROGRAMS. This subchapter does not affect the authority of the commissioners court of a county to provide eligibility standards or other requirements relating to assistance programs or services that are not covered by this subchapter.

Added by Acts 1999, 76th Leg., ch. 62, Sec. 13.11(g), eff. Sept. 1, 1999.

Sec. 61.023. GENERAL ELIGIBILITY PROVISIONS. (a) A person is eligible for assistance under this subchapter if:

(1) the person does not reside in the service area of a public hospital or hospital district;

(2) the person meets the basic income and resources requirements established by the department under Sections 61.006 and 61.008 and in effect when the assistance is requested; and

(3) no other adequate source of payment exists.

(b) A county may use a less restrictive standard of eligibility for residents than prescribed by Subsection (a). A county may credit toward eligibility for state assistance under this subchapter the services provided to each person who is an eligible resident under a standard that incorporates a net

income eligibility level that is less than 50 percent of the federal poverty level based on the federal Office of Management and Budget poverty index.

(c) A county may contract with the department to perform eligibility determination services.

(d) Not later than the beginning of a state fiscal year, the county shall adopt the eligibility standards it will use during that fiscal year and shall make a reasonable effort to notify the public of the standards. The county may change the eligibility standards to make them more or less restrictive than the preceding standards, but the standards may not be more restrictive than the standards established by the department under Section 61.006.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.
Amended by Acts 1989, 71st Leg., ch. 1100, Sec. 5.10(a), eff. Sept. 1, 1989; Acts 1999, 76th Leg., ch. 1377, Sec. 1.06, eff. Sept. 1, 1999.

Sec. 61.024. COUNTY APPLICATION PROCEDURE. (a) A county shall adopt an application procedure.

(b) The county may use the application, documentation, and verification procedures established by the department under Sections 61.006 and 61.007 or may use a less restrictive application, documentation, or verification procedure.

(c) Not later than the beginning of a state fiscal year, the county shall specify the procedure it will use during that fiscal year to verify eligibility and the documentation required to support a request for assistance and shall make a reasonable effort to notify the public of the application procedure.

(d) The county shall furnish an applicant with written application forms.

(e) On request of an applicant, the county shall assist the applicant in filling out forms and completing the application process. The county shall inform an applicant of the availability of assistance.

(f) The county shall require an applicant to sign a written statement in which the applicant swears to the truth of the information supplied.

(g) The county shall explain to the applicant that if the application is approved, the applicant must report to the county any change in income or resources that might affect the applicant's eligibility. The report must be made not later than the 14th day after the date on which the change occurs. The county shall explain the possible penalties for failure to report a change.

(h) The county shall review each application and shall accept or deny the application not later than the 14th day after the date on which the county receives the completed application.

(i) The county shall provide a procedure for reviewing applications and for allowing an applicant to appeal a denial of assistance.

(j) The county shall provide an applicant written notification of the county's decision. If the county denies assistance, the written notification shall include the reason for the denial and an explanation of the procedure for appealing the denial.

(k) The county shall maintain the records relating to an application at least until the end of the third complete state fiscal year following the date on which the application is submitted.

(l) If an applicant is denied assistance, the applicant may resubmit an application at any time circumstances justify a redetermination of eligibility.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.

Sec. 61.025. COUNTY AGREEMENT WITH MUNICIPALITY. (a) This section applies to a municipality that has a population of less than 15,000, that owns, operates, or leases a hospital, and that has made a transfer agreement before August 31, 1989, by

the adoption of an ordinance, resolution, or order by the commissioners court and the governing body of the municipality.

(b) The transfer agreement may transfer partial responsibility to the county under which the municipal hospital continues to provide health care services to eligible residents of the municipality, but the county agrees to assume the hospital's responsibility to reimburse other providers who provide:

(1) mandatory inpatient or outpatient services to eligible residents that the municipal hospital cannot provide; or

(2) emergency services to eligible residents.

(c) The hospital is a public hospital for the purposes of this chapter, but it does not have a responsibility to provide reimbursement for services it cannot provide or for emergency services provided in another facility.

(d) Expenditures made by the county under Subsection (b) may be credited toward eligibility for state assistance under this subchapter if the person who received the health care services meets the eligibility standards established under Section 61.052 and would have been eligible for assistance under the county program if the person had not resided in a public hospital's service area.

(e) The agreement to transfer partial responsibility to a county under this section must take effect on a September 1 that occurs not later than two years after the date on which the county and municipality agree to the transfer. A county and municipality may not revoke or amend an agreement made under this section, except that the county may revoke or amend the agreement if a hospital district is created after the effective date of the agreement and the boundaries of the district cover all or part of the county.

(f) The county, the hospital, and any other entity in the county that provides services under this chapter shall adopt coordinated application and eligibility verification procedures. In establishing the coordinated procedures, the county and other

entities shall focus on facilitating the efficient and timely referral of residents to the proper entity in the county. In addition, the procedures must comply with the requirements of Sections 61.024 and 61.053. Expenditures made by a county in establishing the coordinated procedures prescribed by this section may not be credited toward eligibility for state assistance under this subchapter.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.
Amended by Acts 1997, 75th Leg., ch. 1103, Sec. 1, eff. Sept. 1, 1997; Acts 1999, 76th Leg., ch. 1377, Sec. 1.07, eff. Sept. 1, 1999.

Sec. 61.026. REVIEW OF ELIGIBILITY. A county shall review at least once every six months the eligibility of a resident for whom an application for assistance has been granted and who has received assistance under this chapter.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.

Sec. 61.027. CHANGE IN ELIGIBILITY STATUS. (a) An eligible resident must report any change in income or resources that might affect the resident's eligibility. The report must be made not later than the 14th day after the date on which the change occurs.

(b) If an eligible resident fails to report a change in income or resources as prescribed by this section and the change has made the resident ineligible for assistance under the standards adopted by the county, the resident is liable for any benefits received while ineligible. This section does not affect a person's criminal liability under any relevant statute.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.

Sec. 61.028. BASIC HEALTH CARE SERVICES. (a) A county shall, in accordance with department rules adopted under Section [61.006](#), provide the following basic health care services:

- (1) primary and preventative services designed to meet the needs of the community, including:
 - (A) immunizations;
 - (B) medical screening services; and
 - (C) annual physical examinations;
- (2) inpatient and outpatient hospital services;
- (3) rural health clinics;
- (4) laboratory and X-ray services;
- (5) family planning services;
- (6) physician services;
- (7) payment for not more than three prescription drugs a month; and
- (8) skilled nursing facility services, regardless of the patient's age.

(b) The county may provide additional health care services, but may not credit the assistance toward eligibility for state assistance, except as provided by Section [61.0285](#).

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.
Amended by Acts 1999, 76th Leg., ch. 1377, Sec. 1.08, eff. Sept. 1, 1999.

Sec. 61.0285. OPTIONAL HEALTH CARE SERVICES. (a) In addition to basic health care services provided under Section [61.028](#), a county may, in accordance with department rules adopted under Section [61.006](#), provide other medically necessary services or supplies that the county determines to be cost-effective, including:

- (1) ambulatory surgical center services;
- (2) diabetic and colostomy medical supplies and equipment;
- (3) durable medical equipment;
- (4) home and community health care services;

(5) social work services;
(6) psychological counseling services;
(7) services provided by physician assistants, nurse practitioners, certified nurse midwives, clinical nurse specialists, and certified registered nurse anesthetists;
(8) dental care;
(9) vision care, including eyeglasses;
(10) services provided by federally qualified health centers, as defined by 42 U.S.C. Section 1396d(1)(2)(B);
(11) emergency medical services;
(12) physical and occupational therapy services; and
(13) any other appropriate health care service identified by department rule that may be determined to be cost-effective.

(b) A county must notify the department of the county's intent to provide services specified by Subsection (a). If the services are approved in accordance with Section [61.006](#), or if the department fails to notify the county of the department's disapproval before the 31st day after the date the county notifies the department of its intent to provide the services, the county may credit the services toward eligibility for state assistance under this subchapter.

(c) A county may provide health care services that are not specified in Subsection (a), or may provide the services specified in Subsection (a) without actual or constructive approval of the department, but may not credit the services toward eligibility for state assistance.

Added by Acts 1999, 76th Leg., ch. 1377, Sec. 1.09, eff. Sept. 1, 1999. Amended by Acts 2001, 77th Leg., ch. 874, Sec. 9, eff. Sept. 1, 2001; Acts 2003, 78th Leg., ch. 892, Sec. 24, eff. Sept. 1, 2003.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 947 (H.B. [871](#)), Sec. 1, eff. September 1, 2011.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0181, eff. April 2, 2015.

Sec. 61.029. PROVISION OF HEALTH CARE SERVICES. (a) A county may arrange to provide health care services through a local health department, a publicly owned facility, or a contract with a private provider regardless of the provider's location, or through the purchase of insurance for eligible residents.

(b) The county may affiliate with other governmental entities or with a public hospital or hospital district to provide regional administration and delivery of health care services.

(c) A county may provide or arrange to provide health care services for eligible county residents through the purchase of health coverage or other health benefits, including benefits described by Chapter 75.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 916 (H.B. 2963), Sec. 2, eff. September 1, 2009.

Sec. 61.030. MANDATED PROVIDER. A county may select one or more providers of health care services. The county may require eligible county residents to obtain care from a mandated provider except:

- (1) in an emergency;
- (2) when medically inappropriate; or
- (3) when care is not available.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.

Sec. 61.031. NOTIFICATION OF PROVISION OF NONEMERGENCY SERVICES. (a) A county may require any provider, including a

mandated provider, to obtain approval from the county before providing nonemergency health care services to an eligible county resident.

(b) If the county does not require prior approval and a provider delivers or will deliver nonemergency health care services to a patient who the provider suspects may be eligible for assistance under this subchapter, the provider shall notify the patient's county of residence that health care services have been or will be provided to the patient. The notice shall be made:

(1) by telephone not later than the 72nd hour after the provider determines the patient's county of residence; and

(2) by mail postmarked not later than the fifth working day after the date on which the provider determines the patient's county of residence.

(c) If the provider knows that the patient's county of residence has selected a mandated provider or if, after contacting the patient's county of residence, that county requests that the patient be transferred to a mandated provider, the provider shall transfer the patient to the mandated provider unless it is medically inappropriate to do so.

(d) Not later than the 14th day after the date on which the patient's county of residence receives sufficient information to determine eligibility, the county shall determine if the patient is eligible for assistance from that county. If the county does not determine the patient's eligibility within that period, the patient is considered to be eligible. The county shall notify the provider of its decision.

(e) If a provider delivers nonemergency health care services to a patient who is eligible for assistance under this subchapter and fails to comply with this section, the provider is not eligible for payment for the services from the patient's county of residence.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.
Amended by Acts 1999, 76th Leg., ch. 1377, Sec. 1.10, eff. Sept. 1, 1999.

Sec. 61.032. NOTIFICATION OF PROVISION OF EMERGENCY SERVICES. (a) If a nonmandated provider delivers emergency services to a patient who the provider suspects might be eligible for assistance under this subchapter, the provider shall notify the patient's county of residence that emergency services have been or will be provided to the patient. The notice shall be made:

(1) by telephone not later than the 72nd hour after the provider determines the patient's county of residence; and

(2) by mail postmarked not later than the fifth working day after the date on which the provider determines the patient's county of residence.

(b) The provider shall attempt to determine the patient's county of residence when the patient first receives services.

(c) The provider, the patient, and the patient's family shall cooperate with the county of which the patient is presumed to be a resident in determining if the patient is an eligible resident of that county.

(d) Not later than the 14th day after the date on which the patient's county of residence receives notification and sufficient information to determine eligibility, the county shall determine if the patient is eligible for assistance from that county. If the county does not determine the patient's eligibility within that period, the patient is considered to be eligible. The county shall notify the provider of its decision.

(e) If the county and the provider disagree on the patient's residence or eligibility, the county or the provider may submit the matter to the department as provided by Section [61.004](#).

(f) If a provider delivers emergency services to a patient who is eligible for assistance under this subchapter and fails

to comply with this section, the provider is not eligible for payment for the services from the patient's county of residence.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.
Amended by Acts 1999, 76th Leg., ch. 1377, Sec. 1.11, eff. Sept. 1, 1999; Acts 2001, 77th Leg., ch. 1128, Sec. 2, eff. Sept. 1, 2001.

Sec. 61.033. PAYMENT FOR SERVICES. (a) To the extent prescribed by this chapter, a county is liable for health care services provided under this subchapter by any provider, including a public hospital or hospital district, to an eligible county resident. A county is not liable for payment for health care services provided:

(1) by any provider, including a public hospital or hospital district, to a resident of that county who resides in the service area of a public hospital or hospital district; or

(2) to an eligible resident of that county who does not reside within the service area of a public hospital or hospital district by a hospital having a Hill-Burton or state-mandated obligation to provide free services and considered to be in noncompliance with the requirements of the Hill-Burton or state-mandated obligation.

(b) To the extent prescribed by this chapter, if another source of payment does not adequately cover a health care service a county provides to an eligible county resident, the county shall pay for or provide the health care service for which other payment is not available.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.

Sec. 61.034. PAYMENT STANDARDS FOR HEALTH CARE SERVICES. (a) A county is not liable for the cost of a health care service provided under Section [61.028](#) or [61.0285](#) that is in excess of the payment standards for that service established by the department under Section [61.006](#).

(b) A county may contract with a provider of assistance to provide a health care service at a rate below the payment standard set by department rule.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.

Amended by Acts 1999, 76th Leg., ch. 1377, Sec. 1.12, eff. Sept. 1, 1999.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0182, eff. April 2, 2015.

Sec. 61.035. LIMITATION OF COUNTY LIABILITY. The maximum county liability for each state fiscal year for health care services provided by all assistance providers, including a hospital and a skilled nursing facility, to each eligible county resident is:

(1) \$30,000; or

(2) the payment of 30 days of hospitalization or treatment in a skilled nursing facility, or both, or \$30,000, whichever occurs first, if the county provides hospital or skilled nursing facility services to the resident.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.

Sec. 61.036. DETERMINATION OF ELIGIBILITY FOR PURPOSES OF STATE ASSISTANCE. (a) A county may not credit an expenditure made to assist an eligible county resident toward eligibility for state assistance under this subchapter unless the county complies with the department's application, documentation, and verification procedures.

(b) Except as provided by Section 61.023(b), a county may not credit an expenditure for an applicant toward eligibility for state assistance if the applicant does not meet the department's eligibility standards.

(c) Regardless of the application, documentation, and verification procedures or eligibility standards established

under Subchapter A, a county may credit an expenditure for an eligible resident toward eligibility for state assistance if the eligible resident received the health care services at:

(1) a hospital maintained or operated by a state agency that has a contract with the county to provide health care services;

(2) a federally qualified health center delivering federally qualified health center services, as those terms are defined in 42 U.S.C. Sections 1396d(1)(2)(A) and (B), that has a contract with the county to provide health care services; or

(3) a hospital or other health care provider if the eligible resident is an inmate of a county jail or another county correctional facility.

(d) Regardless of the application, documentation, and verification procedures or eligibility standards established under Subchapter A, a county may credit an intergovernmental transfer to the state toward eligibility for state assistance if the transfer was made to provide health care services as part of the Texas Healthcare Transformation and Quality Improvement Program waiver issued under 42 U.S.C. Section 1315.

(e) A county may credit toward eligibility for state assistance intergovernmental transfers made under Subsection (d) that in the aggregate do not exceed four percent of the county's general revenue levy in any state fiscal year, provided:

(1) the commissioners court determines that the expenditure fulfills the county's obligations to provide indigent health care under this chapter;

(2) the commissioners court determines that the amount of care available through participation in the waiver is sufficient in type and amount to meet the requirements of this chapter; and

(3) the county receives periodic reports from health care providers that receive supplemental or incentive payments under the Texas Healthcare Transformation and Quality Improvement Program waiver that document the number and types of

services provided to persons who are eligible to receive services under this chapter.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.
Amended by Acts 1989, 71st Leg., ch. 1100, Sec. 5.10(b), eff. Sept. 1, 1989; Acts 1999, 76th Leg., ch. 1377, Sec. 1.13, eff. Sept. 1, 1999.

Amended by:

Acts 2005, 79th Leg., Ch. 1133 (H.B. [2618](#)), Sec. 1, eff. September 1, 2005.

Acts 2013, 83rd Leg., R.S., Ch. 1007 (H.B. [2454](#)), Sec. 1, eff. September 1, 2013.

Acts 2013, 83rd Leg., R.S., Ch. 1176 (S.B. [872](#)), Sec. 1, eff. June 14, 2013.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. [219](#)), Sec. 3.0183, eff. April 2, 2015.

Sec. 61.037. COUNTY ELIGIBILITY FOR STATE ASSISTANCE. (a) The department may distribute funds as provided by this subchapter to eligible counties to assist the counties in providing health care services under Sections [61.028](#) and [61.0285](#) to their eligible county residents.

(b) Except as provided by Subsection (c), (d), (e), or (g), to be eligible for state assistance, a county must:

(1) spend in a state fiscal year at least eight percent of the county general revenue levy for that year to provide health care services described by Subsection (a) to its eligible county residents who qualify for assistance under Section [61.023](#); and

(2) notify the department, not later than the seventh day after the date on which the county reaches the expenditure level, that the county has spent at least six percent of the applicable county general revenue levy for that year to provide health care services described by Subsection (a) to its eligible county residents who qualify for assistance under Section [61.023](#).

(c) If a county and a health care provider signed a contract on or before January 1, 1985, under which the provider agrees to furnish a certain level of health care services to indigent persons, the value of services furnished in a state fiscal year under the contract is included as part of the computation of a county expenditure under this section if the value of services does not exceed the payment rate established by the department under Section 61.006.

(d) If a hospital district is located in part but not all of a county, that county's appraisal district shall determine the taxable value of the property located inside the county but outside the hospital district. In determining eligibility for state assistance, that county shall consider only the county general revenue levy resulting from the property located outside the hospital district. A county is eligible for state assistance if:

(1) the county spends in a state fiscal year at least eight percent of the county general revenue levy for that year resulting from the property located outside the hospital district to provide health care services described by Subsection (a) to its eligible county residents who qualify for assistance under Section 61.023; and

(2) the county complies with the other requirements of this subchapter.

(e) A county that provides health care services described by Subsection (a) to its eligible residents through a hospital established by a board of managers jointly appointed by a county and a municipality under Section 265.011 is eligible for state assistance if:

(1) the county spends in a state fiscal year at least eight percent of the county general revenue levy for the year to provide the health care services to its eligible county residents who qualify for assistance under Section 61.052; and

(2) the county complies with the requirements of this subchapter.

(f) If a county anticipates that it will reach the eight percent expenditure level, the county must notify the department as soon as possible before the anticipated date on which the county will reach the level.

(g) The department may waive the requirement that the county meet the minimum expenditure level imposed by Subsection (b), (d), or (e) and provide state assistance under this chapter at a lower level determined by the department if the county demonstrates, through an appropriate actuarial analysis, that the county is unable to satisfy the eight percent expenditure level:

(1) because, although the county's general revenue tax levy has increased significantly, expenditures for health care services described by Subsection (a) have not increased by the same percentage;

(2) because the county is at the maximum allowable ad valorem tax rate, has a small population, or has insufficient taxable property; or

(3) because of a similar reason.

(h) The executive commissioner shall adopt rules governing the circumstances under which a waiver may be granted under Subsection (g) and the procedures to be used by a county to apply for the waiver. The procedures must provide that the department shall make a determination with respect to an application for a waiver not later than the 90th day after the date the application is submitted to the department in accordance with the procedures established by department rule. To be eligible for state assistance under Subsection (g), a county must submit monthly financial reports, in the form required by the department, covering the 12-month period preceding the date on which the assistance is sought.

(i) The county must give the department all necessary information so that the department can determine if the county meets the requirements of Subsection (b), (d), (e), or (g).

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.
Amended by Acts 1997, 75th Leg., ch. 651, Sec. 1, eff. June 11, 1997; Acts 1999, 76th Leg., ch. 272, Sec. 1, eff. May 28, 1999; Acts 1999, 76th Leg., ch. 1377, Sec. 1.14, eff. Sept. 1, 1999.
Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0184, eff. April 2, 2015.

Sec. 61.038. DISTRIBUTION OF ASSISTANCE FUNDS. (a) If the department determines that a county is eligible for assistance, the department shall distribute funds appropriated to the department from the indigent health care assistance fund or any other available fund to the county to assist the county in providing health care services under Sections 61.028 and 61.0285 to its eligible county residents who qualify for assistance as described by Section 61.037.

(b) State funds provided under this section to a county must be equal to at least 90 percent of the actual payment for the health care services for the county's eligible residents during the remainder of the state fiscal year after the eight percent expenditure level is reached.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.
Amended by Acts 1999, 76th Leg., ch. 272, Sec. 2, eff. May 28, 1999; Acts 1999, 76th Leg., ch. 1377, Sec. 1.14, eff. Sept. 1, 1999.

Sec. 61.039. FAILURE TO PROVIDE STATE ASSISTANCE. If the department fails to provide assistance to an eligible county as prescribed by Section 61.038, the county is not liable for payments for health care services provided to its eligible county residents after the county reaches the eight percent expenditure level.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.
Amended by Acts 1999, 76th Leg., ch. 1377, Sec. 1.14, eff. Sept. 1, 1999.

Sec. 61.0395. LIMITED TO APPROPRIATED FUNDS. (a) The total amount of state assistance provided to counties under this chapter for a fiscal year may not exceed the amount appropriated for that purpose for that fiscal year.

(b) The executive commissioner may adopt rules governing the distribution of state assistance under this chapter that establish a maximum annual allocation for each county eligible for assistance under this chapter in compliance with Subsection (a).

(c) The rules adopted under this section:

(1) may consider the relative populations of the service areas of eligible counties and other appropriate factors; and

(2) notwithstanding Subsection (b), may provide for, at the end of each state fiscal year, the reallocation of all money that is allocated to a county under Subsection (b) but that the county is not eligible to receive and the distribution of that money to other eligible counties.

Added by Acts 1999, 76th Leg., ch. 1377, Sec. 1.15, eff. Sept. 1, 1999. Amended by Acts 2001, 77th Leg., ch. 1128, Sec. 3, eff. Sept. 1, 2001.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. [219](#)), Sec. 3.0185, eff. April 2, 2015.

Sec. 61.040. TAX INFORMATION. The comptroller shall give the department information relating to:

(1) the taxable value of property taxable by each county and each county's applicable general revenue tax levy for the relevant period; and

(2) the amount of sales and use tax revenue received by each county for the relevant period.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.
Amended by Acts 1991, 72nd Leg., 2nd C.S., ch. 6, Sec. 64, eff. Sept. 1, 1991.

Sec. 61.041. COUNTY REPORTING. (a) The department shall establish monthly reporting requirements for a county seeking state assistance and establish procedures necessary to determine if the county is eligible for state assistance.

(b) The department shall establish requirements relating to:

(1) documentation required to verify the eligibility of residents to whom the county provides assistance; and

(2) county expenditures for health care services under Sections [61.028](#) and [61.0285](#).

(c) The department may audit county records to determine if the county is eligible for state assistance.

(d) The department shall establish annual reporting requirements for each county that is required to provide indigent health care under this chapter but that is not required to report under Subsection (a). A county satisfies the annual reporting requirement of this subsection if the county submits information to the department as required by law to obtain an annual distribution under the Agreement Regarding Disposition of Settlement Proceeds filed on July 24, 1998, in the United States District Court, Eastern District of Texas, in the case styled *The State of Texas v. The American Tobacco Co., et al.*, No. 5-96CV-91.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.
Amended by Acts 1999, 76th Leg., ch. 1377, Sec. 1.16, eff. Sept. 1, 1999.

Sec. 61.042. EMPLOYMENT SERVICES PROGRAM. (a) A county may establish procedures consistent with those used by the commission under Chapter 31, Human Resources Code, for administering an employment services program and requiring an applicant or eligible resident to register for work with the Texas Workforce Commission.

(b) The county shall notify all persons with pending applications and eligible residents of the employment service program requirements not less than 30 days before the program is established.

Added by Acts 1993, 73rd Leg., ch. 880, Sec. 1, eff. Sept. 1, 1993. Amended by Acts 1995, 74th Leg., ch. 76, Sec. 8.122, eff. Sept. 1, 1995.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0186, eff. April 2, 2015.

Sec. 61.043. PREVENTION AND DETECTION OF FRAUD. (a) The county shall adopt reasonable procedures for minimizing the opportunity for fraud, for establishing and maintaining methods for detecting and identifying situations in which a question of fraud may exist, and for administrative hearings to be conducted on disqualifying persons in cases where fraud appears to exist.

(b) Procedures established by a county for administrative hearings conducted under this section shall provide for appropriate due process, including procedures for appeals.

Added by Acts 1993, 73rd Leg., ch. 880, Sec. 1, eff. Sept. 1, 1993.

Sec. 61.044. SUBROGATION. (a) The filing of an application for or receipt of services constitutes an assignment of the applicant's or recipient's right of recovery from:

- (1) personal insurance;
- (2) other sources; or

(3) another person for personal injury caused by the other person's negligence or wrong.

(b) A person who applies for or receives services shall inform the county, at the time of application or at any time during eligibility, of any unsettled tort claim that may affect medical needs and of any private accident or sickness insurance coverage that is or may become available. An applicant or eligible resident shall inform the county of any injury that is caused by the act or failure to act of some other person. An applicant or eligible resident shall inform the county as required by this subsection within 10 days of the date the person learns of the person's insurance coverage, tort claim, or potential cause of action.

(c) A claim for damages for personal injury does not constitute grounds for denying or discontinuing services under this chapter.

(d) A separate and distinct cause of action in favor of the county is hereby created, and the county may, without written consent, take direct civil action in any court of competent jurisdiction. A suit brought under this section need not be ancillary to or dependent on any other action.

(e) The county's right of recovery is limited to the amount of the cost of services paid by the county. Other subrogation rights granted under this section are limited to the cost of the services provided.

(f) An applicant or eligible resident who knowingly and intentionally fails to disclose the information required by Subsection (b) commits a Class C misdemeanor.

(g) An applicant or eligible resident is subject to denial of services under this chapter following an administrative hearing.

Added by Acts 1993, 73rd Leg., ch. 880, Sec. 1, eff. Sept. 1, 1993.

SUBCHAPTER C. PERSONS WHO RESIDE IN AN AREA SERVED BY A PUBLIC
HOSPITAL OR HOSPITAL DISTRICT

Sec. 61.051. APPLICATION OF SUBCHAPTER. (a) This subchapter applies to health care services and assistance provided to a person who resides in the service area of a public hospital or hospital district.

(b) For the purposes of this subchapter, a hospital is not considered to be a public hospital and is not responsible for providing care under this subchapter if the hospital:

(1) is owned, operated, or leased by a municipality with a population of less than 5,500;

(2) was leased before January 1, 1981, by a municipality that at the time of the lease did not have a legal obligation to provide indigent health care; or

(3) was established under Section [265.031](#).

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.
Amended by Acts 1991, 72nd Leg., ch. 14, Sec. 16, eff. Sept. 1, 1991.

Sec. 61.052. GENERAL ELIGIBILITY PROVISIONS. (a) A public hospital or hospital district shall provide health care assistance to each eligible resident in its service area who meets:

(1) the basic income and resources requirements established by the department under Sections [61.006](#) and [61.008](#) and in effect when the assistance is requested; or

(2) a less restrictive income and resources standard adopted by the hospital or hospital district serving the area in which the person resides.

(b) If a public hospital used an income and resources standard during the operating year that ended before January 1, 1985, that was less restrictive than the income and resources requirements established by the department under Section [61.006](#),

the hospital shall adopt that standard to determine eligibility under this subchapter.

(c) If a public hospital did not use an income and resources standard during the operating year that ended before January 1, 1985, but had a Hill-Burton obligation during part of that year, the hospital shall adopt the standard the hospital used to meet the Hill-Burton obligation to determine eligibility under this subchapter.

(d) A public hospital established after September 1, 1985, shall provide health care services to each resident who meets the income and resources requirements established by the department under Sections 61.006 and 61.008, or the hospital may adopt a less restrictive income and resources standard. The hospital may adopt a less restrictive income and resources standard at any time.

(e) If because of a change in the income and resources requirements established by the department under Sections 61.006 and 61.008 the standard adopted by a public hospital or hospital district becomes stricter than the requirements established by the department, the hospital or hospital district shall change its standard to at least comply with the requirements established by the department.

(f) A public hospital or hospital district may contract with the department to perform eligibility determination services.

(g) A county that provides health care services to its eligible residents through a hospital established by a board of managers jointly appointed by a county and a municipality under Section 265.011 and that establishes an income and resources standard in accordance with Subsection (a)(2) may credit the services provided to all persons who are eligible under that standard toward eligibility for state assistance as described by Section 61.037(e).

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.
Amended by Acts 1999, 76th Leg., ch. 1377, Sec. 1.17, eff. Sept. 1, 1999.

Sec. 61.053. APPLICATION PROCEDURE. (a) A public hospital or hospital district shall adopt an application procedure.

(b) Not later than the beginning of a public hospital's or hospital district's operating year, the hospital or district shall specify the procedure it will use during the operating year to determine eligibility and the documentation required to support a request for assistance and shall make a reasonable effort to notify the public of the procedure.

(c) The public hospital or hospital district shall furnish an applicant with written application forms.

(d) On request of an applicant, the public hospital or hospital district shall assist an applicant in filling out forms and completing the application process. The hospital or district shall inform an applicant of the availability of assistance.

(e) The public hospital or hospital district shall require an applicant to sign a written statement in which the applicant swears to the truth of the information supplied.

(f) The public hospital or hospital district shall explain to the applicant that if the application is approved, the applicant must report to the hospital or district any change in income or resources that might affect the applicant's eligibility. The report must be made not later than the 14th day after the date on which the change occurs. The hospital or district shall explain the possible penalties for failure to report a change.

(g) The public hospital or hospital district shall review each application and shall accept or deny the application not later than the 14th day after the date on which the hospital or district receives the completed application.

(h) The public hospital or hospital district shall provide a procedure for reviewing applications and for allowing an applicant to appeal a denial of assistance.

(i) The public hospital or hospital district shall provide an applicant written notification of the hospital's or district's decision. If the hospital or district denies assistance, the written notification shall include the reason for the denial and an explanation of the procedure for appealing the denial.

(j) The public hospital or hospital district shall maintain the records relating to an application for at least three years after the date on which the application is submitted.

(k) If an applicant is denied assistance, the applicant may resubmit an application at any time circumstances justify a redetermination of eligibility.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.

Sec. 61.054. BASIC HEALTH CARE SERVICES PROVIDED BY A PUBLIC HOSPITAL. (a) Except as provided by Subsection (c), a public hospital shall endeavor to provide the basic health care services a county is required to provide under Section [61.028](#).

(b) If a public hospital provided additional health care services to eligible residents during the operating year that ended before January 1, 1985, the hospital shall continue to provide those services.

(c) A public hospital shall coordinate the delivery of basic health care services to eligible residents and may provide any basic health care services the hospital was not providing on January 1, 1999, but only to the extent the hospital is financially able to do so.

(d) A public hospital may provide health care services in addition to basic health care services.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.
Amended by Acts 1999, 76th Leg., ch. 1377, Sec. 1.18, eff. Sept. 1, 1999.

Sec. 61.055. BASIC HEALTH CARE SERVICES PROVIDED BY HOSPITAL DISTRICTS. (a) Except as provided by Subsection (b), a hospital district shall endeavor to provide the basic health care services a county is required to provide under Section [61.028](#), together with any other services required under the Texas Constitution and the statute creating the district.

(b) A hospital district shall coordinate the delivery of basic health care services to eligible residents and may provide any basic health care services the district was not providing on January 1, 1999, but only to the extent the district is financially able to do so.

(c) This section may not be construed to discharge a hospital district from its obligation to provide the health care services required under the Texas Constitution and the statute creating the district.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.
Amended by Acts 1999, 76th Leg., ch. 1377, Sec. 1.19, eff. Sept. 1, 1999.

Sec. 61.056. PROVISION OF HEALTH CARE SERVICES. (a) A public hospital or hospital district may arrange to provide health care services through a local health department, a publicly owned facility, or a contract with a private provider regardless of the provider's location, or through the purchase of insurance for eligible residents.

(b) The public hospital or hospital district may affiliate with other public hospitals or hospital districts or with a governmental entity to provide regional administration and delivery of health care services.

(c) A hospital district created in a county with a population of more than 800,000 that was not included in the boundaries of a hospital district before September 1, 2003, may affiliate with any public or private entity to provide regional administration and delivery of health care services. The regional affiliation, in accordance with the affiliation agreement, shall use money contributed by an affiliated governmental entity to provide health care services to an eligible resident of that governmental entity.

Text of subsection as added by Acts 2009, 81st Leg., R.S., Ch. 217 (S.B. 1063), Sec. 3

(d) A hospital district created in a county with a population of more than 800,000 that was not included in the boundaries of a hospital district before September 1, 2003, may provide or arrange to provide health care services for eligible residents through the purchase of health coverage or other health benefits, including benefits described by Chapter 75. For purposes of this subsection, the board of managers of the district has the powers and duties provided to the commissioners court of a county under Chapter 75.

Text of subsection as added by Acts 2009, 81st Leg., R.S., Ch. 916 (H.B. 2963), Sec. 3

(d) A public hospital or hospital district may provide or arrange to provide health care services for eligible residents through the purchase of health coverage or other health benefits, including benefits described by Chapter 75. For purposes of this subsection, the board of directors or managers of the hospital or district have the powers and duties provided to the commissioners court of a county under Chapter 75.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 164 (S.B. 1107), Sec. 3, eff. September 1, 2007.

Acts 2009, 81st Leg., R.S., Ch. 217 (S.B. 1063), Sec. 3, eff. May 27, 2009.

Acts 2009, 81st Leg., R.S., Ch. 916 (H.B. 2963), Sec. 3, eff. September 1, 2009.

Sec. 61.057. MANDATED PROVIDER. A public hospital may select one or more providers of health care services. A public hospital may require eligible residents to obtain care from a mandated provider except:

- (1) in an emergency;
- (2) when medically inappropriate; or
- (3) when care is not available.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.

Sec. 61.058. NOTIFICATION OF PROVISION OF NONEMERGENCY SERVICES. (a) A public hospital may require any provider, including a mandated provider, to obtain approval from the hospital before providing nonemergency health care services to an eligible resident in the hospital's service area.

(b) If the public hospital does not require prior approval and a provider delivers or will deliver nonemergency health care services to a patient who the provider suspects might be eligible for assistance under this subchapter, the provider shall notify the hospital that health care services have been or will be provided to the patient. The notice shall be made:

- (1) by telephone not later than the 72nd hour after the provider determines that the patient resides in the hospital's service area; and
- (2) by mail postmarked not later than the fifth working day after the date on which the provider determines that the patient resides in the hospital's service area.

(c) If the provider knows that the public hospital serving the area in which the patient resides has selected a mandated provider or if, after contacting the hospital, the hospital requests that the patient be transferred to a mandated provider, the provider shall transfer the patient to the mandated provider unless it is medically inappropriate to do so.

(d) Not later than the 14th day after the date on which the public hospital receives sufficient information to determine eligibility, the hospital shall determine if the patient is eligible for assistance from the hospital. If the hospital does not determine the patient's eligibility within that period, the patient is considered to be eligible. The hospital shall notify the provider of its decision.

(e) If a provider delivers nonemergency health care services to a patient who is eligible for assistance under this subchapter and fails to comply with this section, the provider is not eligible for payment for the services from the public hospital serving the area in which the patient resides.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.
Amended by Acts 1999, 76th Leg., ch. 1377, Sec. 1.20, eff. Sept. 1, 1999.

Sec. 61.059. NOTIFICATION OF PROVISION OF EMERGENCY SERVICES. (a) If a nonmandated provider delivers emergency services to a patient who the provider suspects might be eligible for assistance under this subchapter, the provider shall notify the hospital that emergency services have been or will be provided to the patient. The notice shall be made:

(1) by telephone not later than the 72nd hour after the provider determines that the patient resides in the hospital's service area; and

(2) by mail postmarked not later than the fifth working day after the date on which the provider determines that the patient resides in the hospital's service area.

(b) The provider shall attempt to determine if the patient resides in a public hospital's service area when the patient first receives services.

(c) The provider, the patient, and the patient's family shall cooperate with the public hospital in determining if the patient is an eligible resident of the hospital's service area.

(d) Not later than the 14th day after the date on which the public hospital receives sufficient information to determine eligibility, the hospital shall determine if the patient is eligible for assistance from the hospital. If the hospital does not determine the patient's eligibility within that period, the patient is considered to be eligible. The hospital shall notify the provider of its decision.

(e) If the public hospital and the provider disagree on the patient's residence or eligibility, the hospital or the provider may submit the matter to the department as provided by Section 61.004.

(f) If a provider delivers emergency services to a patient who is eligible for assistance under this subchapter and fails to comply with this section, the provider is not eligible for payment for the services from the public hospital serving the area in which the patient resides.

(g) If emergency services are customarily available at a facility operated by a public hospital, that hospital is not liable for emergency services furnished to an eligible resident by another provider in the area the hospital has a legal obligation to serve.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.
Amended by Acts 1999, 76th Leg., ch. 1377, Sec. 1.21, eff. Sept. 1, 1999; Acts 2001, 77th Leg., ch. 1128, Sec. 4, eff. Sept. 1, 2001.

Sec. 61.060. PAYMENT FOR SERVICES. (a) To the extent prescribed by this chapter, a public hospital is liable for health care services provided under this subchapter by any

provider, including another public hospital, to an eligible resident in the hospital's service area. A public hospital is not liable for payment for health care services provided to:

(1) a person who does not reside in the hospital's service area; or

(2) an eligible resident of the hospital's service area by a hospital having a Hill-Burton or state-mandated obligation to provide free services and considered to be in noncompliance with the requirements of the Hill-Burton or state-mandated obligation.

(b) A hospital district is liable for health care services as provided by the Texas Constitution and the statute creating the district.

(c) A public hospital is the payor of last resort under this subchapter and is not liable for payment or assistance to an eligible resident in the hospital's service area if any other public or private source of payment is available.

(d) If another source of payment does not adequately cover a health care service a public hospital provides to an eligible resident of the hospital's service area, the hospital shall pay for or provide the health care service for which other payment is not available.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.

Sec. 61.061. PAYMENT RATES AND LIMITS. The payment rates and limits prescribed by Sections 61.034 and 61.035 that relate to county services apply to inpatient and outpatient hospital services a public hospital is required to provide if:

(1) the hospital cannot provide the services or emergency services that are required; and

(2) the services are provided by an entity other than the hospital.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.

Sec. 61.062. RESPONSIBILITY OF GOVERNMENTAL ENTITY. A governmental entity that owns, operates, or leases a public hospital shall provide sufficient funding to the hospital to provide basic health care services.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.
Amended by Acts 1999, 76th Leg., ch. 1377, Sec. 1.22, eff. Sept. 1, 1999.

Sec. 61.063. PROCEDURE TO CHANGE ELIGIBILITY STANDARDS OR SERVICES PROVIDED. (a) A public hospital may not change its eligibility standards to make the standards more restrictive and may not reduce the health care services it offers unless it complies with the requirements of this section.

(b) Not later than the 90th day before the date on which a change would take effect, the public hospital must publish notice of the proposed change in a newspaper of general circulation in the hospital's service area and set a date for a public hearing on the change. The published notice must include the date, time, and place of the public meeting. The notice is in addition to the notice required by Chapter 551, Government Code.

(c) Not later than the 30th day before the date on which the change would take effect, the public hospital must conduct a public meeting to discuss the change. The meeting must be held at a convenient time in a convenient location in the hospital's service area. Members of the public may testify at the meeting.

(d) If, based on the public testimony and on other relevant information, the governing body of the hospital finds that the change would not have a detrimental effect on access to health care for the residents the hospital serves, the hospital may adopt the change. That finding must be formally adopted.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.
Amended by Acts 1995, 74th Leg., ch. 76, Sec. 5.95(82), eff. Sept. 1, 1995.

Sec. 61.064. TRANSFER OF A PUBLIC HOSPITAL. (a) A governmental entity that owns, operates, or leases a public hospital and that closes, sells, or leases the hospital:

(1) has the obligation to provide basic health care services under this chapter;

(2) shall adopt the eligibility standards that the hospital was or would have been required to adopt; and

(3) shall provide the same services the hospital was or would have been required to provide under this chapter on the date of the closing, sale, or lease.

(b) If the governmental entity owned, operated, or leased the public hospital before January 1, 1985, and sold or leased the hospital on or after that date but before September 1, 1986, the obligation retained is the obligation the hospital would have had on September 1, 1986.

(c) Notwithstanding Subsections (a) and (b), if a hospital district that owns, operates, or leases a public hospital dissolves, the district has no responsibility under this chapter. If on or before dissolution the district sold or transferred its hospital to another governmental entity, that governmental entity assumes the district's responsibility to provide health care services in accordance with this subchapter. If the district did not sell or transfer the hospital to another governmental entity, the county shall provide health care services to the residents of the district's service area in accordance with Subchapter B.

(d) This section does not apply to a governmental entity that sold or leased a public hospital to a hospital district or a hospital authority on or after January 1, 1985, but before September 1, 1986. If a governmental entity sold or leased a hospital as provided by this subsection, the hospital ceased being a public hospital for the purposes of this chapter on the date it was sold or leased, and neither the governmental entity

nor the hospital district or hospital authority has any responsibility under this chapter.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.
Amended by Acts 1999, 76th Leg., ch. 1377, Sec. 1.23, eff. Sept. 1, 1999.

Sec. 61.065. COUNTY RESPONSIBILITY FOR HOSPITAL SOLD ON OR AFTER JANUARY 1, 1988. (a) This section applies to a county that, on or after January 1, 1988, sells to a purchaser that is not a governmental entity a county hospital that was leased at the time of the sale to a person who is not a governmental entity.

(b) On the date the hospital is sold, the hospital ceases being a public hospital for the purposes of this chapter, and the county shall provide health care services to county residents in accordance with Subchapter B.

(c) If the contract for the sale of the hospital provides for the provision by the hospital of health care services to county residents, the value of the health care services credited or paid in a state fiscal year under the contract is included as part of the computation of a county expenditure under Section [61.037](#) to the extent that the value of the services does not exceed the payment standard established by department rule for allowed inpatient and outpatient services.

Added by Acts 1989, 71st Leg., ch. 1100, Sec. 5.10(c), eff. Sept. 1, 1989.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. [219](#)), Sec. 3.0187, eff. April 2, 2015.

Sec. 61.066. PREVENTION AND DETECTION OF FRAUD. (a) A hospital district may adopt reasonable procedures for minimizing the opportunity for fraud, for establishing and maintaining methods for detecting and identifying situations in which a

question of fraud may exist, and for administrative hearings to be conducted on disqualifying persons in cases where fraud appears to exist.

(b) Procedures established by a hospital district for administrative hearings conducted under this section shall provide for appropriate due process, including procedures for appeals.

(c) A hospital district may recover, from the eligible resident perpetrating a fraud, an amount equal to the value of any fraudulently obtained health care services provided to the eligible resident disqualified under this section.

Added by Acts 2001, 77th Leg., ch. 563, Sec. 1, eff. Aug. 27, 2001.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1320 (S.B. 303), Sec. 1, eff. September 1, 2011.

Sec. 61.067. LIEN BY NON-PROVIDER HOSPITAL DISTRICT. (a) This section applies to a hospital district that does not operate a hospital.

(b) After the hospital district pays the providing hospital for the actual cost of the service, the district may file a lien on a tort cause of action or claim of an eligible resident who receives health care services for injuries caused by an accident that is attributed to the negligence of another person.

(c) A person who applies for or receives health care services shall inform the hospital district, at the time of application or at any time during eligibility for services, of:

(1) any unsettled tort claim that may affect medical needs;

(2) any private accident or health insurance coverage that is or may become available; and

(3) any injury that is caused by the act or failure to act of some other person.

(d) An applicant or eligible resident shall inform the hospital district of information required by Subsection (c) within 30 days of the date the person learns of the person's insurance coverage, tort claim, or potential cause of action.

(e) A claim for damages for personal injury does not constitute grounds for denying or discontinuing services under this chapter.

(f)(1) A lien under this chapter attaches to:

(A) a tort cause of action for damages arising from an injury for which the injured eligible resident receives health care services;

(B) a judgment of a court in this state or the decision of a public agency in a proceeding brought by the eligible resident or by another person entitled to bring the suit in case of the death of the eligible resident to recover tort damages arising from an injury for which the eligible resident receives health care services; and

(C) the proceeds of a settlement of a tort cause of action or a tort claim by the eligible resident or another person entitled to make the claim, arising from an injury for which the eligible resident receives health care services.

(2) If the eligible resident has health insurance, the providing hospital is obligated to timely bill the applicable health insurer in accordance with Chapter 146, Civil Practice and Remedies Code.

(g) The lien does not attach to a claim under the workers' compensation law of this state, the Federal Employers' Liability Act, or the Federal Longshore and Harbor Workers' Compensation Act.

(h) A hospital district's lien established under Subsection (b) is for the amount actually paid by the hospital district for services provided to the eligible resident for health care services caused by an accident that is attributed to the negligence of another person.

(i) To secure the lien, a hospital district must file written notice of the lien with the county clerk of the county

in which the services were provided. The notice must be filed and indexed before money is paid by the third-party liability insurer. The notice must contain:

- (1) the injured individual's name and address;
- (2) the date of the accident;
- (3) the name and location of the hospital district claiming the lien; and
- (4) the name of the person alleged to be liable for damages arising from the injury, if known.

(j) The county clerk shall record the name of the injured individual, the date of the accident, and the name and address of the hospital district and shall index the record in the name of the injured individual.

(k) The procedures set forth in Sections 55.006 and 55.007, Property Code, for discharging and releasing the lien shall apply to liens filed under this section.

(l) Procedures established by a hospital district for administrative hearings under this section shall provide for appropriate due process, including procedures for appeals.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1320 (S.B. 303), Sec. 2, eff. September 1, 2011.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0188, eff. April 2, 2015.

Sec. 61.068. EMPLOYMENT SERVICES PROGRAM. (a) A public hospital or hospital district may establish procedures consistent with those used by the commission under Chapter 31, Human Resources Code, for administering an employment services program and requiring an applicant or eligible resident to register for work with the Texas Workforce Commission.

(b) The public hospital or hospital district shall notify each person with a pending application and all eligible residents of the requirements of the employment services program not less than 30 days before the program is established.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1206 (S.B. 304), Sec. 1, eff. June 17, 2011.

Redesignated from Health and Safety Code, Section 61.067 by Acts 2013, 83rd Leg., R.S., Ch. 161 (S.B. 1093), Sec. 22.001(24), eff. September 1, 2013.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0189, eff. April 2, 2015.

Health and Human Services Commission

County Indigent Health Care Program

HANDBOOK

**HEALTH AND HUMAN SERVICES COMMISSION (HHSC)
COUNTY INDIGENT HEALTH CARE PROGRAM HANDBOOK**

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CHAPTER 61, HEALTH AND SAFETY CODE may be accessed at

http://www.dshs.state.tx.us/cihcp/cihcp_info.shtm

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TECHNICAL ASSISTANCE

The County Indigent Health Care may be contacted at:

Health and Human Services Commission
Health, Developmental, & Independence
Services Department (HDIS)
Indigent Health Care Program MC- 2831
P.O. Box 149347
Austin, Texas 78714-9347
Main Phone: (512) 776-**6467**
Fax: (512) 776-7203

www.dshs.state.tx.us/cihcp

E-mail policy questions to:

IHCNET@dshs.state.tx.us

E-mail Forms 105 & 300 and State
Assistance questions to :

CIHCP@dshs.state.tx.us

E-mail Billing and TMHP questions to:

cihcpbilling@dshs.state.tx.us

Individual staff members can be contacted at (512) 776-6467.

Vacant, Program Manager

Ms. Mary Kathryn Zambrano, Program Specialist III

(Program Policy, TMHP Liaison)

Phone: (512) 776-6467

E-mail: MaryKathryn.Zambrano@hhsc.state.tx.us

Mr. Taran Champagne, Program Specialist III

(Data, State Assistance Fund, Pharmacy Reimbursements)

Phone: (512) 776-6631

Email: Taran.Champagne@hhsc.state.tx.us

Ms. Liz Gregg, Program Specialist III

(Medicaid Reimbursements, TMHP Liaison)

Phone: (512) 776-2105

E-mail: Liz.Gregg@hhsc.state.tx.us

SECTION ONE

PROGRAM ADMINISTRATION

Introduction

Chapter 61, Health and Safety Code

A law passed by the First Called Special Session of the 69th Legislature in 1985 that:

- Defines who is indigent,
- Assigns responsibilities for indigent health care,
- Identifies health care services eligible people can receive, and
- Establishes a state assistance fund to match expenditures for counties that exceed certain spending levels and meet state requirements.

Chapter 61, Health and Safety Code, is intended to ensure that needy Texas residents, who do not qualify for other state or federal health care assistance programs, receive health care services.

Chapter 61, Health and Safety Code, may be accessed at:

http://www.dshs.state.tx.us/cihcp/cihcp_info.shtm

CIHCP Rules

The Texas Administrative Code (TAC) is the compilation of all state agency rules in Texas.

The County Indigent Health Care Program (CIHCP) rules are in: TAC, Title 25 (Health Services), Part 1 (TDSHS), Chapter 14 (CIHCP), and the following Subchapters:

- A - Program Administration
- B - Determining Eligibility
- C - Providing Services

The CIHCP rules may be accessed at:

http://www.dshs.state.tx.us/cihcp/cihcp_info.shtm

CIHCP Handbook

The purpose of the CIHCP Handbook is to:

- Establish the eligibility standards and application, documentation, and verification procedures for counties,
 - Define basic and department-established optional health care services,
 - Establish the payment standards for basic and department-established optional health care services, and
 - Outline the procedures for administering the state assistance fund.
-

Introduction (continued)

**County
Responsibility**

A county not fully served by a public facility must:

- Administer a County Indigent Health Care Program,
- Provide basic health care services to eligible county residents who do not live in a county area served by a public facility,
- Follow either the policies and procedures described in this handbook or less restrictive policies and procedures,
- Establish procedures for administrative hearings that provide for appropriate due process, including procedures for appeals requested by households that are denied,
- Adopt reasonable procedures
 - o For minimizing the opportunity for fraud,
 - o For establishing and maintaining methods for detecting and identifying situations in which a question of fraud may exist, and
 - o For administrative hearings to be conducted on disqualifying persons in cases where fraud appears to exist, and
- Maintain the records relating to an application at least until the end of the third complete state fiscal year following the date on which the application is submitted.

Public Notice. Not later than the beginning of the state fiscal year (September 1), a county not covered by a public facility shall specify the procedure it will use during that fiscal year to verify eligibility and the documentation required to support a request for assistance and make reasonable effort to notify the public of the application procedure.

**Public Hospital
and Hospital
District**

Public Notice. Not later than the beginning of a public hospital's or hospital district's operating year the hospital or district shall specify the procedure it will use during the operating year to determine eligibility and the documentation required to support a request for assistance and shall make a reasonable effort to notify the public of the procedure.

Options

- A county not fully served by a public facility may file for Texas Medicaid reimbursement through the local provider or through HHSC for eligible SSI appellant CIHCP recipients who become eligible for retroactive Medicaid. For instructions regarding the filing process through HHSC, request the "CIHCP Medicaid Reimbursement Manual."
-

Introduction (continued)

Options
(continued)

- An entity that chooses to establish an optional work registration procedure may contact its local Texas Workforce Commission (TWC) office to determine how to establish the county's procedure and to negotiate what type of information can be provided. In addition, a county must follow the guidelines below.
 - 1.) Notify all eligible residents and those with pending applications of the program requirements at least 30 days before the program begins.
 - 2.) Allow an exemption from work registration if applicants or eligible residents meet one of the following criteria:
 - o Receive food stamp benefits,
 - o Receive unemployment insurance benefits or have applied but not yet been notified of eligibility,
 - o Physically or mentally unfit for employment,
 - o Undocumented alien,
 - o Distance prohibits walking or transportation is not available,
 - o Commuting time (not including taking a child to and from a childcare facility) is greater than two hours a day,
 - o Age 15 or younger,
 - o Age 16 or 17 and not the head of household,
 - o Age 16 17, or 18 and attending school, including home school, or on employment training program on at least a half-time basis,
 - o Age 60 or older,
 - o 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,
 - o Employed or self-employed at least 30 hours per week,
 - o Receive earnings equal to 30 hours per week multiplied by the federal minimum wage,
 - o Migrant in the mainstream,
 - o A regular participant or outpatient in a drug addiction or alcoholic treatment and rehabilitation program, or
 - o Three to nine months pregnant.
 - 3.) If a non-exempt applicant or CIHCP eligible resident fails without good cause to comply with work registration requirements, disqualify him from CIHCP benefits as follows:
 - o For one month or until he agrees to comply, whichever is later, for the first non-compliance;
 - o For three consecutive months or until he agrees to comply, whichever is later, for the second non-compliance; or
 - o For six consecutive months or until he agrees to comply, whichever is later, for the third or subsequent non-compliance.
-

Definitions

Approval Date The date that Form 109, Notice of Eligibility, is issued to the household.

Claim HCFA-1500, **UB-04**, or pharmacy statement.

**Claim
Pay Date** The date that the county writes a check to pay a claim.

**Complete
Application** A complete application includes:

- Application for Health Care Assistance, Form 100, and
 - o The applicant's full name and address,
 - o The applicant's county of residence,
 - o The names of everyone who lives in the house with the applicant and their relationship to the applicant,
 - o The type and value of the CIHCP household's resources,
 - o The CIHCP household's monthly gross income,
 - o Information about any health care assistance that household members may receive,
 - o The applicant's Social Security number, if available,
 - o The applicant's/spouse's signature with the date the Form 100 is signed, and

- All needed information, such as verifications.

The date that the Form 100 and all information necessary to make an eligibility determination is received is the **application completion date**.

County

- A county not fully served by a public facility, namely, a public hospital or a hospital district; or
- A county that provides indigent health care services to its eligible residents through a hospital established by a board of managers jointly appointed by a county and a municipality.

Definitions (continued)

Days	All days are calendar days, except as specifically identified as workdays.
Denial Date	The date that Form 117, Notice of Ineligibility, is issued to the household.
Disqualified Member	A person receiving or is categorically eligible to receive Medicaid.
Eligibility Effective Date	The date that a household's eligibility begins.
Eligibility End Date	The date that a household's eligibility ends.
Expenditure	Funds spent on basic or department-established optional health care services.
Expenditure Tracking	A county should track monthly basic and department-established optional health care expenditures.
Governmental Entity	A county, municipality, or other political subdivision of the state, excluding a hospital district or hospital authority.
GRTL	The county's General Revenue Tax Levy (GRTL) is used to determine eligibility for state assistance funds. For information on determining and reporting the GRTL, contact Liz Alvarado, Property Tax Division of the Texas State Comptroller of Public Accounts at 512-475-1826 .
HHSC	The Texas Health and Human Services Commission.
Hospital Authority	<p>A hospital authority created under</p> <ul style="list-style-type: none">• Article 4437E, Sec. 3, City-created Hospital Authorities, or• Article 4494R, Sec. 3, County-created Hospital Authorities. <p>Hospital authorities have no obligation under Chapter 61, Health and Safety Code, to provide indigent health care assistance.</p>

Definitions (continued)

Hospital District	A hospital district created under the authority of the Texas Constitution Article IX, Sections 4 – 11.
Identifiable Application	An application is identifiable if it includes: the applicant's name, the applicant's address, the applicant's signature, and the date the applicant signed the application.
Mandated Provider	A health care provider, selected by the county, who agrees to provide health care services to eligible residents.
Medicaid	The Texas state-paid insurance program for recipients of Supplemental Security Income (SSI), Temporary Assistance for Needy Families (TANF), and health care assistance programs for families and children.
Optional Services	Department-established optional health care services that a county may choose to provide.
Public Facility	<ul style="list-style-type: none">• A public hospital or• A hospital owned, operated, or leased by a hospital district.
Public Hospital	A hospital owned, operated, or leased by a county, city, town, or other political subdivision of the state, excluding a hospital district and a hospital authority. For additional information, refer to Chapter 61, Health and Safety Code, Subchapter C.
Reimbursable Expenditure	A health care expenditure that may be applied to state assistance funds eligibility/reimbursement and that is for a service provided to a person who is eligible under a monthly net income standard that is at least 21% of the Federal Poverty Guideline (FPG) or up to 50% of the FPG. For additional information, refer to Section 5, State Assistance Funds.
Service Area	The geographic region in which a governmental entity, public hospital, or hospital district has a legal obligation to provide health care services.
State Fiscal Year	The twelve-month period beginning September 1 of each calendar year and ending August 31 of the following calendar year.

SECTION TWO

ELIGIBILITY CRITERIA

Residence

General Principles

-
- A person must live in the Texas county in which he applies. There is no durational requirement for residency.
 - An inmate of a county correctional facility, who is a resident of another Texas county, would not be required to apply for assistance to their county of residence. They may apply for assistance to the county of where they are incarcerated.
 - A person lives in the county if the person's home or fixed place of habitation is located in the county and he intends to return to the county after any temporary absences.
 - A person with no fixed residence or a new resident in the county who declares intent to remain in the county is also considered a county resident.
 - A person does not lose his residency status because of a temporary absence from the county. No time limits are placed on a person's absence from the county.
 - A person cannot qualify for CIHCP from more than one county simultaneously.
 - Persons Not Considered Residents:
 - o An inmate or resident of a state school or institution operated by any state agency,
 - o An inmate, patient, or resident of a school or institution operated by a federal agency,
 - o A minor student primarily supported by his parents whose home residence is in another county or state, and
 - o A person who moved into the county solely for the purpose of obtaining health care assistance.

Verifying Residence

Residency may be verified, if it is questionable.

Proof may include but is not limited to:

- Mail addressed to the applicant, his spouse, or children,
- Texas driver's license or other official identification,
- Rent, mortgage payment, or utility receipt,
- Property tax receipt,
- Voting record,
- School enrollment records, and
- Statement from a landlord, a neighbor, or other reliable source.

Documenting Residence

On Form 101, Worksheet, document why information regarding residence is questionable and how questionable residence is verified.

Household

General Principles

- A CIHCP household is a person living alone or two or more persons living together where legal responsibility for support exists, excluding disqualified persons.
 - Legal responsibility for support exists between:
 - o Persons who are legally married, (including common-law marriage)
 - o A legal parent and a minor child, (including unborn children), or
 - o A managing conservator and a minor child.
 - Medicaid is the only program that disqualifies a person from the County Indigent Health Care Program.
-

Definitions

Adult – a person at least age 18 or a younger person who is or has been married or had the disabilities of minority removed for general purposes.

Common Law Marriage – relationship in which the parties age 18 or older are free to marry, live together, and hold out to the public that they are **spouses**.

A minor child in Texas is not legally allowed to enter a common law marriage unless the claim of common law marriage began before September 1, 1997.

Emancipated Minor – a person under age 18 who has been married. The marriage must not have been annulled.

Managing Conservator – a person designated by a court to have daily responsibility for a child.

Married Minor – an individual, age 14-17, who is married. These individuals must have parental consent or court permission. An individual under age 18 may not be a party to an informal (common law) marriage.

Minor Child – a person under age 18 who is not or has not been married and has not had the disabilities of minority removed for general purposes

Household

CIHCP Household

The CIHCP household is a person living alone or two or more persons living together where legal responsibility for support exists, excluding disqualified persons.

Disqualified Persons

- A person who receives or is categorically eligible to receive Medicaid,
- A person who receives TANF benefits,
- A person who receives SSI benefits,
- A person who receives Qualified Medicare Beneficiary (QMB), Medicaid Qualified Medicare Beneficiary (MQMB), Specified Low-Income Medicare Beneficiary (SLMB), Qualified Individual-1 (QI-1); or Qualified Disabled and Working Individuals (QDWI), and
- A Medicaid recipient who partially exhausts some component of his Medicaid benefits.

A disqualified person is not a CIHCP household member regardless of his legal responsibility for support.

CIHCP One-Person Household

- A person living alone,
- An adult living with others who are not legally responsible for the adult's support,
- A minor child living alone or with others who are not legally responsible for the child's support,
- A Medicaid-ineligible spouse,
- A Medicaid-ineligible parent whose spouse and/or minor children are Medicaid-eligible,
- A Medicaid-ineligible foster child, and
- An inmate in a county jail.

CIHCP Group Households – two or more persons who are living together and meet one of the following descriptions:

- Two persons legally married to each other,
- One or both legal parents and their legal minor children,
- A managing conservator and a minor child and the conservator's spouse and other legal minor children, if any,
- Minor children, including unborn children, who are siblings, and
- Both Medicaid-ineligible parents of Medicaid-eligible children.

Household

**Screening
Tools**

- Your Texas Benefits screens for potential eligibility for Medicaid and other programs provided by Texas state agencies. Your Texas Benefits may be accessed at:

<https://www.yourtexasbenefits.com>

- The Benefit Eligibility Screening Tool (BEST) screens for potential eligibility for benefits from any of the programs that Social Security administers. BEST may be accessed at:

<http://www.benefits.gov/ssa>

**Verifying
Household**

Verify household, if questionable.

Proof may include but is not limited to:

- Lease agreement or
 - Statement from a landlord, a neighbor, or other reliable source
-

**Documenting
Household**

On Form 101, Worksheet, document why information regarding household is questionable and how questionable household is verified

Resources

General Principles

- A household must pursue all resources to which the household is legally entitled unless it is unreasonable to pursue the resource. Reasonable time (at least three months) must be allowed for the household to pursue the resource, which is not considered accessible during this time.
- The resources of all CIHCP household members are considered.
- Resources are either countable or exempt.
- Resources from disqualified and non-household members are excluded, but may be included if processing an application for a sponsored alien.
- A household is not eligible if the total countable household resources exceed
 - o \$3,000.00 when a person living in the home is aged or has disabilities and they meet relationship requirements
 - o \$2,000.00 for all other households.
- A household is not eligible if their total countable resources exceed the limit on or after the first interview date or the process date for cases processed without an interview.
- In determining eligibility for a prior month, the household is not eligible if their total countable resources exceed the limit anytime during the prior month.
- Consider a joint bank account with a nonmember as inaccessible if the money in the account is used solely for the nonmember's benefit. The CIHCP household must provide verification that the bank account is used solely for the nonmember's benefit and that no CIHCP household member uses the money in the account for their benefit. If a household member uses any of the money for their benefit or if any household member's money is also in the account, consider the bank account accessible to the household.

Definitions

Accessible resources – resources legally available to the household.

Aged person – someone age 60 or older as of the last day of the month for which benefits are being requested.

Alien Sponsor – a person who signed an affidavit of support (namely, INS Form I-864 or I-864-A) on or after December 19, 1997, agreeing to support an alien as a condition of the alien's entry into the United States

Resources

Definitions (continued)

Assets – all items of monetary value owned by an individual.

Equity – the amount of money that would be available to the owner after the sale of a resource. Determine this amount by subtracting from the fair market value any money owed on the item and the costs normally associated with the sale and transfer of the item.

Fair market value – the amount a resource would bring if sold on the current local market.

Inaccessible resources – resources not legally available to the household. Examples include but are not limited to: irrevocable trust funds, property in probate, security deposits on rental property and utilities.

Person with disabilities – someone who is physically or mentally unfit for employment.

Personal possessions – appliances, clothing, farm equipment, furniture, jewelry, livestock, and other items if the household uses them to meet personal needs essential for daily living.

Real property – land and any improvements on it.

Reimbursement – repayment for a specific item or service.

Relative – a person who has one of the following relationships biologically or by adoption:

- Mother or father,
- Child, grandchild, stepchild,
- Grandmother or grandfather,
- Sister or brother,
- Aunt or uncle,
- Niece or nephew,
- First cousin,
- First cousin once removed, and
- Stepmother or stepfather.

Relationship also extends to:

- The spouse of the relatives listed above, even after the marriage is terminated by death or divorce,
- The degree of great-great aunt/uncle and niece/nephew, &
- The degree of great-great-great grandmother/grandfather

Resources

Definitions (continued)

Resources – both liquid and non-liquid assets a person can convert to meet his needs. Examples include but are not limited to: bank accounts, boats, bonds, campers, cash, certificates of deposit, gas rights, livestock (unless the livestock is used to meet personal needs essential for daily living), mineral rights, notes, oil rights, real estate (including buildings and land, other than a homestead), stocks, and vehicles.

Sponsored Alien – a sponsored alien means a person who has been lawfully admitted to the United States for permanent residence under the Immigration and Nationality Act (8 U.S.C. Section 1101 et seq.) and who, as a condition of admission, was sponsored by a person who executed an affidavit of support on behalf of the person.

Resources

Alien Sponsor's Resources

If an entity chooses to include the resources of a person who executed an affidavit of support on behalf of a sponsored alien and the resources of the person's spouse, the entity shall adopt written procedures for processing the resources of the sponsor and the sponsor's spouse.

Bank Accounts

Count the cash value of checking and savings accounts unless exempt for another reason.

Burial Insurance (Prepaid)

Exempt up to \$7,500 cash value of a prepaid burial insurance policy, funeral plan, or funeral agreement for each certified household member.

Count the cash value exceeding \$7,500 as a liquid resource.

Burial Plots

Exempt all burial plots.

Crime Victim's Compensation Payments

Exempt.

Energy Assistance Payments

Exempt payments or allowances made under any federal law for the purpose of energy assistance.

Exemption: Resources / Income Payments

If a payment or benefit counts as income for a particular month, do not count it as a resource in the same month. If you prorate a payment as income over several months, do not count any portion of the payment as a resource during that time.

If the client combines this money with countable funds, such as a bank account, exempt the prorated amounts for the time you prorate it.

Resources

Homestead

Exempt the household's usual residence and surrounding property not separated by property owned by others. The exemption remains in effect if public rights of way, such as roads, separate the surrounding property from the home. The homestead exemption applies to any structure the person uses as a primary residence, including additional buildings on contiguous land, a houseboat, or a motor home, as long as the household lives in it. If the household does not live in the structure, count it as a resource.

Houseboats and Motor Homes. Count houseboats and motor homes according to vehicle policy, if not considered the household's primary residence or otherwise exempt.

Own or Purchasing a Lot. For households that currently do not own a home, but own or are purchasing a lot on which they intend to build, exempt the lot and partially-completed home.

Real Property Outside of Texas. Households cannot claim real property outside of Texas as a homestead, except for migrant and itinerant workers who meet the residence requirements.

Homestead Temporarily Unoccupied. Exempt a homestead temporarily unoccupied because of employment, training for future employment, illness (including health care treatment), casualty (fire, flood, state of disrepair, etc.), or natural disaster, if the household intends to return.

Sale of a Homestead. Count money remaining from the sale of a homestead as a resource.

Income-Producing Property

Exempt property that:

- Is essential to a household member's employment or self-employment (examples: tools of a trade, farm machinery, stock and inventory). Continue to exempt this property during temporary periods of unemployment if the household member expects to return to work;
- Annually produces income consistent with its fair market value, even if used only on a seasonal basis; or
- Is necessary for the maintenance or use of a vehicle that is exempt as income-producing or as necessary for transporting a physically disabled household member. Exempt the portion of the property used for this purpose.

For farmers or fishermen, continue to exempt the value of the land or equipment for one year from the date that the self-employment ceases.

Resources

Insurance Settlement

Count, minus any amount spent or intended to be spent for the household's bills for burial, health care, or damaged/lost possessions.

Lawsuit Settlement

Count, minus any amount spent or intended to be spent for the household's bills for burial, legal expenses, health care expenses, or damaged/lost possessions.

Life Insurance

Exempt the cash value of life insurance policies.

Liquid Resources

Count, if readily available. Examples include but are not limited to: cash, checking accounts, savings accounts, certificates of deposit (CDs), notes, bonds, and stocks.

Loans (Non-Educational)

Exempt these loans from resources.

Consider financial assistance as a loan if there is an understanding that the loan will be repaid and the person can reasonably explain how he will repay it.

Count assistance not considered a loan as unearned income (contribution).

Lump-Sum Payments

Count lump-sum payments received once a year or less frequently as resources in the month received, unless specifically exempt.

Countable lump-sum payments include, but are not limited to, retroactive lump-sum RSDI, public assistance, retirement benefits, lump-sum insurance settlements, refunds of security deposits on rental property or utilities, and lump-sum payments on child support.

Effective January 1, 2013 exempt federal tax refunds permanently as income and resources for 12 months after receipt. Exempt the Earned Income Credit (EIC) for a period of 12 months after receipt through December 31, 2018.

Count lump-sum payments received or anticipated to be received more often than once a year as unearned income in the month received.

Exception: Count contributions, gifts, and prizes as unearned income in the month received, regardless of the frequency of receipt.

Personal Possessions

Exempt.

Resources

Real Property

Count the equity value of real property unless it is otherwise exempt.

Exempt any portion of real property directly related to the maintenance or use of a vehicle necessary for employment or to transport a physically disabled household member. Count the equity value of any remaining portion unless it is otherwise exempt.

Good Faith Effort to Sell. Exempt real property if the household is making a good effort to sell it.

Jointly-Owned Property. Exempt property jointly owned by the household and other individuals not applying for or receiving benefits if the household provides proof that he cannot sell or divide the property without consent of the other owners and the other owners will not sell or divide the property

Reimbursement

Exempt a reimbursement in the month received. Count as a resource in the month after receipt.

Exempt a reimbursement earmarked and used for replacing and repairing an exempt resource. Exempt the reimbursement indefinitely.

Retirement Accounts

A retirement account is one in which an employee and/or his employer contribute money for retirement. There are several types of retirement plans.

Some of the most common plans authorized under Section 401 (a) of the Internal Revenue Services (IRS) Code are the 401 (k) plan, Keogh, Roth Individual Retirement Account (IRA), and a pension or traditional benefit plan. Common plans under Section 408 of the IRS Code are the IRA, Simple IRA and Simplified Employer Plan.

A pension or traditional defined benefit plan is employed based and promises a certain benefit upon retirement regardless or investment performance.

(Retirement Accounts continued on next page)

Resources

**Retirement
Accounts**
(continued)

Exclude all retirement accounts or plans established under:

- Internal Revenue Code of 1986, Sections 401(a), 403(a), 403(b), 408, 408A, 457(b), 501(c)(18);
- Federal Thrift Savings Plan, Section 8439, Title 5, United States Code; and
- Other retirement accounts determined to be tax exempt under the Internal Revenue Code of 1986.

Count any other retirement accounts not established under plans or codes listed above.

Trust Fund

Exempt a trust fund if all of the following conditions are met:

- The trust arrangement is unlikely to end during the certification period; and
 - No household member can revoke the trust agreement or change the name of the beneficiary during the certification period; and
 - The trustee of the fund is either a
 - Court, institution, corporation, or organization not under the direction or ownership of a household member; or
 - Court-appointed individual who has court-imposed limitations placed on the use of the funds; and
 - The trust investments do not directly involve or help any business or corporation under the control, direction, or influence of a household member. Exempt trust funds established from the household's own funds if the trustee uses the funds
 - Only to make investments on behalf of the trust or
 - To pay the education or health care expenses of the beneficiary.
-

Vehicles

Exempt a vehicle necessary to transport physically disabled household members, even if disqualified and regardless of the purpose of the trip.

Exempt no more than one vehicle for each disabled member. There is no requirement that the vehicle be used primarily for the disabled person.

Resources

Vehicles
(continued)

Exempt vehicles if the equity value is less than \$4,650, regardless of the number of vehicles owned by the household. Count the value in excess of \$4,650 toward the household's resource limit. **Examples listed below:**

<table style="width: 100%; border-collapse: collapse;"> <tr><td style="text-align: right;">\$15,000</td><td>(FMV)</td></tr> <tr><td style="text-align: right;">- 12,450</td><td>(Amount still owed)</td></tr> <tr><td style="text-align: right; border-top: 1px solid black;">\$ 2,550</td><td>(Equity Value)</td></tr> <tr><td style="text-align: right;">- 4,650</td><td></td></tr> <tr><td style="text-align: right; border-top: 1px solid black;">\$ 0</td><td>(Countable resource)</td></tr> </table>	\$15,000	(FMV)	- 12,450	(Amount still owed)	\$ 2,550	(Equity Value)	- 4,650		\$ 0	(Countable resource)		<table style="width: 100%; border-collapse: collapse;"> <tr><td style="text-align: right;">\$ 9,000</td><td>(FMV)</td></tr> <tr><td style="text-align: right;">- 0</td><td>(Amount still owed)</td></tr> <tr><td style="text-align: right; border-top: 1px solid black;">\$ 9,000</td><td>(Equity Value)</td></tr> <tr><td style="text-align: right;">- 4,650</td><td></td></tr> <tr><td style="text-align: right; border-top: 1px solid black;">\$ 4,350</td><td>(Countable resource)</td></tr> </table>	\$ 9,000	(FMV)	- 0	(Amount still owed)	\$ 9,000	(Equity Value)	- 4,650		\$ 4,350	(Countable resource)
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- 0	(Amount still owed)																					
\$ 9,000	(Equity Value)																					
- 4,650																						
\$ 4,350	(Countable resource)																					

Income-producing Vehicles. Exempt the total value of all licensed vehicles used for income-producing purposes. This exemption remains in effect when the vehicle is temporarily not in use. A vehicle is considered income-producing if it:

- Is used as a taxi, a farm truck, or fishing boat,
- Is used to make deliveries as part of the person's employment,
- Is used to make calls on clients or customers,
- Is required by the terms of employment, or
- Produces income consistent with its fair market value.

Solely-Owned Vehicles. A vehicle, whose title is solely in one person's name, is considered an accessible resource for that person. This includes the following situations:

- Consider vehicles involved in community property issues to belong to the person whose name is on the title.
- If a vehicle is solely in the household member's name and the household member claims he purchased it for someone else, the vehicle is considered as accessible to the household member.

Exceptions: The vehicle is inaccessible if the title holder verifies:

- That he sold the vehicle but has not transferred the title. In this situation, the vehicle belongs to the buyer. Note: Count any payments made by the buyer to the household member or the household member's creditors (directly) as self-employment income.
- That he sold the vehicle but the buyer has not transferred the title into the buyer's name.
- That the vehicle was repossessed.
- That the vehicle was stolen.
- That he filed for bankruptcy (Title 7, 11, or 13) and that the household member is not claiming the vehicle as exempt from the bankruptcy. Note: In most bankruptcy petitions, the court will allow each adult individual to keep one vehicle as exempt for the bankruptcy estate. This vehicle is a countable resource

Resources

Vehicles (continued)

A vehicle is accessible to a household member even though the title is not in the household member's name if the household member purchases or is purchasing the vehicle from the person who is the title holder or if the household member is legally entitled to the vehicle through an inheritance or divorce settlement.

Jointly-Owned Vehicles. Consider vehicles jointly-owned with another person not applying for or receiving benefits as inaccessible if the other owner is not willing to sell the vehicle.

Leased Vehicles. When a person leases a vehicle, they are not generally considered the owner of the vehicle because the

- Vehicle does not have any equity value,
- Person cannot sell the vehicle, and
- Title remains in the leasing company's name.

Exempt a leased vehicle until the person exercises his option to purchase the vehicle. Once the person becomes the owner of the vehicle, count it as a resource. The person is the owner of the vehicle if the title is in their name, even if the person and the dealer refer to the vehicle as leased. Count the vehicle as a resource.

How To Determine Fair Market Value of Vehicles.

- Determine the current fair market value of licensed vehicles using the average trade-in or wholesale value listed on a reputable automotive buying resource website (i. e., National Automobile Dealers Association (NADA), Edmunds, or Kelley Blue Book). **Note:** If the household claims that the listed value does not apply because the vehicle is in less-than-average condition, allow the household to provide proof of the true value from a reliable source, such as a bank loan officer or a local licensed car dealer.
- Do not increase the basic value because of low mileage, optional equipment, or special equipment for the handicapped.
- Accept the household's estimate of the value of a vehicle no longer listed on an automotive buying resource website unless it is questionable and would affect the household's eligibility. In this case, the household must provide an appraisal from a licensed car dealer or other evidence of the vehicle's value, such as a tax assessment or a newspaper advertisement indicating the sale value of similar vehicles.

Determine the value of new vehicles not listed on an automotive buying resource website by asking the household to provide an estimate of the average trade-in or wholesale value from a new car dealer or a bank loan officer. If this cannot be done, accept the household's estimate unless it is questionable and would affect eligibility. Use loan value only if other sources are unavailable. Request proof of the value of licensed antique, custom made, or classic vehicles from the household.

Resources

Penalty for Transferring Resources

A household is ineligible if, within three months before application or any time after certification, they transfer a countable resource for less than its fair market value to qualify for county health care assistance.

This penalty applies if the total of the transferred resource added to other resources affects eligibility.

Base the length of denial on the amount by which the transferred resource exceeds the resource maximum when added to other countable resources.

Use the chart below to determine the length of denial.

Amount in Excess of Resource Limit	Denial Period
\$.01 to \$ 249.99	1 month
\$ 250.00 to \$ 999.99	3 months
\$1,000.00 to \$2,999.99	6 months
\$3,000.00 to \$4,999.99	9 months
\$5,000.00 to \$5,000.00 and more	12 months

If spouses separate and one spouse transfers his property, it does not affect the eligibility of the other spouse.

Verifying Resources

Verify countable resources.

Proof may include but is not limited to:

- Bank account statements and
- Award letters.

Documenting Resources

On Form 101, Worksheet, document whether a resource is countable or exempt and why resources are verified.

Income

General Principles

- A household must pursue and accept all income to which the household is legally entitled, unless it is unreasonable to pursue the income. Reasonable time (at least three months) must be allowed for the household to pursue the income, which is not considered accessible during this time.
 - The income of all CIHCP household members is considered.
 - Income is either countable or exempt.
 - If attempts to verify income are unsuccessful because the payer fails or refuses to provide information and other proof is not available, the household's statement is used as best available information.
 - Income of disqualified and non-household members is excluded, but may be included if processing an application for a sponsored alien.
-

Definitions

Alien Sponsor – a person who signed an affidavit of support (namely, INS Form I-864 or I-864-A) on or after December 19, 1997, agreeing to support an alien as a condition of the alien's entry into the United States.

Budgeting – the method used to determine eligibility by calculating income and deductions using the best estimate of the household's current and future circumstances and income.

Earned income – income a person receives for a certain degree of activity or work. Earned income is related to employment and, therefore, entitles the person to work-related deductions not allowed for unearned income.

Gross income – income before deductions.

Income – any type of payment that is of gain or benefit to a household.

Net income – gross income minus allowable deductions.

Real Property – land and any improvements on it.

Sponsored Alien – a sponsored alien means a person who has been lawfully admitted to the United States for permanent residence under the Immigration and Nationality Act (8 U.S.C. Section 1101 et seq.) and who, as a condition of admission, was sponsored by a person who executed an affidavit of support on behalf of the person.

Income

Definitions
(continued)

Tip Income –income earned in addition to wages that is paid by patrons to people employed in service-related occupations, such as beauticians, waiters, valets, pizza delivery staff, etc.

Unearned income – payments received without performing work-related activities.

Adoption Payments

Exempt.

Alien Sponsor's Income

If an entity chooses to include the income of a person who executed an affidavit of support on behalf of a sponsored alien and the income of the person's spouse, the entity shall adopt written procedures for processing the income of the sponsor and the sponsor's spouse.

Cash Gifts and Contributions

Count as unearned income unless they are made by a private, nonprofit organization on the basis of need; and total \$300 or less per household in a federal fiscal quarter. The federal fiscal quarters are January - March, April - June, July - September, and October-December. If these contributions exceed \$300 in a quarter, count the excess amount as income in the month received.

Exempt any cash contribution for common household expenses, such as food, rent, utilities, and items for home maintenance, if it is received from a non-certified household member who:

- Lives in the home with the certified household member,
- Shares household expenses with the certified household member, and
- No landlord/tenant relationship exists.

If a noncertified household member makes additional payments for use by a certified member, it is a contribution.

Income

Child's Earned Income

Exempt a child's earned income if the child, who is under age 18 and not an emancipated minor, is a full-time student (including a home schooled child) or a part-time student employed less than 30 hours a week.

Child Support Payments

Exempt.

Crime Victim's Compensation Payments

Exempt.

These are payments from the funds authorized by state legislation to assist a person who has been a victim of a violent crime; was the spouse, parent, sibling, or adult child of a victim who died as a result of a violent crime; or is the guardian of a victim of a violent crime. The payments are distributed by the Office of the Attorney General in monthly payments or in a lump sum.

Income

Disability Insurance Payments

Count disability payments as unearned income, including Social Security Disability Insurance (SSDI) payments and disability insurance payments issued for non-medical expenses. Exception: Exempt Supplemental Security Income (SSI) payments

Dividends and Royalties

Count dividends as unearned income. Exception: Exempt dividends from insurance policies as income.

Count royalties as unearned income, minus any amount deducted for production expenses and severance taxes.

Educational Assistance

Exempt educational assistance, including educational loans, regardless of source. Educational assistance also includes college work study.

Energy Assistance

Exempt the following types of energy assistance payments:

- Assistance from federally-funded, state or locally-administered programs, including HEAP, weatherization, Energy Crisis, and one-time emergency repairs of a heating or cooling device (down payment and final payment);
- Energy assistance received through HUD, USDA's Rural Housing Service (RHS), or Farmer's Administration (FmHA);
- Assistance from private, non-profit, or governmental agencies based on need.

If an energy assistance payment is combined with other payments of assistance, exempt only the energy assistance portion from income (if applicable).

Foster Care Payments

Exempt.

Government Disaster Payments

Exempt federal disaster payments and comparable disaster assistance provided by states, local governments and disaster assistance organizations if the household is subject to legal penalties when the funds are not used as intended.

Examples: Payments by the Individual and Family Grant Program, Small Business Administration, and/or FEMA.

Income

**In-Kind
Income**

Exempt. An in-kind contribution is any gain or benefit to a person that is not in the form of money/check payable directly to the household, such as clothing, public housing, or food.

Interest

Count as unearned income.

Job Training

Exempt all payments made under the Workforce Investment Act (WIA).

Exempt portions of non-WIA job training payments earmarked as reimbursements for training-related expenses. Count any excess as earned income.

Exempt on-the-job training (OJT) payments received by a child who is under age 19 and under parental control of another household member.

**Loans (Non-
educational)**

Count as unearned income unless there is an understanding that the money will be repaid and the person can reasonably explain how he will repay it.

**Lump-Sum
Payments**

Count as income in the month received if the person receives it or expects to receive it more often than once a year.

Consider retroactive or restored payments to be lump-sum payments and count as a resource. Separate any portion that is ongoing income from a lump-sum amount and count it as income.

Exempt lump sums received once a year or less, unless specifically listed as income. Count them as a resource in the month received. Effective January 1, 2013 exempt federal tax refunds permanently as income and resources for 12 months after receipt. Exempt the Earned Income Credit (EIC) for a period of 12 months after receipt through December 31, 2018.

If a lump sum reimburses a household for burial, legal, or health care bills, or damaged/lost possessions, reduce the countable amount of the lump sum by the amount earmarked for these items.

Military Pay

Count military pay and allowances for housing, food, base pay, and flight pay as earned income, minus pay withheld to fund education under the G.I. Bill.

Mineral Rights

Count Payments for mineral rights as unearned income.

Income

Pensions

Count as unearned income. A pension is any benefit derived from former employment, such as retirement benefits or disability pensions.

Reimbursement

Exempt a reimbursement (not to exceed the individual's expense) provided specifically for a past or future expense. If the reimbursement exceeds the individual's expenses, count any excess as unearned income. Do not consider a reimbursement to exceed the individual's expenses unless the individual or provider indicates the amount is excessive.

Exempt a reimbursement for future expenses only if the household plans to use it as intended.

RSDI Payments

Count as unearned income the Retirement, Survivors, and Disability Insurance (RSDI) benefit amount including the deduction for the Medicare premium, minus any amount that is being recouped for a prior RSDI overpayment.

If a person receives an RSDI check and an SSI check, exempt both checks since the person is a disqualified household member.

If an adult receives a Social Security survivor's benefit check for a child, this check is considered the child's income.

**Self- Employment
Income**

Count as earned income, minus the allowable costs of producing the self-employment income.

Self-employment income is earned or unearned income available from one's own business, trade, or profession rather than from an employer. However, some individuals may have an employer and receive a regular salary. If an employer does not withhold FICA or income taxes, even if required to do so by law, the person is considered self-employed.

Types of self-employment include:

- Odd jobs, such as mowing lawns, babysitting, and cleaning houses;
- Owning a private business, such as a beauty salon or auto mechanic shop;
- Farm income; and
- Income from property, which may be from renting, leasing, or selling property on an installment plan. Property includes equipment, vehicles, and real property.

If the person sells the property on an installment plan, count the payments as income. Exempt the balance of the note as an inaccessible resource.

Income

SSI Payments

Exempt Supplemental Security Income (SSI) benefits.

A person receiving any amount of SSI benefits also receives Medicaid and is, therefore, a disqualified household member.

TANF

Exempt Temporary Assistance to Needy Families (TANF) benefits.

**Terminated
Income**

Count terminated income in the month received. Use actual income and do not use conversion factors if terminated income is less than a full month's income.

Income is terminated if it will not be received in the next usual payment cycle.

Income is not terminated if:

- Someone changes jobs while working for the same employer,
 - An employee of a temporary agency is temporarily not assigned,
 - A self-employed person changes contracts or has different customers without having a break in normal income cycle, or
 - Someone received regular contributions, but the contributions are from different sources.
-

**Third-Party
Payments**

Exempt the money received that is intended and used for the maintenance of a person who is not a member of the household.

If a single payment is received for more than one beneficiary, exclude the amount actually used for the non-member up to the non-member's identifiable portion or prorated portion, if the portion is not identifiable.

Tip Income

Count the actual (not taxable) gross amount of tips as earned income. Add tip income to wages before applying conversion factors.

Tip income is income earned in addition to wages that is paid by patrons to people employed in service-related occupations, such as beauticians, waiters, valets, pizza delivery staff, etc.

Do not consider tips as self-employment income unless related to a self-employment enterprise

Income

Trust Fund

Count as unearned income trust fund withdrawals or dividends that the household can receive from a trust fund that is exempt from resources.

Unemployment Compensation Payments

Count as unearned income the gross benefit less any amount being recouped for a UIB overpayment.

Count the cash value of UIB in a UI debit account, less amounts deposited in the current month, as a resource. Account inquiry is accessible to a UIB recipient online at www.myaccount.chase.com or at any Chase Bank automated teller machine free of charge.

Exception: Count the gross amount if the household agreed to repay a food stamp overpayment through voluntary garnishment.

VA Payments

Count the gross Veterans Administration (VA) payment as unearned income, minus any amount being recouped for a VA overpayment. Exempt VA special needs payments, such as annual clothing allowances or monthly payments for an attendant for disabled veterans.

Vacation Pay

If an individual receives vacation pay....	Consider it...
during or before termination of employment,	earned income.
after termination of employment in one lump sum,	a liquid resource in the month received.
after termination of employment in multiple checks,	unearned income.

Vendor Payments

Exempt vendor payments if made by a person or organization outside the household directly to the household's creditor or person providing the service.

Exception: Count as income money that is legally obligated to the household, but which the payer makes to a third party for a household expense.

Income

**Wages, Salaries,
Commissions**

Count the actual (not taxable) gross amount as earned income.

If a person asks his employer to hold his wages or the person's wages are garnished, count this money as income in the month the person would otherwise have been paid. If, however, an employer holds his employees' wages as a general practice, count this money as income in the month it is paid. Count an advance in the month the person receives it.

**Workers'
Compensation
Payments**

Count the gross payment as unearned income, minus any amount being recouped for a prior worker's compensation overpayment or paid for attorney's fees. NOTE: The Texas Workforce Commission (TWC) or a court sets the amount of the attorney's fee to be paid.

Do not allow a deduction from the gross benefit for court-ordered child support payments.

Exception: Exclude worker's compensation benefits paid to the household for out-of-pocket health care expenses. Consider these payments as reimbursements.

**Other Types of
Benefits and
Payments**

Exempt benefits and payments from the following programs:

- Americorp,
 - Child Nutrition Act of 1966,
 - Food Stamp Program - SNAP (Supplemental Nutrition Assistance Program),
 - Foster Grandparents,
 - Funds distributed or held in trust by the Indian Claims Commission for Indian tribe members under Public Laws 92-254 or 93-135,
 - Learn and Serve,
 - National School Lunch Act,
 - National Senior Service Corps (Senior Corps),
 - Nutrition Program for the Elderly (Title III, Older American Act of 1965),
 - Retired and Senior Volunteer Program (RSVP),
 - Senior Companion Program,
 - Tax-exempt portions of payments made under the Alaska Native Claims Settlement Act,
 - Uniform Relocation Assistance and Real Property Acquisitions Act (Title II),
 - Volunteers in Service to America (VISTA), and
 - Women, Infants, and Children (WIC) Program.
-

Income

Verifying Income

Verify countable income, including recently terminated income, at initial application and when changes are reported.

Proof may include but is not limited to:

- Pay stubs,
 - Statements from employers,
 - W-2 forms,
 - Notes for cash contributions,
 - Business records,
 - Award letters,
 - Court orders or public decrees (support documents),
 - Sales records,
 - Income tax returns, and
 - Statements completed, signed, and dated by the self-employed person.
-

Documenting Income

On Form 101, Worksheet, document the following items.

- Exempt income and the reason it is exempt
 - Unearned income, including the following items:
 - Date income is verified,
 - Type of income,
 - Check or document seen,
 - Amount recorded on check or document,
 - Frequency of receipt, and
 - Calculations used.
 - Self-employment income, including the following items:
 - The allowable costs for producing the self-employment income,
 - Other factors used to determine the income amount.
 - Earned income, including the following items:
 - Payer's name and address,
 - Dates of each wage statement or pay stub used,
 - Date paycheck is received,
 - Gross income amount,
 - Frequency of receipt, and
 - Calculations used.
 - Allowable deductions.
-

Budgeting Income

General Principles

- Count income already received and any income the household expects to receive. If the household is not sure about the amount expected or when the income will be received, use the best estimate.
- Income, whether earned or unearned, is counted in the month that it is received.
- Count terminated income in the month received. Use actual income and do not use conversion factors if terminated income is less than a full month's income.
- View at least two pay amounts in the time period beginning 45 days before the interview date or the process date for cases processed without an interview. However, do not require the household to provide verification of any pay amount that is older than two months before the interview date or the process date for cases processed without an interview.
- When determining the amount of self-employment income received, verify four recent pay amounts that accurately represent their pay. Verify one month's pay amount that accurately represent their pay for self-employed income received monthly. Do not require the household to provide verification of self-employment income and expenses for more than two calendar months before the interview date or the case process date if not interviewed, for income received monthly or more often.
- Accept the applicant's statement as proof if there is a reasonable explanation of why documentary evidence or a collateral source is not available and the applicant's statement does not contradict other individual statements or other information received by the entity.
- The self-employment income projection, usually 12 months, is the period of time that the household expects the income to support the family.
- There are deductions for earned income that are not allowed for unearned income.
- The earned income deductions are not allowed if the income is gained from illegal activities, such as prostitution and selling illegal drugs.

Steps for Budgeting Income

- Determine countable income.
- Determine how often countable income is received.
- Convert countable income to monthly amounts.
- Convert self-employment allowable costs to monthly amounts.
- Determine if countable income is earned or unearned.
- Subtract converted monthly self-employment allowable costs, if any, from converted monthly self-employment income.
- Subtract earned income deductions, if any.
- Subtract the deduction for Medicaid individuals, if applicable.
- Compare the monthly net income to the CIHCP monthly income standard.

Step 1 Determine countable income, using CIHCP guidelines.

Evaluate the household's current and future circumstances and income.

Decide if changes are likely during the current or future months.

If changes are likely, then determine how the change will affect eligibility.

Step 2 Determine how often countable income is received, such as yearly, monthly, twice a month, every other week, weekly.

All income, excluding self-employment. Based on verifications or the person's statement as best available information, determine how often income is received. If the income is based hourly or for piecework, determine the amount of income expected for one week of work.

Self-employment Income.

- Compute self-employment income, using one of these three methods:
 - Annual. Use this method if the person has been self-employed for at least the past 12 months.
 - Monthly. Use this method if the person has at least one full representative calendar month of self-employment income.
 - Daily. Use this method when there is less than one full representative calendar month of self-employment income, and the source or frequency of the income is unknown or inconsistent.

Budgeting Income

- Step 2** (continued)
- Determine if the self-employment income is annual or seasonal, since that will determine the length of the projection period.
 - The projection period is annual if the self-employment is intended to support the household for at least the next 12 months. The projection period is 12 months whether the income is received monthly or less often.
 - The projection period is seasonal if the self-employment income is intended to support the household for less than 12 months since it is available only during certain months of the year. The projection period is the number of months the self-employment is intended to provide support.
 - Determine the costs of producing self-employment income by accepting the deductions listed on the 1040 U.S. Individual Income Tax Return or by allowing the following deductions:
 - Capital asset improvements,
 - Capital asset purchases, such as real property, equipment, machinery and other durable goods, i. e., items expected to last at least 12 months,
 - Fuel,
 - Identifiable costs of seed and fertilizer,
 - Insurance premiums,
 - Interest from business loans on income-producing property,
 - Labor,
 - Linen service,
 - Payments of the principal of loans for income-producing property,
 - Property tax,
 - Raw materials,
 - Rent,
 - Repairs that maintain income-producing property,
 - Sales tax,
 - Stock,
 - Supplies,
 - Transportation costs. The person may choose to use 50.0 cents per mile instead of keeping track of individual transportation expenses. Do not allow travel to and from the place of business.
 - Utilities.

NOTE: If the applicant conducts a self-employment business in his home, consider the cost of the home (rent, mortgage, utilities) as shelter costs, not business expenses, unless these costs can be identified as necessary for the business separately

Budgeting Income

Step 2 Self-Employment Income. (continued)
(continued)

The following are not allowable costs of producing self-employment income:

- Costs not related to self-employment,
 - Costs related to producing income gained from illegal activities, such as prostitution and the sale of illegal drugs,
 - Depreciation,
 - Net loss which occurred in a previous period, and
 - Work-related expenses, such as federal, state and local income taxes, and retirement contributions.
-

Step 3 **Convert countable income to monthly amounts**, if income is not received monthly.

When converting countable income to monthly amounts, use the following conversion factors:

- Multiply weekly amounts by 4.33.
- Multiply amounts received every other week by 2.17.
- Add amounts received twice a month (semi-monthly).
- Divide yearly amounts by 12

Step 4 **Convert self-employment allowable costs to monthly amounts.**

When converting the allowable costs for producing self-employment to monthly amounts, use the conversion factors in Step 3 above.

Step 5 **Determine if countable income is earned or unearned.**

For earned income, proceed with Step 6. For unearned income, skip to Step 8.

Step 6 **Subtract converted monthly self-employment allowable costs, if any, from converted monthly self-employment income.**

Budgeting Income

Step 7 Subtract earned income deductions, if any. Subtract these deductions, if applicable, from the household's monthly gross income, including monthly self-employment income after allowable costs are subtracted:

- Deduct \$120.00 per employed household member for work-related expenses.
- Deduct 1/3 of the remaining earned income per employed household member.
- Dependent childcare or adult with disabilities care expenses shall be deducted from the total income when determining eligibility, if paying for the care is necessary for the employment of a member in the CIHCP household. This deduction is allowed even when the child or adult with disabilities is not included in the CIHCP household. Deduct the actual expenses up to:
 - \$200 per month for each child under age 2,
 - \$175 per month for each child age 2 or older, and
 - \$175 per month for each adult with disabilities.

Exception: For self-employment income from property, when a person spends an average of less than 20 hours per week in management or maintenance activities, count the income as unearned and only allow deductions for allowable costs of producing self-employment income.

Step 8 Subtract the deduction for Medicaid individuals, if applicable. This deduction applies when the household has a member who receives Medicaid and, therefore, is disqualified from the CIHCP household. Using the Deduction chart below, deduct an amount for the support of the Medicaid member(s) as follows: Subtract an amount equal to the deduction for the number (#) of Medicaid-eligible individuals

Deduction for Medicaid-Eligible Individuals

# of Medicaid-Eligible Individuals	Single Adult or Adult with Children	Minor Children Only
1	\$ 78	\$ 64
2	\$163	\$ 92
3	\$188	\$130
4	\$226	\$154
5	\$251	\$198
6	\$288	\$214
7	\$313	\$267
8	\$356	\$293

Budgeting Income

Step 9 Subtract the Deduction for Child Support, Alimony, and Other Payments to Dependents Outside the Home, if applicable.

Allow the following deductions from members of the household group, including disqualified members:

- The actual amount of child support and alimony a household member pays to persons outside the home.
- The actual amount of a household member's payments to persons outside the home that a household member can claim as tax dependents or is legally obligated to support.

Consider the remaining income as the monthly net income for the CIHCP household.

Step 10 Compare the household's monthly net income to the 21% FPG Minimum Income Standard, using the CIHCP Monthly Income Standards chart below.

CIHCP Monthly Income Standards Effective March 2016

Based on the 2016 Federal Poverty Guideline (FPG)

# of Individuals in the CIHCP Household	21% FPG Minimum Income Standard	50% FPG Maximum Income Standard
1	\$208	\$495
2	\$280	\$668
3	\$353	\$840
4	\$425	\$1,013
5	\$498	\$1,185
6	\$570	\$1,358
7	\$643	\$1,530
8	\$716	\$1,704
9	\$788	\$1,877
10	\$861	\$2,050
11	\$934	\$2,224
12	\$1,007	\$2,397

A household is eligible if its monthly net income, after rounding down cents, does not exceed the monthly income standard for the CIHCP household's size

SECTION THREE

CASE PROCESSING

General Principles

General Principles

- Use the application, documentation, and verification procedures established by TDSHS or a less restrictive application, documentation, or verification procedure.
 - Issue Form 100 to the applicant or his representative on the same date that the request is received.
 - Accept an identifiable application.
 - Assist the applicant with accurately completing the Form 100 and getting all needed verifications and information if the applicant requests help in completing the application process. Anyone who helps fill out the Form 100 must sign and date it.
 - If the applicant is incompetent, incapacitated, or deceased, someone acting responsibly for the client (a representative) may represent the applicant in the application and the review process, including signing and dating the Form 100 on the applicant's behalf. This representative must be knowledgeable about the applicant and his household. Document the specific reason for designating this representative.
 - Determine eligibility based on residence, household, resources, and income.
 - Allow at least 14 days for requested information to be provided, unless the household agrees to a shorter timeframe, when issuing Form 103.
 - Use any information received from the provider of service when making the eligibility determination; but counties, public hospitals, and hospital districts may require further eligibility information from the potentially eligible resident if necessary.
 - The date that a complete application is received is the application completion date, which counts as Day 0.
 - Determine eligibility not later than the 14th day after the application completion date. If eligibility is not determined within this 14-day period, the applicant is considered to be eligible and the provider must be notified.
 - Issue written notice, namely, Form 109 or Form 117, of the county's decision. If the county denies health care assistance, the written notice shall include the reason for the denial and an explanation of the procedure for appealing the denial.
 - Review each eligible case record at least once every six months.
-

General Principles (continued)

General Principles
(continued)

- Use the “Prudent Person Principle” in situations where there are unusual circumstances in which an applicant’s statement must be accepted as proof if there is a reasonable explanation why documentary evidence or a collateral contact is not available and the applicant’s statement does not contradict other client statements or other information received by staff.
 - Current eligibility continues until a change resulting in ineligibility occurs and a Form 117 is issued to the household.
 - Consult the county’s legal counsel to develop procedures regarding disclosure of information.
 - The applicant has the right to:
 - Have his application considered without regard to race, color, religion, creed, national origin, age, sex, disability, or political belief;
 - Request a review of the decision made on his application or re-certification for health care assistance; and
 - Request, orally or in writing, a fair hearing about actions affecting receipt or termination of health care assistance.
 - The applicant is responsible for:
 - Completing the Form 100 accurately.
 - Signing and dating the Form 100.
 - Providing all needed information requested by staff. If information is not available or is not sufficient, the applicant may designate a collateral contact for the information. A collateral contact could be any objective third party who can provide reliable information. A collateral contact does not need to be separately and specifically designated if that source is named either on Form 100 or during the interview.
 - Reporting changes, which affect eligibility, within 14 days after the date that the change actually occurred.
-

Processing an Application (continued)

Steps for Processing an Application

- **Accept the identifiable application.**
- **Determine if an interview is needed.**
- **Interview.**
- **Check information.**
- **Request needed information.**
- **Determine eligibility.**
- **Issue the appropriate form.**

- Step 1** **Accept the identifiable application.** On the Form 100, Application for Health Care Assistance, document the date that the identifiable Form 100 is received. This is the application file date.
- Step 2** **Determine if an interview is needed.** Eligibility may be determined without interviewing the applicant if all questions on the Form 100 are answered and all additional information has been provided.
- Step 3** **Interview** the applicant or his representative face-to-face or by telephone if an interview is necessary. If an interview appointment is scheduled, issue Form 102, Appointment Notice, including the date, time, and place of the interview. If the applicant fails to keep the appointment, reschedule the appointment, if requested, or follow the Denial Decision procedure in Step 8.
- Step 4** **Check** that all information is complete, consistent, and sufficient to make an eligibility determination.
- Step 5** **Request needed information** pertaining to the four eligibility criteria, namely, residence, household, resources, and income.

Decision Pended. If eligibility cannot be determined because components that pertain to the eligibility criteria are missing, issue Form 103, Request for Information, listing additional information that needs to be provided as well as listing the due date by which the additional information is needed. If the requested information is not provided by the due date, follow the Denial Decision procedure in Step 8. If the requested information is provided by the due date, proceed with Step 6.

- Decision Pended for an SSI Applicant. If eligibility cannot be determined because the person is also an SSI applicant, issue Form 103, Request for Information, listing additional information that needs to be provided, including the SSI decision, as well as listing the date by which the additional information is needed. If the SSI application is denied for eligibility requirements, proceed with Step 6 whether or not the SSI denial is appealed.
-

Processing an Application (continued)

Step 6 **Repeat** Steps 4 and 5 as necessary.

Step 7 **Determine eligibility** based on the four eligibility criteria.

Document information in the case record to support the decision.

Step 8 **Issue the appropriate form**, namely, Form 117 or Form 109.

Denial Decision. If any one of the eligibility criteria is not met, the applicant is ineligible. Issue Form 117, Notice of Ineligibility, including the reason for denial, the effective date of the denial, if applicable, and an explanation of the procedure for appealing the denial.

Reasons for denial include but are not limited to:

- Not a resident of the county,
- A recipient of Medicaid,
- Resources exceed the resource limit,
- Income exceeds the income limit,
- Failed to keep an appointment,
- Failed to provide information requested,
- Failed to return the review application,
- Failed to comply with requirements to obtain other assistance, or
- Voluntarily withdrew.

Eligible Decision. If all eligibility criteria are met, the applicant is eligible.

Determine the applicant's Eligibility Effective Date. Current eligibility begins on the first calendar day in the month that an identifiable application is filed or the earliest, subsequent month in which all eligibility criteria are met. (Exception: Eligibility effective date for a new county resident begins the date the applicant is considered a county resident. For example, if the applicant meets all four eligibility criteria, but doesn't move to the county until the 15th of the month, the eligibility effective date will be the 15th of the month, not the first calendar day in the month that an identifiable application is filed.)

The applicant may be retroactively eligible in any of the three calendar months before the month the identifiable application is received if all eligibility criteria are met.

Issue Form 109, Notice of Eligibility, including the Eligibility Effective Date.

Denial Decision Disputes

Responses Regarding a Denial Decision

If a denial decision is disputed by the household, the following may occur:

- The household may submit another application to have their eligibility re-determined,
 - The household may appeal the denial, or
 - The county may choose to re-open a denied application.
-

Eligibility Dispute

- If a provider of assistance and a governmental entity or hospital district cannot agree on a household's eligibility for assistance, the provider or the governmental entity or hospital district may submit a Form 106, Eligibility Dispute Resolution Request, within 90 days of the date that the eligibility determination is issued.
 - TDSHS initiates the resolution process by notifying the appropriate entities and requesting any necessary information. TDSHS will make a decision within 45 days.
 - An appeal may be submitted in writing within 30 days.
 - TDSHS shall issue a final decision within 45 days after the date on which the appeal is filed.
-

Employment Services Program

- Reference the CIHCP Handbook, Section One, Program Administration, Page 3.
-

Case Record Maintenance

Case Record Review

Issue the household Form 100. Follow the “Steps for Processing an Application,” beginning with Step 2.

Case Record Filing

Documents relating to eligibility and claim payments may be kept in the same case record or in separate case records. Case record documents may be kept in the order of the chart below.

Left Side of Case Record or Claim Payment Record	Right Side of Case Record or Eligibility Record
<p>From top to bottom:</p> <ul style="list-style-type: none"> • Form 104 for current state fiscal year • Claims for current fiscal year • Divider • Form 113, if applicable • Divider • Form 104 for previous state fiscal years • Claims for previous state fiscal years 	<p>From top to bottom:</p> <ul style="list-style-type: none"> • Current Form 109 or 117 • Current Form 100 • Current Form 101 • Current Form 102, if applicable • Current Form 103 • Current verifications • Current miscellaneous documents • Divider • Retired Documents

Changes

Changes are situations that occur in a household that may affect the eligibility of the household.

Follow the “Steps for Processing an Application,” beginning with Step 4, to determine the effect of the change on the household’s eligibility.

If a change results in the household’s ineligibility, the eligibility end date is the date that Form 117, Notice of Ineligibility, is issued to the household.

SECTION FOUR

SERVICE DELIVERY

General Principles

General Principles

- A county shall provide the basic health care services established by TDSHS in this handbook or less restrictive health care services.
 - The basic health care services are:
 - ◆ Physician services
 - ◆ Annual physical examinations
 - ◆ Immunizations
 - ◆ Medical screening services
 - Blood pressure
 - Blood sugar
 - Cholesterol screening
 - ◆ Laboratory and x-ray services
 - ◆ Family planning services
 - ◆ Skilled nursing facility services
 - ◆ Prescription drugs
 - ◆ Rural health clinic services
 - ◆ Inpatient hospital services
 - ◆ Outpatient hospital services
-

General Principles (continued)

General Principles
(continued)

- In addition to providing basic health care services, a county may provide other department-established optional health care services that the county determines to be cost-effective.
 - o The department-established optional health care services are:
 - ◆ Advanced practice nurse services provided by
 - o Nurse practitioner services
 - o Clinical nurse specialist
 - o Certified nurse midwife (CNM)
 - o Certified registered nurse anesthetist
 - ◆ Ambulatory surgical center (freestanding) services
 - ◆ Colostomy medical supplies and equipment
 - ◆ Counseling services provided by
 - o Licensed clinical social worker (LCSW)
 - o Licensed marriage family therapist (LMFT)
 - o Licensed professional counselor (LPC)
 - o Ph.D. psychologist
 - ◆ Dental Care
 - ◆ Diabetic medical supplies and equipment
 - ◆ Durable medical equipment (DME)
 - ◆ Emergency medical services
 - ◆ Home and community health care services
 - ◆ Physician assistant services
 - ◆ Vision care, including eyeglasses
 - ◆ Federally qualified health center services
 - ◆ Occupational therapy services
 - ◆ Physical therapy services
 - ◆ Other medically necessary services or supplies that the local governmental municipality/entity determines to be cost effective.

General Principles (continued)

General Principles
(continued)

- Services or supplies must be reasonable and medically necessary for diagnosis and treatment.
 - For a listing of services, supplies and expenses that may not be CIHCP benefits, refer to the Texas Provider Procedures Medicaid Manual at http://www.tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx. Section 1 Provider Enrollment and Responsibilities “Texas Medicaid Limitations and Exclusions.”
 - Chapter 61, Health and Safety Code, Section 61.035, states, “The maximum county liability for each state fiscal year for health care services provided by all assistance providers, including hospital and skilled nursing facility, to each eligible county resident is:
 - 1) \$30,000; or
 - 2) the payment of 30 days of hospitalization or treatment in a skilled nursing facility, or both, or \$30,000, whichever occurs first, if the county provides hospital or skilled nursing facility services to the resident.”
 - ◆ 30 days of hospitalization refers to inpatient hospitalization.
 - Use the client’s actual dates-of-service when determining which fiscal year to apply the maximum county liability.
 - For claim payment to be considered, a claim should be received:
 - 1.) Within 95 days from the approval date for services provided before the household was approved
 - 2.) Within 95 days from the date of service for services provided after the approval date, or
 - 3.) Within the agreed upon timeframe in a legal contract between the providers and the local indigent program.
 - The payment standard is determined by the date the claim is paid.
 - For additional information on claim payment, the User’s Guide to Fee Schedules is provided at the end of Section Four, Service Delivery.
-

Basic Health Care Services

TDSHS-established Basic Health Care Services

Payment Method

- **Physician Services** Physician Fee Schedule
- **Annual Physical Examinations** Physician Fee Schedule
- **Immunizations** Physician Fee Schedule
- **Medical Screening Services** Physician Fee Schedule
- **Laboratory and X-Ray Services** Physician Fee Schedule
- **Family Planning Services** Physician Fee Schedule
- **Skilled Nursing Facility Services** Daily Rate
- **Prescription Drugs** Formula
- **Rural Health Clinic Services** Rate per Visit
- **Inpatient Hospital Services** DRG or Inpatient Percent Rate
- **Outpatient Hospital Services** Outpatient Percent Rate or ASC Rate

Negotiate rates with providers for basic service procedure codes not listed in the Fee Schedules. For additional information on claim payment, the User's Guide to Fee Schedules is provided at the end of Section Four, Service Delivery.

Physician Services

Physician services include services ordered and performed by a physician that are within the scope of practice of their profession as defined by state law. Physician services must be provided in the doctor's office, the patient's home, a hospital, a skilled nursing facility, or elsewhere.

Payment Standard for Physicians. Use the Fee Schedule for Texas Medicaid Physician at www.tmhp.com and proceed as follows:

1. Use the amount listed in the age appropriate Facility or Non-Facility Adjusted Fee for Report Date Column.
2. If the Adjusted Fee for Report Date Column is blank and the Note Code is 5 or blank, HHSC does not have a payable amount; however, a payment amount may be negotiated with the provider.

(Physician Services Payment Standard continued on next page)

Basic Health Care Services (continued)

Physician Services
(continued)

Payment Standard for Anesthesia Services. Using the Fee Schedule for Texas Medicaid Physician at www.tmhp.com, use the number of Relative Value Units (RVUs) listed in the Total RVUs column, the conversion factor listed in the Conversion Factor column, and the calculation instructions below.

1. Calculate the anesthesia units of time by using the following formula.

$$\frac{\text{total anesthesia time in minutes}}{15} = \text{anesthesia units of time}$$

2. Calculate the reimbursement for anesthesia services by using the following formula.

$$(\text{anesthesia units of time} + \text{RVUs}) \times \text{Conversion Factor} = \text{reimbursement amount}$$

Reduce the reimbursement amount by 2% for dates of services rendered on or after February 1, 2011.

Payment Standard for Podiatrists. Use the Fee Schedule for Texas Medicaid Podiatrist at www.tmhp.com and proceed using the instructions for Payment Standard for Physicians.

Payment Standard for Injections. Use the Fee Schedule for Texas Medicaid Physician at www.tmph.com.

For additional information on claim payment, the User's Guide to Fee Schedules is provided at the end of Section Four, Service Delivery.

Basic Health Care Services (continued)

**Annual
Physical
Examinations**

These are examinations provided once per calendar year by a physician, a physician assistant (PA), or an Advance Practice Nurse (APN).

Associated testing, such as mammograms, can be covered with a physician's referral.

These services may be provided by an Advanced Practice Nurse (APN) if they are within the scope of practice of the APN in accordance with the standards established by the Board of Nurse Examiners and published in 22 Texas Administrative Code §221.13.

Payment Standard for a Physician. Use the Fee Schedule for Texas Medicaid Physician at www.tmhp.com and proceed as follows:

1. Use the amount listed in the age appropriate Facility or Non-Facility Adjusted Fee for Report Date Column.
2. If the Adjusted Fee for Report Date Column is blank and the Note Code is 5 or blank, HHSC does not have a payable amount; however, a payment amount may be negotiated with the provider.

For additional information on claim payment, the User's Guide to Fee Schedules is provided at the end of Section Four, Service Delivery.

Basic Health Care Services (continued)

Immunizations These are given when appropriate.

Payment Standard. Use the Fee Schedule for Texas Medicaid Physician at www.tmhp.com and proceed as follows:

1. Use the amount listed in the age appropriate Facility or Non-Facility Adjusted Fee for Report Date Column.
2. If the Adjusted Fee for Report Date Column is blank and the Note Code is 5 or blank, HHSC does not have a payable amount; however, a payment amount may be negotiated with the provider.

For additional information on claim payment, the User's Guide to Fee Schedules is provided at the end of Section Four, Service Delivery.

Medical Screenings

These health care services include blood pressure, blood sugar, and cholesterol screening.

Payment Standard. Use the Fee Schedule for Texas Medicaid Physician at www.tmhp.com and proceed as follows:

1. Use the amount listed in the age appropriate Facility or Non-Facility Adjusted Fee for Report Date Column.
2. If the Adjusted Fee for Report Date Column is blank and the Note Code is 5 or blank, HHSC does not have a payable amount; however, a payment amount may be negotiated with the provider.

For additional information on claim payment, the User's Guide to Fee Schedules is provided at the end of Section Four, Service Delivery.

Basic Health Care Services (continued)

**Laboratory
and X-ray
Services**

These are professional and technical services ordered by a physician and provided under the personal supervision of a physician in a setting other than a hospital (inpatient or outpatient).

Payment Standard. Use the Fee Schedule for Texas Medicaid Physician at www.tmhp.com and proceed as follows:

1. Use the amount listed in the age appropriate Facility or Non-Facility Adjusted Fee for Report Date Column.
2. If the Adjusted Fee for Report Date Column is blank and the Note Code is 5 or blank, HHSC does not have a payable amount; however, a payment amount may be negotiated with the provider.

For additional information on claim payment, the User's Guide to Fee Schedules is provided at the end of Section Four, Service Delivery.

Basic Health Care Services (continued)

**Family
Planning
Services**

These are preventive health care services that assist an individual in controlling fertility and achieving optimal reproductive and general health.

Payment Standard. Use the Fee Schedule for Texas Medicaid Physician Fee Schedule at www.tmhp.com and proceed as follows:

1. Use the amount listed in the age appropriate Facility or Non-Facility Adjusted Fee for Report Date Column.
2. If the Adjusted Fee for Report Date Column is blank and the Note Code is 5 or blank, HHSC does not have a payable amount; however, a payment amount may be negotiated with the provider.

For additional information on claim payment, the User's Guide to Fee Schedules is provided at the end of Section Four, Service Delivery.

**Skilled
Nursing
Facility
Services**

Services must be

- Medically necessary,
- Ordered by a physician, and
- Provided in a skilled nursing facility that provides daily services on an inpatient basis.

Payment Standard. The skilled nursing facility rate is \$118.00 per day.

This \$118.00 daily rate does not include physician services or three prescription drugs per month. These additional services must be billed separately.

Basic Health Care Services (continued)

**Prescription
Drugs**

This service includes up to three prescription drugs per month. New and refilled prescriptions count equally toward this three prescription drugs per month total. Drugs must be prescribed by a physician or other practitioner within the scope of practice under law.

The quantity of each prescription depends on the prescribing practice of the physician and the needs of the patient.

Payment Standard. Use the following information and formula.

- Utilizing any pharmaceutical company's database that provides average wholesale pricing, look-up the drug's 11-digit NDC number and the quantity dispensed to determine the average wholesale price (AWP).
- Net Cost for:
 - **Generic** prescription drugs is **AWP minus 50%**
 - **Brand** name prescription drugs is **AWP minus 15%**
- **The drug dispensing fee is \$3.00.**
- The formula for computing the TDSHS Payable is:

Net Cost + drug dispensing fee = TDSHS Payable

Example: Prescription is written for 34 generic tablets

AWP for 25 tablets is \$100.00.

1. \$100.00 divided by 25 = \$4.00 per tablet

2. \$4.00 per tablet x 34 tablets (prescribed quantity) = \$136.00

3. \$136.00 - \$68.00 (50% for generic) = \$68.00

4. \$68.00 + \$3.00 (dispensing fee) = \$71.00 TDSHS Payable

- A payment amount may be negotiated with the provider for:
 - Prescription compound drugs,
 - Prescription drugs not found in any pharmaceutical database, or
 - Prescription drugs that do not have an NDC number.

**Rural Health
Clinic (RHC)
Services**

RHC services must be provided in a freestanding or hospital-based rural health clinic and provided by a physician, a physician assistant, an advanced practice nurse (including a nurse practitioner, a clinical nurse specialist, and a certified nurse midwife), or a visiting nurse.

Payment Standard: Use the Rate per Visit in the "Medicare-Approved Rural Health Clinic Rates" included in Appendix A.

Basic Health Care Services (continued)

**Inpatient
Hospital
Services**

Inpatient hospital services must be medically necessary and be:

- Provided in an acute care hospital,
- Provided to hospital inpatients,
- Provided by or under the direction of a physician, and
- Provided for the care and treatment of patients.

Payment Standard. For the hospital in which the inpatient services were provided, use the **Hospital Inpatient Payment** lists that are located on the Health and Human Services Commission website at <http://www.hhsc.state.tx.us/rad/hospital-svcs/inpatient.shtml>. These lists will be used to calculate the payment rate using either the Percent Standard or the Diagnosis-Related Group (DRG) Standard.

Note: If you are unable to locate payment information for a facility, complete Form 111 Facility Payment Rate Request.

- Inpatient RCC Rates List - Hospitals on this list are paid using the Percent Standard. The percent listed in the Inpatient Rate column reflects all applicable rate reductions.
- Hospital Prospective Standard Dollar Amount (SDA) List - Hospitals on this list are paid using the DRG Standard. The SDA listed in the Final Add-on SDA column reflects all applicable rate reductions.
- Texas APR-DRG Grouper List - This list provides the DRG Code, APR-DRG Title, Relative Weights, Mean Length of Stay (LOS), and Day Threshold needed when using the DRG Standard.

Percent Standard. This standard reimburses hospitals based on a percent of the hospital's total billed amount.

1. From the total billed amount, subtract the cost of services that are not a CIHCP benefit; and
2. Use the Inpatient Rate listed on the Inpatient RCC Rates List, then
3. Multiply the remaining billed amount by the Inpatient Rate listed.

DRG Standard. This standard reimburses hospitals at a predetermined rate for services based on the patient's diagnosis. In some cases, the reimbursement will be more than the actual cost of providing services for that stay; in other cases, the reimbursement will be less than the hospital's actual cost. In either case, use the calculated DRG payment.

The DRG Standard incorporates the DRG code that is assigned to the hospital stay, the Relative Weight (Rel. Wt.) and the Mean Length Of Stay that are assigned to the DRG code, and the Standard Dollar Amount (SDA), which is the blended average dollar amount a hospital recovers for any given patient account.

Basic Health Care Services (continued)

**Inpatient
Hospital
Services**
(continued)

To calculate a full or partial DRG payment use the [APR-DRG Version 29](#) of the Core Grouping Software™ along with the DRG Code, Relative Weight, Mean Length of Stay, and the SDA which are located at <http://www.hhsc.state.tx.us/rad/hospital-svcs/inpatient.shtml>.

Determine the type of DRG Payment based on the following information:

- When one hospital provided the patient care or one hospital provided the majority of the days of care, calculate a full DRG payment.
- When one hospital provided the lesser days of care or when two hospitals provided equal days of care, calculate a partial DRG payment.
- If the patient was CIHCP-eligible for any part of the hospital stay, calculate the full DRG payment.
- If the patient was Medicaid-eligible for any part of the hospital stay, there is no CIHCP payment.

Full DRG Payment. To calculate, proceed as follows:

1. Assign the DRG code using Core Grouping Software™,
2. Refer to the assigned DRG code's Relative Weight,
3. Refer to the hospital's SDA, and
4. Multiply the SDA by the Relative Weight.

Partial DRG Payment. To calculate, proceed as follows:

1. Calculate the full DRG payment,
2. Refer to the assigned DRG code's Mean Length of Stay,
3. Divide the full DRG payment by the Mean Length of Stay, and
4. Multiply the result by the CIHCP-allowed number of days of care.

DRG Software. 3M Health Information Systems Division is the supplier of the [APR-DRG Version 29 Core Grouping Software™](#), which is used to assign a three-digit group or "code" based on the diagnosis code(s). For more information, contact: www.3mhis.com

Mr. Gerry Tracy, Sales
3M Health Information Systems
Telephone: 800/367-2447
E-mail: gwtracy@mmm.com

Mr. Gregg Perfetto, Manager
3M Health Information Systems
Telephone: 800/367-2447
E-mail: gmpfetto@mmm.com

Basic Health Care Services (continued)

**Outpatient
Hospital
Services**

Outpatient hospital services must be medically necessary and be:

- Provided in an acute care hospital or hospital-based ambulatory surgical center (HASC),
- Provided to hospital outpatients,
- Provided by or under the direction of a physician, and
- Diagnostic, therapeutic, or rehabilitative.

Payment Standard. For the hospital in which the outpatient services were provided, use the **Outpatient RCC Rates** list that is located on the Health and Human Services Commission website at <http://www.hhsc.state.tx.us/rad/hospital-svcs/outpatient.shtml>. This list will be used to calculate the payment rate using the Percent Standard.

Outpatient RCC Rates List - Hospitals on this list are paid using the Percent Standard. The percent listed in the Outpatient Rate column reflects all applicable rate reductions.

1. Use the Outpatient Rate listed on the Outpatient RCC Rates List, and
2. Multiply the billed amount by the Outpatient Rate listed.

Exception: If the outpatient service is for a scheduled surgery, the county may use the Fee Schedule for Texas Medicaid Hospital Ambulatory Surgical Center (HASC) Group Rate Amounts and HASC Group # at www.tmhp.com.

A hospital-based ASC service should be billed as one inclusive charge on a UB-04.

Optional Health Care Services

TDSHS-established Optional Health Care Services

	<u>Payment Method</u>
• Advanced Practice Nurse Services	NP/CNS/
• Ambulatory Surgical Center (Freestanding) Services ...	ASC Fee Schedule
• Colostomy Medical Supplies and Equipment	DME Fee Schedule
• Counseling Services	Psychologist Fee Schedule
• Dental Care	Dentist-Orthodontist Fee Schedules
• Diabetic Medical Supplies and Equipment	DME Fee Schedule
• Durable Medical Equipment	DME Fee Schedule
• Emergency Medical Services	Ambulance Fee Schedule
• Home and Community Health Care Services	Rate Per Visit
• Physician Assistant Services	Physician Assistant Fee Schedule
• Vision Care, including Eyeglasses	Optometrist & Optician Fee Schedules
• FQHC (Federally Qualified Health Center) Services ..	Rate Per Visit
• Occupational Therapy Services	Occupational Therapist Fee Schedule
• Physical Therapy Services	Physical Therapist Fee Schedule
• Other medically necessary services or supplies	Fee Schedule or negotiable rate

Negotiate rates with providers for optional service procedure codes not listed in the Fee Schedules. For additional information on claim payment, the User's Guide to Fee Schedules is provided at the end of Section Four, Service Delivery.

Advanced Practice Nurse (APN) Services

An APN must be licensed as a registered nurse (RN) within the categories of practice, specifically, a nurse practitioner, a clinical nurse specialist, a certified nurse midwife (CNM), and a certified registered nurse anesthetist (CRNA), as determined by the Board of Nurse Examiners. APN services must be medically necessary and provided within the scope of practice of the APN.

The Medicaid rate for NPs and CNSs reflect 92% of the rate paid to a physician for the same service and 100 % of the rate paid to physicians for laboratory, X-ray, and injections.

Payment Standard for a Nurse Practitioner, a Clinical Nurse Specialist, and a CNM. Use the Fee Schedule for Texas Medicaid Nurse Practitioner and Clinical Nurse Specialist at www.tmhp.com and proceed as follows:

1. Use the amount listed in the age appropriate Facility or Non-Facility Adjusted Fee for Report Date Column.
2. If the Adjusted Fee for Report Date Column is blank and the Note Code is 5 or blank, HHSC does not have a payable amount; however, a payment amount may be negotiated with the provider.

(APN Payment Standard continued on next page)

Optional HealthCare Services

APN Services
(continued)

Payment Standard for a CRNA. Use the Fee Schedule for Texas Medicaid Certified Registered Nurse Anesthetist at www.tmhp.com.

For Anesthesia, use the number of Relative Value Units (RVUs) listed in the Total RVUs column, the conversion factor listed in the Conversion Factor column, and the calculation instructions below.

1. Calculate the anesthesia units of time by using the following formula.

$$\frac{\text{total anesthesia time in minutes}}{15} = \text{anesthesia units of time}$$

2. Calculate the reimbursement for anesthesia services by using the following formula.

$$(\text{anesthesia units of time} + \text{RVUs}) \times \text{Conversion Factor} = \text{reimbursement amount}$$

3. Use 92% of this physician amount to reimburse CRNA services.

Reduce the CRNA reimbursement by 2% for services rendered on or after February 1, 2011.

For Medical, Surgery, and Laboratory Services proceed as follows:

1. Use the amount listed in the age appropriate Adjusted Fee for Report Date Column.
2. If the Adjusted Fee for Report Date Column is blank and the Note Code is 5 or blank, HHSC does not have a payable amount; however, a payment amount may be negotiated with the provider.

For additional information on claim payment, the User's Guide to Fee Schedules is provided at the end of Section Four, Service Delivery.

Optional Health Care Services

Ambulatory Surgical Center (ASC) Services

These services must be provided in a freestanding ASC and are limited to items and services provided in reference to an ambulatory surgical procedure. A freestanding ASC service should be billed as one inclusive charge on a CMS-1500. If more than one procedure code is listed, only the code with the highest HHSC Payable amount should be paid.

Payment Standard. Use the Fee Schedule for Texas Medicaid ASC Group Rate Amounts and ASC Group # at www.tmhp.com.

Colostomy Medical Supplies and Equipment

These supplies and equipment must be medically necessary and prescribed by a physician or an APN within the scope of their practice in accordance with the standards established by the Board of Nurse Examiners and published in 22 Texas Administrative Code §221.13. The county may require the supplier to receive prior authorization.

Items covered are: cleansing irrigation kits, colostomy bags/pouches, paste or powder, and skin barriers with flange (wafers).

Payment Standard. For covered items listed above, use the Fee Schedule for Texas Medicaid Durable Medical Equipment/Medical Supplies at www.tmhp.com and proceed as follows:

1. Use the amount listed in the age appropriate Facility or Non-Facility Adjusted Fee for Report Date Column.
2. If the Adjusted Fee for Report Date Column is blank and the Note Code is 5 or blank, HHSC does not have a payable amount; however, a payment amount may be negotiated with the provider.

For additional information on claim payment, the User's Guide to Fee Schedules is provided at the end of Section Four, Service Delivery.

Optional Health Care Services

Counseling Services

Behavioral health services must be medically necessary; based on a physician referral; and provided by a licensed clinical social worker (LCSW, previously known as LMSW-ACP), a licensed marriage family therapist (LMFT), licensed professional counselor (LPC), or a Ph.D. psychologist. These services may also be provided based on an APN referral if the referral is within the scope of their practice in accordance with the standards established by the Board of Nurse Examiners and published in 22 Texas Administrative Code §221.13.

Payment Standard for LCSW, LMFT, and LPC. The following procedure codes are covered for TOS 1 counseling services provided by these providers: 90806, 90847, and 90853 (CPT codes only copyright 2004 American Medical Association. All Rights Reserved). The HHSC Payable amounts may be accessed in the Texas Medicaid Physician Fee Schedule.

Payment Standard for Ph.D. Psychologist. Use the appropriate Texas Medicaid Outpatient Behavioral Health Fee Schedule at www.tmhp.com and proceed as follows:

1. Use the amount listed in the age appropriate Facility or Non-Facility Adjusted Fee for Report Date Column.
2. If the Adjusted Fee for Report Date Column is blank and the Note Code is 5 or blank, HHSC does not have a payable amount; however, a payment amount may be negotiated with the provider.

For additional information on claim payment, the User's Guide to Fee Schedules is provided at the end of Section Four, Service Delivery.

Optional HealthCare Services

Dental Care

These services must be medically necessary and provided by a Doctor of Dental Surgery (DDS), a Doctor of Dental Medicine (DMD), or a Doctor of Dental Medicine (DDM). The county may require prior authorization.

Items covered are: an annual routine dental exam, annual routine cleaning, one set of annual x-rays, and the least-costly service for emergency dental conditions for the removal or filling of a tooth due to abscess, infection or extreme pain.

Payment Standard. For covered items listed above, use the Fee Schedule for Texas Medicaid Dentist-Orthodontist at www.tmhp.com and proceed as follows:

1. Use the amount listed in the age appropriate Facility or Non-Facility Adjusted Fee for Report Date Column.
2. If the Adjusted Fee for Report Date Column is blank and the Note Code is 5 or blank, HHSC does not have a payable amount; however, a payment amount may be negotiated with the provider.

For additional information on claim payment, the User's Guide to Fee Schedules is provided at the end of Section Four, Service Delivery.

Optional Health Care Services

**Diabetic
Medical
Supplies and
Equipment**

These supplies and equipment must be medically necessary and prescribed by a physician. These supplies and equipment may also be prescribed by an APN if this is within the scope of their practice in accordance with the standards established by the Board of Nurse Examiners and published in 22 Texas Administrative Code §221.13. The county may require the supplier to receive prior authorization.

Items covered are: test strips, alcohol prep pads, lancets, glucometers, insulin syringes, humulin pens, and needles required for the humulin pens.

Insulin syringes, humulin pens, and the needles required for humulin pens are dispensed with a National Dispensing Code (NDC) number and are paid as prescription drugs; they do not count toward the three prescription drugs per month limitation. Insulin and humulin pen refills are prescription drugs (not optional services) and count toward the three prescription drugs per month limitation.

Payment Standard. For covered items listed above, use the Fee Schedule for Texas Medicaid Durable Medical Equipment/Medical Supplies at www.tmhp.com and proceed as follows:

1. Use the amount listed in the age appropriate Facility or Non-Facility Adjusted Fee for Report Date Column.
2. If the Adjusted Fee for Report Date Column is blank and the Note Code is 5 or blank, HHSC does not have a payable amount; however, a payment amount may be negotiated with the provider.

For additional information on claim payment, the User's Guide to Fee Schedules is provided at the end of Section Four, Service Delivery.

Optional Health Care Services

**Durable
Medical
Equipment
(DME)**

This equipment must be medically necessary; meet the Medicare/Texas Title XIX Medicaid requirements; and be provided under a physician's prescription. These supplies and equipment may also be prescribed by an APN if this is within the scope of their practice in accordance with the standards established by the Board of Nurse Examiners and published in 22 Texas Administrative Code §221.13. Items can be rented or purchased, whichever is the least costly. The county may require the supplier to receive prior authorization.

Items covered are: appliances for measuring blood pressure that are reasonable and appropriate, canes, crutches, home oxygen equipment (including masks, oxygen hose, and nebulizers), hospital beds, standard wheelchairs, walkers.

Payment Standard. For covered items listed above, use the Fee Schedule for Texas Medicaid DME at www.tmhp.com and proceed as follows:

1. Use the amount listed in the age appropriate Facility or Non-Facility Adjusted Fee for Report Date Column.
2. If the Adjusted Fee for Report Date Column is blank and the Note Code is 5 or blank, HHSC does not have a payable amount; however, a payment amount may be negotiated with the provider.

For additional information on claim payment, the User's Guide to Fee Schedules is provided at the end of Section Four, Service Delivery.

Optional Health Care Services

Emergency Medical Services

Emergency Medical Services (EMS) services are ground ambulance transport services. When the person's condition is life-threatening and requires the use of special equipment, life support systems, and close monitoring by trained attendants while en route to the nearest appropriate facility, ground transport is an emergency service.

Payment Standard. Use the Fee Schedule for Texas Medicaid Ambulance at www.tmph.com and proceed as follows:

1. Use the amount listed in the age appropriate Facility or Non-Facility Adjusted Fee for Report Date Column.
 2. If the Adjusted Fee for Report Date Column is blank and the Note Code is 5 or blank, HHSC does not have a payable amount; however, a payment amount may be negotiated with the provider.
-

Optional Health Care Services

**Home and
Community
Health Care
Services**

These services must be medically necessary; meet the Medicare/Medicaid requirements; and are provided by a certified home health agency.

A plan of care must be recommended, signed, and dated by the recipient's attending physician prior to care being provided.

The county may require prior authorization.

Items covered are: Registered Nurse (RN) visits for skilled nursing observation, assessment, evaluation, and treatment provided a physician specifically requests the RN visit for this purpose. A home health aide to assist with administering medication is also covered.

Visits made for performing household services are not covered.

The skilled nurse visit is also called an SNV, RN, or LVN visit. The CPT code G0154 in the chart below includes \$10 maximum for incidental supplies used during the visit.

The home health aide visit is also called an HHA visit. The CPT code G0156 in the chart below includes incidental supplies used during the visit.

Payment Standard. Use the TDSHS Payable in the chart below.

TOS	Procedure Code
C	G0154 / Visit
C	G0156 / Visit

**Physician
Assistant (PA)
Services**

These services must be medically necessary and provided by a PA under the supervision of a physician and billed by and paid to the supervising physician.

Payment Standard. Use the Fee Schedules for Texas Medicaid Nurse Practitioner, Clinical Nurse Specialist, and Physician Assistant at www.tmhp.com.

The Medicaid rate for PAs reflects 92% of the rate paid to a physician for the same service and 100 % of the rate paid to physicians for laboratory, X-ray, and injections.

Optional Health Care Services

Vision Care, Including Eyeglasses

Every 24 months one examination of the eyes by refraction and one pair of prescribed eyeglasses may be covered. The county may require prior authorization.

Payment Standard for Examination of the Eyes by Refraction. Use the Fee Schedule for Texas Medicaid Optometrist at www.tmhp.com and proceed as follows:

1. Use the amount listed in the age appropriate Facility or Non-Facility Adjusted Fee for Report Date Column.
2. If the Adjusted Fee for Report Date Column is blank and the Note Code is 5 or blank, HHSC does not have a payable amount; however, a payment amount may be negotiated with the provider.

Payment Standard for Prescribed Eyeglasses. Use the Fee Schedule for Texas Medicaid Optician at www.tmhp.com and proceed as follows:

1. Use the amount listed in the age appropriate Facility or Non-Facility Adjusted Fee for Report Date Column.
2. If the Adjusted Fee for Report Date Column is blank and the Note Code is 5 or blank, HHSC does not have a payable amount; however, a payment amount may be negotiated with the provider.

For additional information on claim payment, the User's Guide to Fee Schedules is provided at the end of Section Four, Service Delivery.

Optional Health Care Services

Federally Qualified Health Center (FQHC) Services

These services must be provided in an approved FQHC by a physician, a physician assistant, an advanced practice nurse, a clinical psychologist, or a clinical social worker.

Payment Standard. Use the Rate Per Visit in the “FQHC Rates” included in Appendix B.

Occupational Therapy Services

These services must be medically necessary and may be covered if provided in a physician’s office, a therapist’s office, in an outpatient rehabilitation or free-standing rehabilitation facility, or in a licensed hospital. Services must be within the provider’s scope of practice, as defined by Occupations Code, Chapter 454.

Payment Standard. Use the Fee Schedule for Texas Medicaid Occupational Therapist at www.tmph.com and proceed as follows:

1. Use the amount listed in the age appropriate Facility or Non-Facility Adjusted Fee for Report Date Column.
-

Physical Therapy Services

These services must be medically necessary and may be covered if provided in a physician’s office, a therapist’s office, in an outpatient rehabilitation or free-standing rehabilitation facility, or in a licensed hospital. Services must be within the provider’s scope of practice, as defined by Occupations Code, Chapter 453.

1. Payment Standard. Use the Fee Schedule for Texas Medicaid Physical Therapist at www.tmph.com and proceed as follows:
2. Use the amount listed in the age appropriate Facility or Non-Facility Adjusted Fee for Report Date Column.

Fee Schedules

ALL TEXAS MEDICAID FEE SCHEDULES ARE AVAILABLE AT THE FOLLOWING LINK: www.tmhp.com

- The Texas Medicaid Fee Schedule is categorized by field descriptions. TOS (Types of Service) codes are listed in the first field. The TOS identifies the specific field or specialty of services provided. The TOS descriptions are listed below:

0 Blood Products	5 Laboratory	9 DME – Other
1 Medical Services	6 Radiation Therapy	E Eyeglasses
2 Surgery	7 Anesthesia	I Interpretation
3 Consultation	8 Assistant Surgery	T Technical
4 Radiology	F ASC / HASC	

Procedure Code. The third field lists the current procedure codes. The Texas Medicaid Physician, APN, and CRNA Fee Schedules each contain a list of payment rates for Current Procedural Terminology (CPT) codes, including the (TOS 7) American Society of Anesthesiologists (ASA) procedure codes. The five-character alphanumeric procedure codes follow the numeric procedure codes.

Modifier. It is placed after the five-digit procedure code, if applicable. A modifier describes and qualifies services that are provided however not all procedures require a modifier. Modifiers may affect the CIHCP payment amount. A list of frequently used modifiers is located in the Texas Medicaid Providers Procedures Manual in Section 6 “Claims Filing” at http://www.tmhp.com/TMHP_File_Library/Provider_Manuals/TMPPM/2011_Texas_Medicaid_Provider_Procedures_Manual.pdf

Child Age. The sixth and seventh fields list the age range for pricing determination.

Resource-Based Units. Texas Medicaid Reimbursement Methodology. The eighth field lists the payable amount for the TOS and procedure code.

Total RVUs. The ninth field lists the relative value units for the procedure code.

Conv Factor. The tenth field lists the conversion factor used in the calculation formula for anesthesia services in determining the TMRM payable amount.

PPS Fee. The eleventh field lists the prospective payment system (PPS) fee. **Not applicable for CIHCP.**

Fee Schedules
(continued)

Access-Based or Max Fee. The twelfth field lists the access-based fee amount or maximum fee.

Effective Date. The thirteenth field lists the effective date for total RVUs for RBFs. For fees other than RBFs, the effective date for the PPS, access-based, or max fee.

Note Code. The fourteenth field lists the note code indicator. For CIHCP, a payment amount may be negotiated with the provider when the Note Code is 5.

- TOS. The CPT codes are divided into sections based on the type of service (TOS) codes. The 1-digit TOS code identifies the specific field or specialty of services provided.

TOS 0 and TOS 9 are not basic health care services.

Use the following TOS definitions and payment information.

TOS

DEFINITION and PAYMENT INFORMATION

- 1 Medical Services** – includes office, inpatient hospital, and emergency room visits; allergy treatment; chemotherapy; injections; physical therapy; dialysis; psychotherapy; ophthalmology; dermatology; ventilation; etc. Excludes anesthesia, radiological interpretations, and laboratory interpretations.

Fee Schedules
(continued)

2 Surgery – includes invasive diagnostic procedures.

Single Surgical Procedure. Unless the description for a surgical procedure clearly states otherwise, a single surgical procedure code represents the full scope of activities performed to complete the surgical procedure.

Multiple Surgical Procedures. Some surgical services involve multiple surgical procedures that may be payable as separate procedures **but only** if they are not a component of a more comprehensive procedure.

Determine if the multiple surgical procedure codes are:

- o components of one comprehensive procedure, or
- o a primary procedure and secondary procedure(s).

If you are unable to make this determination, contact the provider for further clarification.

The payment standard for paying multiple surgical procedures that are not components of one comprehensive procedure is to allow the full TDSHS physician payment standard for the primary procedure and half of the TDSHS physician payment standard for the other procedure(s).

3 Consultations – used when the attending physician consults with another physician concerning some non-surgical aspect of the patient's treatment.

Fee Schedules
Types of Service
(continued)

TOS

DEFINITION and PAYMENT INFORMATION

- 4 Radiology** (total component, i. e., technical and interpretation) – includes radiological exams (x-rays), computerized axial tomography (CAT scans), magnetic resonance imaging (MRI), mammography, echography (ultrasound), and other types of internal organ and vascular x-rays.

Procedure codes with a TOS 4 include radiology services that are both the technical component and the interpretation (professional) component of x-ray services.

Use the following information for processing bills for TOS 4 (Radiology), TOS T (Technical), and TOS I (Interpretation).

Providers who perform both the technical and the interpretation service may be paid for the total component (TOS 4).

Providers who perform only the technical service may be paid only for the technical component (TOS T).

Providers who perform only the interpretation service may be paid only for the interpretation component (TOS I).

TOS 4 = total component (Technical + Interpretation)

TOS 4 = TOS T + TOS I

In summary,

- o If a TOS 4 is paid first, then the total component has been met.
 - o If a TOS T is paid first, then a TOS I may be payable.
 - o If a TOS I is paid first, then a TOS T may be payable.
-

Fee Schedules
Types of Service
(continued)

TOS

DEFINITION and PAYMENT INFORMATION

- 5 Laboratory** (total component, i. e., technical and interpretation) – includes most types of blood, urine, feces, and sputum tests and tests on other bodily fluids or by-products; tissue studies and analysis; various hearing and speech tests; electrocardiograms (EKGs) and cardiovascular stress tests; respiratory (pulmonary) function tests; electroencephalograms (EEGs) and other brain activity tests.

Procedure codes with a TOS 5 include laboratory services that are both the technical component and the interpretation (professional) component of laboratory services.

Use the following information for processing bills for TOS 5 (Laboratory), TOS T (Technical), and TOS I (Interpretation).

Providers who perform both the technical and the interpretation service may be paid for the total component (TOS 5).

Providers who perform only the technical service may be paid only for the technical component (TOS T).

Providers who perform only the interpretation service may be paid only for the interpretation component (TOS I).

TOS 5 = total component (Technical + Interpretation)

TOS 5 = TOS T + TOS I

In summary,

- o If a TOS 5 is paid first, then the total component has been met.
 - o If a TOS T is paid first, then a TOS I may be payable.
 - o If a TOS I is paid first, then a TOS T may be payable.
-

Fee Schedules
Types of Service
(continued)

TOS

DEFINITION and PAYMENT INFORMATION

- 6 Radiation Therapy** (total component, i. e., technical and interpretation) – includes radiology treatment planning, radiological dosimetry, teletherapy, megavoltage treatment, and radioelement application.

Procedure codes with a TOS 6 include radiation therapy services that are both the technical component and the interpretation (professional) component of radiology treatment planning, radiological dosimetry, teletherapy, megavoltage treatment, and radioelement application services.

Use the following information for processing bills for TOS 6 (Radiation Therapy), TOS T (Technical), and TOS I (Interpretation).

Providers who perform both the technical and the interpretation service may be paid for the total component (TOS 6).

Providers who perform only the technical service may be paid only for the technical component (TOS T).

Providers who perform only the interpretation service may be paid only for the interpretation component (TOS I).

TOS 6 = total component (Technical + Interpretation)

TOS 6 = TOS T + TOS I

In summary,

- o If a TOS 6 is paid first, then the total component has been met.
- o If a TOS T is paid first, then a TOS I may be payable.
- o If a TOS I is paid first, then a TOS T may be payable.

Fee Schedules
Types of Service
(continued)

TOS

DEFINITION and PAYMENT INFORMATION

- 7 Anesthesia** – usually provided by or under the supervision of a physician in a hospital setting.

Fee Schedules
Types of Service
(continued)

TOS

DEFINITION and PAYMENT INFORMATION

- 8 Assistant Surgery** – a surgical procedure that requires the assistance of another surgeon.

Procedure codes with a TOS 8 include assistant surgical services. In addition, use of a modifier code of 80, 81, and 82 with a surgical procedure code results in TOS 8 being assigned to the procedure.

Although certain surgical procedures require the service of an assistant surgeon, not all surgical procedures require this service.

Single Surgical Procedure. Unless the description for a surgical procedure clearly states otherwise, a single surgical procedure code represents the full scope of activities performed to complete the surgical procedure.

Multiple Surgical Procedures. Some surgical services involve multiple surgical procedures that may be payable as separate procedures **but only** if they are not a component of a more comprehensive procedure.

Determine if the multiple surgical procedure codes are:

- o components of one comprehensive procedure, or
- o a primary procedure and secondary procedure(s).

If you are unable to make this determination, contact the provider for further clarification.

The payment standard for paying multiple surgical procedures that are not components of one comprehensive procedure is to allow the full TDSHS physician payment standard for the primary procedure and pay half of the TDSHS physician payment standard for the other procedure(s).

Fee Schedules
Types of Service
(continued)

TOS

DEFINITION and PAYMENT INFORMATION

- I Interpretation** – professional component for radiology, laboratory, or radiation therapy services.

Only one provider is entitled to reimbursement for interpreting a radiology, laboratory or radiation therapy procedure.

Providers who perform both the technical and the interpretation service may be paid for the total component (TOS 4, 5, or 6).

Providers who perform only the technical service may be paid only for the technical component (TOS T).

Providers who perform only the interpretation service may be paid only for the interpretation component (TOS I).

TOS 4, 5, or 6 = total component (Technical and Interpretation)

TOS 4, 5, or 6 = TOS T + TOS I

In summary,

- o If a TOS 4, 5, or 6 is paid first, then the total component has been met.
- o If a TOS T is paid first, then a TOS I may be payable.
- o If a TOS I is paid first, then a TOS T may be payable.

Fee Schedules
Types of Service
(continued)

TOS

DEFINITION and PAYMENT INFORMATION

T Technical – technical component for radiology, laboratory, or radiation therapy services.

Only one provider is entitled to reimbursement for performing the technical component of a radiology, laboratory, or radiation therapy procedure.

Providers who perform both the technical and the interpretation service may be paid for the total component (TOS 4, 5, or 6).

Providers who perform only the technical service may be paid only for the technical component (TOS T).

Providers who perform only the interpretation service may be paid only for the interpretation component (TOS I).

TOS 4, 5, or 6 = total component (Technical + Interpretation)

TOS 4, 5, or 6 = TOS T + TOS I

In summary,

- o If a TOS 4, 5, or 6 is paid first, then the total component has been met.
- o If a TOS T is paid first, then a TOS I may be payable.
- o If a TOS I is paid first, then a TOS T may be payable.

SECTION FIVE

STATE ASSISTANCE FUNDS

General Principles

General Principles

- Based on an annual allocation, subject to funding, TDSHS distributes state assistance funds to counties not fully served by a public hospital or a hospital district.
 - In order to receive state assistance funds, a county must comply with the TDSHS-established standards and procedures contained in this handbook.
 - Expenditures are reimbursable if they are:
 - o Paid for CIHCP eligible county residents,
 - o Paid for CIHCP basic or department-approved optional health care services, and
 - o Paid according to the CIHCP payment standards.
 - Reimbursable expenditures must be paid in the state fiscal year for which state assistance funds are being requested.
 - The county is eligible for state assistance funds when it exceeds the 8.0% GRTL expenditure level.
-

Steps for Applying

Steps for Applying for State Assistance Funds

- **Submit Forms 105 and 300.**
- **Report the county's GRTL to the Texas State Comptroller.**
- **Notify TDSHS.**
- **Request state assistance funds.**

Step 1 **Submit a Form 105** to be received by the TDSHS County Indigent Health Care **Program** (CIHCP) by the 10th of the month following the report month. Form 105 must have been submitted for each of the 12 months prior to the month state assistance funds are requested.

Submit Form 300 to TDSHS CIHCG in Austin by the 30th of September.

Step 2 **Report the county's GRTL** to the Texas State Comptroller of Public Accounts.

Step 3 **Notify TDSHS CIHCG** by **email** within seven days after the date that the county will expend 6% of its GRTL and follow up with a written notification.

6% Program Review. Upon receiving written notification that a county has expended 6% of its GRTL, TDSHS may complete a review of the county's eligibility system **and billing**, and provide the county with a written report on the findings of the review.

If deficiencies are identified, the county must correct them within five workdays from the date the deficiencies are identified. The county must subtract any uncorrectable deficiencies from reimbursable expenditures.

Step 4 **Request state assistance funds** when the county exceeds the 8.0% GRTL expenditure level.

Compute the dollar amount that will be paid when the court authorizes payment. Request 90% of that amount from TDSHS.

Contact TDSHS by telephone or e-mail to request state assistance funds prior to the Commissioners Court authorizing payment of the health care claims. TDSHS will provide the county with a State Assistance Request Number.

Complete and submit to TDSHS Form 500, Request for State Assistance Funds, and supporting documentation within 30 days after the request.

SECTION SIX

SSI REIMBURSEMENT

General Principles

General Principles

- In order to receive retroactive Medicaid reimbursement for SSI appellants, a county must comply with the TDSHS-established standards and procedures contained in this handbook.
 - In order to receive retroactive Medicaid reimbursement for SSI appellants, a county must comply with the TDSHS-established standards and procedures contained in this handbook.
 - Effective October 1, 2008, HHSC can only file Medicaid claims for reimbursement if they are:
 - Paid for CIHCP eligible county residents,
 - received within 95 days from the "SSI add date",
 - AND within 365 days from the date of service.
 - In addition, due to changes in the Texas Administrative Code, all Medicaid claims processed through HHSC must meet the 365-day federal filing deadline.
-

Steps for Applying

Steps for requesting Medicaid reimbursement for SSI appellants.

- **Submit a TMHP Confidentiality Form**
- **Have client sign 113**
- **Have provider sign 113**
- **Submit Form 112 & 113 to HHSC**

Step 1 County staff must sign and submit a Confidentiality Form to HHSC.

Step 2 County staff must have a potential SSI appellant sign a Form 113, the form must then also be signed by the provider. ****claims paid before signatures are obtained will not be eligible for reimbursement!!****

Step 3 Submit Form 112 with requested reimbursement costs and Medicaid approved claim forms (1500, UB-04 or pharmacy statement).

The full Medicaid reimbursement manual may be accessed at:

<http://www.dshs.state.tx.us/cihcp/Medicaid-Reimbursement-Process>

Health and Human Services Commission

County Indigent Health Care Program

FORMS

FOR OFFICE USE ONLY / PARA USO DE LA OFICINA

Status <input type="checkbox"/> Application <input type="checkbox"/> 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? Si es el caso, enumere los nombres que ha usado. <input type="checkbox"/> Yes/Sí <input type="checkbox"/> 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.

- | | | |
|--|---|---|
| <input type="checkbox"/> Own or paying for home
Soy dueño de mi casa o la estoy comprando | <input type="checkbox"/> Live in a house provided by someone else
Vivo en una casa ajena | <input type="checkbox"/> No permanent residence
No tengo residencia permanente |
| <input type="checkbox"/> Live with someone else
Vivo con otra persona | <input type="checkbox"/> Rent House/Apartment
Rento una casa o apartamento | <input type="checkbox"/> 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 "Sí," ¿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; 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.

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.

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.

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**SOLICITUD DE ASISTENCIA DE ATENCIÓN MÉDICA**

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.

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.) Contestar 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 la escuela; registros de volante; 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 artículos 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 salarios 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 Necesitadas (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 días para determinar su elegibilidad.

Después de entregar su solicitud, usted debe reportar dentro de un plazo de 14 días cualquier cambio de dirección, ingreso, recursos, el número de personas que viven con usted, o si solicita o recibe Medicaid, TANF, o SSI.

PURPOSE

Use [as the application for](#):

- The County Indigent Health Care Program (CIHCP) [and](#)
- CIHCP case [record](#) reviews.

PROCEDURE

Issue Form 100 on the date requested.

[Provide assistance in completing the Form 100, if necessary.](#)

[Complete the “For Office Use Only” section of Form 100.](#) The applicant completes the remainder of Form [100](#).

[File](#) the completed Form [100](#) in the case record.

DETAILED INSTRUCTIONS for the “FOR OFFICE USE ONLY” SECTION

Status.

- Check the “Application” box if the Form [100](#) is being submitted as:
 - o An initial application or
 - o [A subsequent application when there has been a break in eligibility periods.](#)
- Check the “Review” box if the Form [100](#) is being [submitted](#) for a [case record](#) review.

Date Form 100 is Requested/Issued. Enter the date [that](#) the [Form 100](#) is requested [and issued](#).

Date Identifiable Form 100 is Received in Office. Enter the date that the county receives an identifiable [Form 100](#). This date is the application file date.

The identifiable application includes [these four, shaded](#) items, namely:

- 1.) The applicant’s name,
- 2.) The applicant’s address,
- 3.) The applicant’s signature, and
- 4.) The date the applicant signed the application.

Case Record Number. Enter the county’s case [record](#) number for the application.

Appointment Date and Time. Enter the date and the time of the interview, [if applicable](#).

FORM RETENTION

Maintain the records at least until the end of the third complete state fiscal year following the date on which the application is submitted.



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

Form 100A, Page 1 of 2 / February 2016

FOR OFFICE USE ONLY / PARA USO DE LA OFICINA

<input type="checkbox"/> Application <input type="checkbox"/> Review	Date Form 100-B is Requested/Issued	Date Identifiable Form100-B Received	Case Record Number	Appointment Date and Time, if applicable
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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 / codigo postal
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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.

Date of Birth / Fecha de nacimiento	Sex	SSN / Numero de seguro social
-------------------------------------	-----	-------------------------------

1. What is your county and state of residence (where you make your permanent home)? Do you plan to remain in this county? Yes/Sí No
 ¿En qué condado y en qué estado viven (tienen su hogar permanente)? Usted planea permanecer en este condado?

County/Condado _____ State/Estado _____

2. Are you receiving benefits/coverage from (Medicare, Medicaid, SSI, TANF, health insurance, CHIP, V. A., worker's compensation)?
 ¿Recibe usted beneficios de Medicare, Medicaid, SSI, TANF, seguro medico, CHIP, VA, o indemnización laboral) ? Yes/Sí No

If Yes, please explain?
 Si tienes, explique? _____

3. Are you pregnant?
 ¿Está usted embarazada? Yes/Sí No

4. Do you have unpaid health care bills from the last three months?
 ¿Tiene usted cuentas médicas sin pagar de los últimos tres meses? Yes/Sí No

If Yes, which months?
 Si contesto "Sí," ¿Cuáles meses? _____

5. How much money do you have on your commissary or jail account?
 ¿Cuánto dinero tiene usted en su comisario? \$

6. Have you worked in the last three months?
 ¿Ha trabajado usted en los últimos tres meses? Yes/Sí No

7. List all of your income that was received this month, prior to incarceration. Be sure to include the following: Government checks; money from work; money from charging room and board; cash gifts, loans, or contributions from relatives and others; sponsor's income; school grants or loans; and unemployment./
 Haga una lista de los ingresos que recibió este mes, antes de su encarcelamiento. Asegúrese de anotar: Cheques del gobierno; ingresos de trabajo o de capacitación; dinero que recibe por 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 statement 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 any information necessary to prove statements about my eligibility. 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 toda la información necesaria para comprobar mis declaraciones sobre la elegibilidad. Yo entiendo y acepto que al proporcionar información falsa puede resultar in que yo no califique y que tenga que devolver el pago al Programa.

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 - 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
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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 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 provide an explanation of the information that you write on your application or what you tell the person interviewing you.

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 provide information regarding health care insurance and any other third party benefits that may be 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.

The CIHCP must determine if you are eligible within 14 days of you submitting a completed application for health care assistance.

After turning in your application, you must report within 14 days any changes regarding your address, status of your incarceration, income, and resources.

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.) Contestar tantas preguntas que pueda sobre esta solicitud.

Entregue su solicitud, o envíela por 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:

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.

El CIHCP debe determinar si eres elegible dentro de 14 días de presentar una solicitud para asistencia de cuidado de salud.

Después de entregar su solicitud, usted debe reportar dentro de un plazo de 14 días cualquier cambio de dirección, status de su encarcelamiento, ingreso, o recursos.

ELIGIBILITY ITEMS

DOCUMENTATION

3. Residence

A. Is each CIHCP household member a county resident?.....
 Yes No

B. Does each CIHCP household member plan to remain in the county?
 Yes No

[Verify residence if questionable.]

4. Resources *[Exempt all resources of the Medicaid recipients listed in 2C.]*

A. Does any CIHCP household member own the following?

Resource	Yes	No	Countable Value
1. Cash on Hand			
2. Certificates of Deposit			
3. Checking Accounts			
4. Insurance Settlements			
5. Lawsuit Settlements			
6. Livestock			
7. Lump Sum Payments			
8. Notes, Bonds, Stocks			
9. Prepaid Burial Insurance			
10. Real Estate (excluding homestead)			
11. Retirement (including IRAs)			
12. Savings Accounts			
13. Vehicles			
14. Alien Sponsor's Resources			
15. Other Resources			
16. TOTAL COUNTABLE RESOURCES <i>[This amount is not rounded.]</i>			\$

B. Has any CIHCP household member transferred a countable resource within 3 months before application? . Yes No

[Document regarding countable resources for the application month and the 3 months prior. Verify resources if questionable or if the countable value is close to the resource limit.]

5. Income *[Exempt all income of the Medicaid recipients listed in 2C.]*

A. Does any CIHCP household member have terminated income in the application month or the 3 months prior? Yes No

B. Does any CIHCP household member have any other countable income in the application month or the 3 months prior?.....
 Yes No

[Document and verify all countable income, including terminated income, for the application month and the 3 months prior.]

ELIGIBILITY ITEMS

DOCUMENTATION

6. Budget Calculation

A. Determine the household's monthly total countable income.

Type of Income	Name of Member(s) w/ Income		
Earned Income (#1 through #7)			
1. Monthly Gross Earned Income			
2. Standard Work-Related Expense	-	-	
3. Subtotal (Line 1 minus Line 2)	=		
4. Calculate 1/3 of Line 3	-	-	
5. Subtotal (Line 3 minus Line 4)	=		
6. Child / Incapacitated Adult Care	-	-	
7. Countable Earned Income	=		
Unearned Income (#8 through #17)			
8. Alien Sponsor's Income			
9. Cash Gifts, Contributions, Prizes			
10. Interest and Dividend Payments			
11. Retirement Benefit Payments			
12. Social Security Benefit Payments			
13. Unemployment Benefit Payments			
14. V. A. Benefit Payments			
15. Worker's Compensation Payments			
16. Other Unearned Income			
(Add Line 7 plus Lines 8 through 17.)			
17. TOTAL COUNTABLE INCOME	+	+	= \$

B. Complete 6B if anyone in the CIHCP household is making child support payments, alimony payments, other payments to persons they can claim as tax dependents or are legally obligated to support and who reside outside the CIHCP home, or if a household member was disqualified due to receiving Medicaid (refer to section 2C page1). If none of these exist, then proceed to 6C.

1. Total countable Income from 6A, Line 18	\$
2. Deduction for the support of the Medicaid recipients listed in 2C (See Handbook, Section 2, Page 29.)	-
3. Deduction for the actual amount of household member's payments made to dependents outside the household group including child support, alimony, and other payments made to persons they can claim as tax dependents or are legally obligated to support.	-
4. Net Countable Income (Line 1 minus Lines 2 and 3)	= \$

C. Compare the CIHCP Household's Net Countable Income to the CIHCP Monthly Income Standard.

1. NET COUNTABLE INCOME (from 6A, Line 18 or from 6B, Line 4) with cents rounded down.	\$
2. CIHCP Monthly Income Standard for the CIHCP household (See Handbook, Section 2, Page 30.)	\$

If the Line 1 amount is equal to or less than the Line 2 amount, the CIHCP household is income eligible.

If the Line 1 amount is greater than the Line 2 amount, the CIHCP household is not income eligible.

PURPOSE

Use to:

- Document all pertinent information and
- Calculate monthly net income.

PROCEDURE

Complete a separate Form 101 for each application and each review.

File Form 101 in the case record with the accompanying Form 100.

DETAILED INSTRUCTIONS

On the top of Form 101, enter the date the identifiable Form 100 is received in the office, the case record number, the type of determination, the case record name, the case record action, the eligibility effective date, and the prior eligibility effective dates, if applicable.

The Eligibility Determiner signs and dates the Form 101 when the decision is made.

For Eligibility Items:

- Check all Yes-No-N/A items.
- Answer all questions, if applicable.
- Refer to Section 2, Pages 24 - 30 to complete Item 6, Budget Calculation.

In the Documentation column, record exempt resources, exempt income, clarification of questionable information, collateral contacts, verifications, and additional information.

FORM RETENTION

Maintain the records at least until the end of the third complete state fiscal year following the date on which the application is submitted.

County Indigent Health Care Program (CIHCP)

REPORT OF CHANGES

Case Record Name (Last, First, Middle)	Case Record Number

--

[Empty form area]

PURPOSE

Use to:

- Document reported changes and
- Document other reported or gathered information that is pertinent to the case record.

PROCEDURE

Complete the case record name and the case record number.

Document.

File the Form 101-A in the case record.

FORM RETENTION

Maintain the records at least until the end of the third complete state fiscal year following the date on which the application is submitted.

**COUNTY INDIGENT HEALTH CARE PROGRAM
APPOINTMENT NOTICE**
PROGRAMA DE ATENCIÓN MÉDICA PARA INDIGENTES DEL CONDADO
AVISO DE CITA

--	--

Date/Fecha	Case Record No./Núm de Caso
Office Address and Telephone No./Oficina y Teléfono	

(Only the checked box applies to you.)

(Solo la sección marcada se aplica a su caso.)

Before I can determine your eligibility for assistance, I need to interview you about your circumstances and to answer any questions you may have. I have scheduled an interview for:

Antes de poder determinar su elegibilidad para asistencia, necesito hacerle una entrevista para discutir con usted su situación y para contestarle cualquier pregunta que tenga. Tiene usted una entrevista conmigo el:

Date/Fecha	Time/Hora	Place/Lugar

I need to review your case to see if you are still eligible for assistance. I have scheduled an interview for:

Necesito repasar su caso para determinar si todavía califica para asistencia. Tiene usted una entrevista conmigo el:

Date/Fecha	Time/Hora	Place/Lugar

If you cannot keep this appointment, please notify me as soon as possible so that I can make other arrangements. If you do not come to the interview or contact me, I will assume you do not want to receive assistance. Contact me if you have any questions.

Si usted no puede venir a la hora especificada, avíseme lo más pronto posible para arreglar otra cita. Si usted no viene a la entrevista ni se comunica conmigo, voy a suponer que no quiere recibir asistencia. Si tiene alguna pregunta, hábleme.

By/De: _____

Applicant Information

1. When you have your interview, it would be helpful for you to bring the following information:
 - Identification, such as your driver's license or your voter's registration card.
 - Proof of county residence, such as mail addressed to you, your spouse, or other members of your household; voting records; Texas driver's license or other official identification; payment of property tax; or any other relevant information.
 - Proof of resources, such as checking or savings account statements, tax statements for real estate, or stocks and bonds.
 - Proof of all household income, such as paycheck stubs, a letter from employer, award letters, or self-employment records.
 - Proof of child-care expenses, such as receipts for payment.
 - Social security numbers (if available) for you and the other members of your household for whom you are requesting assistance.
2. You may not be eligible if you transfer ownership of property just to make yourself eligible for assistance.
3. You have the right to:
 - **Receive** an application when you ask for it.
 - Have assistance in completing the application.
 - Have your eligibility determined no later than the 14th day after a complete application, including all requested verifications, is received.
 - Receive written notification of the county's decision. If a county denies assistance, this notification must include reason for the denial and an explanation of the procedure for appealing the denial.
 - Appeal a denial of assistance.
 - Resubmit an application at any time circumstances justify a re-determination of your eligibility if you have been denied assistance.
 - Equal treatment without regard to your race, color, religion, sex, age, national origin, political beliefs, or disability.
4. Your application may be denied if you do not provide all needed information.

Información Para el Solicitante

1. Cuando venga a su entrevista, se le recomienda que traiga la siguiente información:
 - Identificación, como, por ejemplo, su licencia de manejar o su certificado de Registro Electoral.
 - Prueba de residencia en el condado, como, por ejemplo, correo dirigido a usted, su esposa (o) u otro miembro de la casa; récords electorales; licencia de manejar u otra identificación oficial; recibo de impuestos sobre propiedades; u otra cosa por el estilo.
 - Prueba de recursos, como, por ejemplo, extractos de cuentas de cheques o de ahorros, recibos de impuestos de bienes raíces, o acciones y bonos.
 - Prueba de los ingresos de todos los miembros de la casa como, por ejemplo, talones de cheque de paga, una carta del empleador, cartas de concesión, o récords de negocio propio.
 - Prueba de gastos de sostenimiento para niños, como, por ejemplo, recibos de pagos.
 - Número de Seguro Social (si lo tiene disponible) para usted y para cada miembro de su casa para quien solicita asistencia.
2. Si traspasa propiedad con la intención de hacerse elegible para asistencia, corre el riesgo de no calificar.
3. Usted tiene derecho a:
 - **Recibir** una solicitud cuando la pide.
 - Obtener ayuda para llenar la solicitud.
 - Recibir una determinación sobre su elegibilidad, a los 14 días del día en que se recibe su solicitud completa, junto con todas las verificaciones pedidas.
 - Recibir un aviso por escrito de la decisión del condado. Si el condado le niega asistencia, el aviso tiene que incluir la razón para la negación y una explicación del procedimiento para apelar la negación.
 - Apelar una negación de asistencia.
 - Solicitar asistencia de nuevo si su situación lo justifica cuando asistencia se le ha negado.
 - Igualdad en el trato sin distinción de raza, color, religión, sexo, edad, origen nacional, creencias políticas, o incapacidad.
4. Su solicitud per negada si usted no da toda la información necesitada.

PURPOSE

Use to:

- Schedule an interview appointment,
- Provide the household with examples of the type of information to bring to the interview, and
- Provide the household with information about their rights.

PROCEDURE

Complete an original and [one copy of Form 102](#).

Issue the original [Form 102](#) to the household.

File [the copy of the Form 102](#) in the case record.

DETAILED INSTRUCTIONS

At the top of Form 102, enter the client's name and address, the date the Form 102 is issued, the case [record](#) number, the office address and telephone number.

Check the appropriate box and enter the interview date, time, and place.

The staff person issuing the Form 102 should sign the Form 102.

FORM RETENTION

Maintain the records at least until the end of the third complete state fiscal year following the date on which the application is submitted.

**COUNTY INDIGENT HEALTH CARE PROGRAM
REQUEST FOR INFORMATION
PROGRAMA DE ATENCIÓN MÉDICA PARA INDIGENTES DEL CONDADO
SOLICITUD DE INFORMACIÓN**

Date/Fecha	Case Record No./Núm de Caso
Office Address and Telephone No./Oficina y Teléfono	

Your application for assistance is not complete. To determine your eligibility, we need the following additional information./Su solicitud de asistencia no está completa. Para determinar su elegibilidad, necesitamos la siguiente información.

ONLY THE CHECKED BOXES APPLY TO YOU./SOLAMENTE LAS CASILLAS MARCADAS SE APLICAN A SU CASO.

- | | |
|---|--|
| <input type="checkbox"/> Mail Addressed to You or Another Household Member
Correo Dirigido a Usted o a Otra Persona de su Casa | <input type="checkbox"/> Federal Income Tax Return
Declaración de los Impuestos Federales Sobre los Ingresos |
| <input type="checkbox"/> Texas Driver's License or Other Official Identification
Licencia de Manejar de Texas u Otra Identificación Oficial | <input type="checkbox"/> Self-Employment Bookkeeping, Sales, Expenditure Records
Comprobantes de Cuentas, Ventas, Gastos de Trabajo Independiente |
| <input type="checkbox"/> Voter Registration Card
Certificado de Registro Electoral | <input type="checkbox"/> Social Security Award Letter, Check, or Denial Notice
Cheque de Seguro Social o Carta Diciendo si se lo Van a Dar o No |
| <input type="checkbox"/> Automobile Registration
Registro del Automóvil | <input type="checkbox"/> Disability Insurance Award Letter or Check
Cheque de Seguro por Incapacidad or Carta Diciendo que Van a Dárselo |
| <input type="checkbox"/> Notice of TANF, SNAP (Food Stamps), or Medicaid Benefits
Aviso de Beneficios de TANF, Estampillas para Comida o Medicaid | <input type="checkbox"/> Unemployment Compensation Award Letter or Check
Cheque de Compensación de Desempleo o Carta Diciendo que Van a Dárselo |
| <input type="checkbox"/> Checking Account Statement
Estado de Cuenta de Cheques | <input type="checkbox"/> Veterans Administration Award Letter or Check
Cheque de la Administración de Veteranos o Carta Diciendo que Van a Dárselo |
| <input type="checkbox"/> Savings Account Statement
Estado de Cuenta de Ahorros | <input type="checkbox"/> Worker's Compensation Award Letter or Check
Cheque del Seguro Obrero o Carta Diciendo que Van a Dárselo |
| <input type="checkbox"/> Paychecks or Paycheck Stubs
Cheques de Paga o Talones de Cheques de Paga | <input type="checkbox"/> Verification of Application for Social Security or SSI
Verificación de Aplicación para Seguro Social o Seguridad de Ingreso |
| <input type="checkbox"/> Earnings Statement from Employer
Verificación de Sueldo Preparada por el Empleador | <input type="checkbox"/> Verification of Application for Other Assistance Programs
Verificación de Aplicación para Otros Programas de Asistencia |
| <input type="checkbox"/> Other Items
Otra _____

_____ | |

PLEASE RETURN THE ITEMS CHECKED ABOVE BY:
HAGA EL FAVOR DE ENVIAR LOS DOCUMENTOS ENUMERADOS PARA EL:

A decision about your eligibility will be made no later than 14 days after your application is complete, including all requested information. If we do not receive the information we need and you do not contact me, I will assume that you do not want assistance. Call me if you have any questions./Se tomará una decisión en cuanto a su elegibilidad a más tardar 14 días después de que tengamos su solicitud completa, incluyendo todas información pedidas. Si no recibimos la información que necesitamos y usted no se comunica conmigo, supondré que usted no quiere asistencia. Si tiene alguna pregunta, hábleme.

Signature/Firma: _____

PURPOSE

Use to:

- Notify the applying household that their application is not complete and what additional information is needed to complete it,
- Notify the eligible household that additional information is needed for their case record and what additional information is needed, and
- Notify the household regarding the date by which additional information is needed.

PROCEDURE

Complete an original and one copy of Form 103.

Issue the original Form 103 to the household.

File the copy of the Form 103 in the case record.

DETAILED INSTRUCTIONS

At the top of Form 103, enter the household's name and mailing address, the date the Form 103 is issued, the case record number, the office address and telephone number.

Check the box to the left of each specific information item the household needs to provide.

Enter the date (MM-DD-YY) by which the household must provide the requested information.

The person issuing the Form 103 should sign the Form 103.

FORM RETENTION

Maintain the records at least until the end of the third complete state fiscal year following the date on which the application is submitted.

PURPOSE

Use to record [expenditures for](#) health care services provided to eligible persons.

PROCEDURE

[Maintain Form 104 for each client.](#)

Enter information on [the](#) Form 104 as information becomes available.

[File the Form 104 in the case record.](#)

DETAILED INSTRUCTIONS

Columns 1 – 6 are self-explanatory.

Date Paid (Column 7). Enter the date that the county writes a check to pay the claim.

Reimbursements (Column 8). Enter the amount of reimbursements received, if any, from the client, provider, any third party resource, and SSI Medicaid reimbursements.

FORM RETENTION

Maintain the records at least until the end of the third complete state fiscal year following the date on which the application is submitted.

**COUNTY INDIGENT HEALTH CARE PROGRAM
MONTHLY FINANCIAL REPORT**

County Name _____ Report for (Month/Year) _____
 or
 Amendment of the Report for (Month/Year) _____

I. REIMBURSABLE EXPENDITURES during This Report Month

Physician Services	1.	
Prescription Drugs	2.	
Hospital, Inpatient Services	3.	
Hospital, Outpatient Services	4.	
Laboratory/X-Ray Services	5.	
Skilled Nursing Facility Services	6.	
Family Planning Services	7.	
Rural Health Clinic Services	8.	
State Hospital Contracts	9.	
Optional Health Care Services	10.	
Amount of Intergovernmental Transfer	11.	
Total Expenditures (Add #1 through #11.)		12.
Reimbursements Received (Do not include State Assistance.)	13. ()	
6% Eligibility System Review Findings (\$ in error)	14. ()	
Total to be Deducted (Add #13 + #14.)		15. ()
Applied to State Assistance Eligibility/Reimbursement (#12 minus #15)		16.

II. EXPENDITURE TRACKING for State Assistance Funds Eligibility/Reimbursement

TOTAL EXPENDITURES for Current State Fiscal Year (9/1 – 8/31) \$ _____
GRTL \$ _____
4% of GRTL \$ _____
6% of GRTL \$ _____
8% of GRTL \$ _____

----- Signature of Person Submitting Form 105 ----- Date -----

PURPOSE

Use to provide information about county program expenditures in order to provide statewide information for HHSC.

PROCEDURE

Form 105 must be completed and submitted monthly to the HHSC Indigent Health Care Program in Austin by the 10th of the month following the report month.

Any amendments to a report should be identified as such and submitted on the Form 105. The amended item(s) should be circled.

- **Submit a Form 105 even if no expenditures were made for the month.**
- **Do not send claim payment ledgers with Form 105.**

Submit the Form 105 electronically by emailing it to: CIHCP@dshs.state.tx.us.

If you are unable to submit the form electronically, you may fax it to the HHSC at [512/776-7203](tel:5127767203).

It is not necessary to submit the Form 105 by mail once it has been faxed and received by HHSC Primary Care Group.

File the Form 105 for county records.

DETAILED INSTRUCTIONS

I. Reimbursable Expenditures. Enter the dollar amount spent in the calendar report month for each of the categories in Items 1-10. List only expenditures that are applied to state assistance eligibility/reimbursement.

In Item 11, enter amount of dollars spent if an intergovernmental transfer (IGT) was made to provide health care services as part of the Texas Healthcare Transformation and Quality Improvement Program waiver. Four percent of the General Revenue Tax Levy (GRTL) may be allowed toward eligibility for state assistance.

Total the expenditures by adding Items 1-11. Enter this expenditure total in Item 12.

In Item 13, enter the total of all reimbursements received during the calendar report month. Examples of reimbursements include but are not limited to: Medicaid reimbursements for SSI appellants; refunds from providers, clients, insurance companies.

Do not list state assistance funds.

In Item 14, enter the total amount of dollars in error, if any, identified in the 6 percent Eligibility System Review.

Total the deductions by adding Items 13 and 14. Enter this deduction total in Item 15.

For the total expenditures that can be applied to state assistance eligibility/reimbursement, subtract the deduction total listed in Item 15 from the expenditure total in Item 12. In Item 16, enter the total dollar amount applied to State Assistance.

II. Expenditure Tracking. The county completes this section with information from county records.

List the 4 percent, 6 percent, and 8 percent GRTL levels.

FORM RETENTION

Maintain the records at least until the end of the third complete state fiscal year.

COUNTY INDIGENT HEALTH CARE PROGRAM ELIGIBILITY DISPUTE RESOLUTION REQUEST (EDRR)

Case Record Name	Date of Request
------------------	-----------------

Check which eligibility criterion (Residence, Household, Resources, Income) or eligibility item (Other) is being disputed. In the space to the right of the checked box, state the disputed matter.

Residence _____

Household _____

Resources _____

Income _____

Other _____

Entities Involved in the Eligibility Dispute

	Name of the Entity	Name of the Entity
Name of Contact Person		
Mailing Address		
Telephone Number	()	()

Comments: _____

Submitted by: _____ **Telephone:** () _____

PURPOSE

Use to request HHSC to resolve an eligibility dispute between two or more entities when a county, a hospital district, a public hospital, or other provider cannot agree on a household's eligibility.

Only eligibility can be disputed, not claim payment.

PROCEDURE

Complete an original and one copy of Form 106. To the original, attach any relevant information. Mail the original Form 106 and the relevant information to:

Health and Human Services Commission
Indigent Health Care Program MC-2831
PO Box 149347
Austin, TX 78714-9347

File the copy of the Form 106 for county records.

DETAILED INSTRUCTIONS

At the top of Form 106, enter the case record name and the date that resolution of the eligibility dispute is requested.

Check which eligibility criterion or eligibility item is being disputed. Check the appropriate box. State the disputed matter.

Entities Involved in the Eligibility Dispute. List the name of the entity, the contact person, the mailing address, and the telephone number, including area code, for each entity involved in the eligibility dispute.

Comments. Summarize the issues involved in the eligibility dispute.

Signature/Telephone. The person submitting the Form 106 should sign their name and list their telephone number, including area code.

FORM RETENTION

Maintain the records at least until the end of the third complete state fiscal year following the date on which the application is submitted.

**COUNTY INDIGENT HEALTH CARE PROGRAM
CASE RECORD INFORMATION RELEASE**
PROGRAMA DEL CONDADO DE ATENCIÓN MÉDICA AL INDIGENTE
REVELACIÓN DE INFORMACIÓN DE EXPEDIENTE DE CASO

Case Record Name/Nombre en el expediente de caso	Case Record Number/Número de expediente de caso
--	---

I do hereby authorize persons, organizations, or establishments having information or records concerning me/us (or) my/our circumstances, to furnish such information to a representative of the County Indigent Health Care Program.

Yo, por este medio, autorizo a las personas, organizaciones o establecimientos que tengan información o documentos sobre mí/nosotros o sobre mis/nuestras circunstancias para que den dicha información a un representante del Programa del Condado de Atención Médica al Indigente.

I hereby grant permission for the County Indigent Health Care Program to obtain information which may have a bearing on my/our eligibility for assistance.

Yo, por este medio, doy permiso al Programa del Condado de Atención Médica al Indigente para que obtenga la información que pudiera incidir en mi/nuestro derecho a recibir asistencia.

This release form is valid for six months after the date signed.

Este formulario de revelación es válido por seis meses a partir de la fecha en que se firma.

Person or Agency to Whom Information Will Be Released/Persona o agencia a quien se revelará la información
--

Specific Request (Specify in 1 and 2 below.)
Petición específica (especifique en 1 y 2 a continuación).

1. Information Requested/Información pedida: _____

2. Period Covered (Dates)/Periodo cubierto (fechas): _____

General Request (Any information available may be released.)
Petición general (puede revelarse toda la información disponible).

Signature- Applicant or Recipient/Firma – Solicitante o beneficiado

Date/Fecha

Signature – Spouse/ Firma - Cónyuge

Date/Fecha

Signature – Guardian, Power of Attorney, Parent of Minor Child/ Firma - Tutor, poder notarial o padre/madre del menor

Date/Fecha

PURPOSE

Use as the household member's authorization to release information that will help determine the household's CIHCP eligibility.

PROCEDURE

Complete an original and one copy of the Form 108.

Issue the original Form 108 to the person or agency that will provide the requested information.

File the copy of the Form 108 in the case record.

DETAILED INSTRUCTIONS

Enter the case record name.

Enter the case record number.

Enter the name of the person or agency to whom information will be released.

Specific Request. Check this box if the client wants to limit the release of information to specific items or a specific time period.

- Enter the type of Information Requested, such as:
 - o Type and amount of benefits,
 - o Amount of income, or
 - o Degree of disability.
- Enter the Period Covered for specific information to be released, such as:
 - o "for September 2002" and
 - o "pertinent to the September certification."

General Request. Check this box if there are no restrictions on the type of information to be released.

The person about whom the information is being requested must sign and date Form 108.

One witness signs and dates Form 108, if applicable.

FORM RETENTION

Maintain the records at least until the end of the third complete state fiscal year following the date on which the application is submitted.

**COUNTY INDIGENT HEALTH CARE PROGRAM
NOTICE OF ELIGIBILITY**
PROGRAMA DE ATENCIÓN MÉDICA PARA INDIGENTES DEL CONDADO
AVISO DE ELEGIBILIDAD

Date/Fecha	Case Record No./Núm de Caso
County, Address, Telephone No./Condado, Oficina y Teléfono	

Your application for County Indigent Health Care Program benefits is approved. You are eligible for health care services beginning:

Su solicitud para beneficios del Programa de Atención Médica para Indigentes fue aprobada. Califica para servicios médicos comenzando el:

_____ (Eligibility Effective Date)

Comments/Comentarios: _____

By/De: _____

Your Responsibilities	Sus Responsabilidades
<p>You must notify this office within 14 days of any changes in your situation, such as changes in:</p> <ul style="list-style-type: none"> Address Household members Property Income Application for or receipt of SSI, TANF, or Medicaid. <p>If a change occurs that makes you ineligible and you fail to report the change as required, you may be held responsible for payment of any health care services you receive after you become ineligible and/or you may be subject to prosecution under the Texas Penal Code.</p>	<p>Tiene que avisar a esta oficina dentro de 14 días de cualquier cambio en su situación, como por ejemplo, cambios en:</p> <ul style="list-style-type: none"> Su dirección El número de miembros de su casa Propiedades que tenga Sus ingresos Solicitud de SSI, TANF, o Medicaid o recibo de cualquier de estas. <p>Si ocurre un cambio que lo descalifica y usted deja de cumplir con su deber de reportar el cambio, puede ser responsable de pagar cualquier servicio médico que reciba después de su descalificación o puede ser sujeto a prosecución bajo las leyes de Texas Penal Code.</p>

PURPOSE

Use to notify the household of:

- Their eligibility for health care assistance,
- The date their eligibility begins,
- The household's responsibility to report changes, and
- The consequences if the household does not report changes as required.

PROCEDURE

Complete an original and one copy of Form 109.

Issue the original Form 109 to the household.

File the copy of the Form 109 in the case record.

DETAILED INSTRUCTIONS

At the top of Form 109, enter the household's name and address, the date the Form 109 is issued, the case record number, and the office address and telephone number.

Enter the household's Eligibility Effective Date and any necessary comments.

The staff person issuing the Form 109 should sign the Form 109.

FORM RETENTION

Maintain the records at least until the end of the third complete state fiscal year following the date on which the application is submitted.

COUNTY INDIGENT HEALTH CARE PROGRAM CLAIM PROCESSING NOTIFICATION

To: _____	From: _____
_____	_____
_____	_____

1st Date Original Claim is Received

Date Form 110 is Issued

Patient's Name

CIHCP Case Record Number

The attached claim cannot be processed for payment due to the following checked item(s):

1. This claim was not received within the CIHCP 95-day billing timeframe.
2. This patient was not eligible for CIHCP on the date(s) of service listed on the attached claim.
3. This patient has reached the CIHCP \$30,000 or 30-day maximum county liability.
4. Appropriate CIHCP provider notification requirements were not followed.*
5. This claim is not for a CIHCP basic or department-established optional service.
6. This claim must be submitted on the following claim form: CMS-1500 UB-04.
7. The services on this claim are not itemized.
8. The patient is now Medicaid eligible. ID# _____ Add Date: _____
9. The patient has applied for SSI/Medicaid benefits; claim will be held until a decision is received.
10. The attached Form 113 must be completed, signed, and dated.
11. Other: _____

* Refer to Chapter 61, Health and Safety Code, §§ 61.031 and 61.032.

This claim may not be resubmitted.

If the above-checked items are corrected, this claim may be resubmitted and will be processed for payment if it is received in this office by: _____
(Deadline Date)

**If the corrected claim is not received by this deadline date,
we will assume that your office is not interested in pursuing payment.**

If you have any questions regarding this claim, please contact our office at _____.

Sincerely,

Signature

PURPOSE

Use to:

- Return to the provider claims that cannot be processed for payment and
- Notify the provider of the deadline date for claim resubmission, if applicable.

PROCEDURE

Complete an original and one copy of Form 110.

Issue the original Form 110 and corresponding claim to the provider.

File the copy of the Form 110 in the case record.

DETAILED INSTRUCTIONS

At the top of Form 110, enter the provider's name and mailing address, your office name and mailing address, the first date that the original claim is received, the date that the Form 110 is issued, the patient's name, and the CIHCP case record number.

Check off the appropriate reason(s) that the claim cannot be processed for payment.

Check off whether the claim may or may not be resubmitted and enter the deadline date, if applicable.

Enter the office telephone number.

The staff person issuing the Form 110 should sign the Form 110.

FORM RETENTION

Maintain the records at least until the end of the third complete state fiscal year following the date on which the application is submitted.

FOR HHSC USE ONLY	
Date Received	Date Returned to County

COUNTY INDIGENT HEALTH CARE PROGRAM FACILITY PAYMENT RATE REQUEST

County	Submitted by	Fax Number	Telephone Number	Date Submitted to HHSC
--------	--------------	------------	------------------	------------------------

Name of Facility:	HHSC PAYABLE Please check <input type="checkbox"/> for rate(s) requested
Facility's 10-digit National Provider Identifier (NPI) #:	<input type="checkbox"/> Inpatient Rate:
Address of Facility:	<input type="checkbox"/> Outpatient Rate:
County of Facility	<input type="checkbox"/> Rate Per Visit:

Name of Facility:	HHSC PAYABLE Please check <input type="checkbox"/> for rate(s) requested
Facility's 10-digit National Provider Identifier (NPI) #:	<input type="checkbox"/> Inpatient Rate:
Address of Facility:	<input type="checkbox"/> Outpatient Rate:
County of Facility	<input type="checkbox"/> Rate Per Visit:

Name of Facility:	HHSC PAYABLE Please check <input type="checkbox"/> for rate(s) requested
Facility's 10-digit National Provider Identifier (NPI) #:	<input type="checkbox"/> Inpatient Rate:
Address of Facility:	<input type="checkbox"/> Outpatient Rate:
County of Facility	<input type="checkbox"/> Rate Per Visit:

PURPOSE

Use to request payment rates for Facilities whose rates are not listed in Section Four, Service Delivery, namely,

- Hospitals
- Rural Health Clinics (RHCs)
- Federally Qualified Health Centers (FQHCs)

PROCEDURE

Make no entry in the columns headed *For HHSC Use Only*.

Complete only the sections that pertain to the county's request.

Fax the Form 111 to [512-776-7203](tel:512-776-7203).

File one copy of the HHSC-completed Form 111 in each case record needing the information.

DETAILED INSTRUCTIONS

County. Enter the name of the county requesting the information.

Submitted by. Enter the name of the person qualified to provide information about entries on the Form 111 that is submitted.

Fax Number. Enter the fax number, including the area code, to which the HHSC-completed form may be returned.

Telephone Number. Enter the county's telephone number, including the area code.

Date Submitted. Enter the date the form is submitted to HHSC.

Facility Rate Request. Enter the facility's name, address, and 10-digit [Medicaid National Provider Identifier \(NPI\)](#) number. If this information is not included on the claim, contact the provider for it.

HHSC Payable.

HHSC enters the payment rate, if available.

If the payment rate is not available, HHSC enters "0."

The listed *HHSC Payable* does not include the 2.5% deduction, if applicable.

The listed *HHSC Payable* is not a guarantee that the service is a reimbursable expenditure.

To be reimbursable, the claim must comply with policies and procedures in the CIHCP Handbook.

FORM RETENTION

Maintain the records at least until the end of the third complete state fiscal year following the date on which the application is submitted.

**COUNTY INDIGENT HEALTH CARE PROGRAM
NOTICE OF INELIGIBILITY**
PROGRAMA DE ATENCIÓN MÉDICA PARA INDIGENTES DEL CONDADO
AVISO DE INELIGIBILIDAD

--	--

Date/Fecha	Case Record No./Núm de Caso
Office Address and Telephone No./Oficina y Teléfono	

On the basis of information received by this office, the following action is being taken.

Se basa la siguiente decisión sobre información recibida por esta oficina.

(Only the checked box applies to you.)

(Sólo casilla marcada se aplica a su caso.)

Your application for County Indigent Health Care Program benefits has been denied because:

Su solicitud de beneficios del Programa de Atención Médica para Indigentes del Condado se ha terminado porque:

You will not be eligible for County Indigent Health Care Program benefits after

Usted no calificará para beneficios del Programa de Atención Médica para Indigentes del Condado despues de

(Eligibility End Date)

(Fecha de Fin de Elegibilidad)

because: _____

porque: _____

If you believe this decision is not correct, you may request a fair hearing within 90 days to appeal the decision. If you have any questions, please contact this office.

Si usted cree que esta decisión no es correcta, puede apelarla y pedir una audiencia justa. Si tiene alguna pregunta, sírvase de hablar con esta oficina.

Signature/Firma:: _____

I do want to appeal this decision./Yo deseo apelar esta decisión.	
_____	_____
Signature/Firma	Date/Fecha

PURPOSE

Use to:

- Notify the household that they are not eligible for assistance,
- State the reason for the denial, and
- Notify the household regarding their right to appeal.

PROCEDURE

Complete an original and one copy of [Form 117](#).

Issue the original [Form 117](#) to the household.

File the copy of [the Form 117](#) in the case record.

DETAILED INSTRUCTIONS

Enter the household's name and address, the date the Form 117 is issued, the case [record](#) number, the office address and telephone number.

Check and complete the appropriate section.

The staff person issuing the Form 117 should sign the Form 117.

To appeal the decision, the household may contact the office or complete and submit the bottom of Form 117.

FORM RETENTION

Maintain the records at least until the end of the third complete state fiscal year following the date on which the application is submitted.

Definitions of CIHCP Optional Health Care Services

- 1. Advanced Practice Nurse (APN)** services must be medically necessary and provided within the scope of practice of an APN and covered by the Texas Medicaid Program when provided by a licensed physician.
- 2. Ambulatory Surgical Center (ASC)** services must be provided in a freestanding ASC, and are limited to items and services furnished in reference to an ambulatory surgical procedure, including those services on the Center for Medicare and Medicaid Services (CMS)-approved list and selected Medicaid-only procedures.
- 3. Colostomy medical supplies and/or equipment** must be medically necessary and prescribed by a physician or an APN if this is within the scope of their practice in accordance with the standards established by the Board of Nurse Examiners and published in 22 TAC §221.13. Items covered are colostomy bags/pouches, cleansing irrigation kits, paste or powder, and skin barriers with flange/wafers. The county may require the supplier to receive prior authorization.
- 4. Counseling (psychotherapy)** services must be medically necessary based on a referral from a physician or an APN if this is within the scope of their practice in accordance with the standards established by the Board of Nurse Examiners and published in 22 TAC §221.13. Psychotherapy services must be provided by a Licensed Clinical Social Worker (LCSW), Licensed Marriage Family Therapist (LMFT), Licensed Professional Counselor (LPC), or a Ph.D. Psychologist.
- 5. Dental care** must be medically necessary and provided by a DDS, DMD, or DDM. Items covered are: an annual routine exam, annual routine cleaning, one set of annual x-rays, and the least costly service for emergency dental conditions for the removal or filling of a tooth due to abscess, infection, or extreme pain. The county may require prior authorization.
- 6. Diabetic supplies and/or equipment** must be medically necessary and prescribed by a physician or an APN if this is within the scope of their practice in accordance with the standards established by the Board of Nurse Examiners and published in 22 TAC §221.13. Items covered are: test strips, alcohol prep pads, lancets, glucometers, insulin syringes, humulin pens, and the needles required for the humulin pens. The county may require the supplier to receive prior authorization.
- 7. Durable medical equipment (DME)** must be medically necessary; meet the Medicare/Medicaid requirements; and be provided under a written, signed and dated prescription from a physician or an APN if this is within the scope of their practice in accordance with the standards established by the Board of Nurse Examiners and published in 22 TAC §221.13. Items may be purchased or rented, whichever is least costly. Items covered are: blood pressure measuring appliances that are reasonable and appropriate, canes, crutches, home oxygen equipment (including masks, oxygen hose, and nebulizers), hospital beds, walkers, and standard wheelchairs. The county may require the supplier to receive prior authorization.
- 8. Emergency medical service** covers ground transportation only for medically necessary, life-threatening conditions.
- 9. Federally Qualified Health Center (FQHC)** services must be provided in an approved FQHC by a physician, physician's assistant, nurse practitioner, clinical psychologist, or clinical social worker.
- 10. Occupational therapy** services must be medically necessary and may be covered if provided in a physician's office, a therapist's office, in an outpatient rehabilitation or free-standing rehabilitation facility, or in a licensed hospital. Services must be within the provider's scope of practice, as defined by Occupations Code, Chapter 454.
- 11. Physical therapy** services must be medically necessary and may be covered if provided in a physician's office, a therapist's office, in an outpatient rehabilitation or free-standing rehabilitation facility, or in a licensed hospital. Services must be within the provider's scope of practice, as defined by Occupations Code, Chapter 453.
- 12. Home and community health care** must be medically necessary, meet the Medicare/Medicaid requirements, and be provided by a certified home health agency. A plan of care must be recommended, signed, and dated by the recipient's attending physician prior to care being given. Items covered are R.N. visits for skilled nursing observation, assessment, evaluation, and treatment provided by a physician who specifically requests the R.N. visit for this purpose. A home health aide to assist with administering medication is also covered. Visits made for performing housekeeping services are not covered. A county may require prior authorization.
- 13. Physician Assistant (PA)** services must be medically necessary and provided by a PA under the direction of an M.D. or a D.O. and must be billed by and paid to the supervising physician.
- 14. Vision care** covers one exam by refraction and one pair of prescribed glasses every 24 months that meet Medicaid criteria.
- 15. Other** medically necessary services or supplies that the local governmental municipality/entity determines to be cost effective.



Form 120, Optional Health Care Services Notification, Page 3 of 3

Instructions for Form 120

Mark an "X" in the appropriate column to indicate each optional health care service the county chooses to provide or chooses to discontinue providing. Sign and date the bottom of the form, and submit the Form 120 electronically to the HHSC Indigent Health Care Group by emailing it to: CIHCP@dshs.state.tx.us.

If you are unable to submit the form electronically, you may fax it to the HHSC at [512/776-7203](tel:5127767203).

It is not necessary to submit the Form 120 by mail once it has been faxed and received by HHSC Primary Care Group.

Maintain the records at least until the end of the third complete state fiscal year.

COUNTY INDIGENT HEALTH CARE PROGRAM EMPLOYMENT VERIFICATION

Date/Fecha	Case Record No./Núm de Caso
Office Address and Telephone No./Oficina y Teléfono	
Fax:	

Employee	Social Security Number
----------	------------------------

This individual is a member of a household applying for health care assistance from the County Indigent Health Care Program. To determine this household's eligibility, it is necessary to verify all earnings. Since this individual is/was/will be your employee, your help is needed.

Please completely and accurately provide the information requested on the back of this letter. If a question does not apply, mark it N/A. After you complete this form, give it to your employee, mail it in the envelope provided, or fax it to the number listed above.

This information is needed by **this date:** _____. If you could send it before this date, it would be most appreciated.

Thank you for helping. If you have questions, please feel free to call.

<p style="text-align: center;">I give my permission to release the information requested on this form.</p> <p style="text-align: center;">Yo doy mi permiso para que mi empleador dé la información que se pide en esta forma.</p>	
_____ Signature / Firma	_____ Date / Fecha

Comments: _____

PURPOSE

Use to verify a household member's income.

PROCEDURE

Issue the Form 128 to the employer or instruct the household member to take the Form 128 to the employer for completion.

File the completed Form 128 in the case record.

DETAILED INSTRUCTIONS

Page 1. Enter the employer's name and address; the date the Form 128 is issued; the case record number; the office address, telephone number, and fax number; the employee's name and social security number, if available.

If applicable, the employee signs and dates the information release statement in the box provided on Page 1 of the Form 128.

Page 2. Enter the month(s) that wage information is needed.

The employer completes the rest of Page 2.

FORM RETENTION

Maintain the records at least until the end of the third complete state fiscal year following the date on which the application is submitted.

If you or any member of your household has any kind of self-employment income, fill out this form and attach it to your application. You may attach a copy of the latest income tax forms in place of this form. If your accounting system is not the same as this form, you may substitute a copy of your accounting statement. You must answer all questions and sign and date at the bottom. **Use additional sheets of paper if you need to.** Sign and date each sheet. Remember, this is your sworn statement. You will need to bring with you to the interview: bills, receipts, checks or stubs, and any other business records you have. Your worker will need to see them. **Your records will be returned to you.**

Self-employment Income. This is any money you earn working for yourself. It is not money you earn working for someone else. If you are in doubt, ask your caseworker.

Questions 1, 2, and 3. These questions are self-explanatory.

Question 4. List your business income and expenses. In the boxes on the left side of the form, list your business **expenses** (see the information below). Write in the dates you paid the expenses and the amount of each expense. Add the amounts, and enter your total in the box "total self-employment expenses." In the boxes on the right side of the form, list your **income** (see the information below). List the dates you received the income, your sources of income, and the amounts. Add the amounts, and enter your total in the box "total self-employment income." Subtract your expenses from your total self-employment income, and enter your "net self-employment income."

Expenses are your costs of doing business. Examples of expenses are supplies, repairs, rent, utilities, seed, feed, business insurance, licenses, fees, payments on principal of loans for income-producing property, capital asset purchases (such as real property, equipment, machinery, and other durable goods and capital asset improvements), your social security contribution for people who worked for you, and labor (not salaries you pay yourself). If you claim labor costs, list each person and the amount you paid them. If you have any other kinds of business expenses, be sure to list them and the date they were paid.

You may not claim:

- Rent, mortgage, taxes, or utilities on your business if it operates out of your home (unless these costs are separate from the costs of your home);
- Cost of goods you buy for the business but use yourself;
- Net business loss from a prior period and
- Depreciation.

If you are in doubt, bring proof of the expense and ask your worker.

Income includes money from sales, cash receipts, crops, commissions, leases, fees, or whatever you do or sell for money. If you have any other kind of income from your business, be sure to list it. Be sure to list the dates income was received.

Who must sign. The form must be signed by the applicant, spouse, or authorized representative. Anyone may help you complete the form, but that person must also sign and date the form. Ask your worker if anyone else needs to sign the form.

Si usted u otra persona de su casa tiene algún tipo de ingresos de negocio propio, llene esta forma y adjúntela a su solicitud. En lugar de esta forma, puede adjuntar una copia de la declaración de impuestos sobre ingresos más reciente. Si el sistema de contabilidad que usa no es igual al de esta forma, puede substituir la forma con una copia de su registro de contabilidad. Tiene que contestar todas las preguntas y firmar y fechar la forma al final. **Use hojas adicionales si las necesita.** Firme y feche cada hoja. Recuerde que ésta es una declaración jurada. Tiene que llevar a la entrevista: cuentas, recibos, cheques o talones de cheques y cualquier otra documentación que tenga del negocio. El trabajador tendrá que verlos. **Estos documentos le serán devueltos.**

Ingresos del Negocio Propio. Este término se refiere al dinero que gana cuando trabaja por su propia cuenta. No es el dinero que recibe cuando trabaja para otra persona. Si tiene alguna duda, consulte con su trabajador de casos.

Preguntas 1, 2, y 3. Estas preguntas no necesitan más explicación.

Pregunta 4. Apunte los ingresos y gastos de su negocio. En las cajas del lado izquierdo de la forma, enumere los **gastos** de su negocio (vea la información abajo). Ponga la fecha en que pagó los gastos y la cantidad de cada gasto. Sume las cantidades y ponga el total en la caja que dice "total de gastos del negocio propio". En las cajas a la derecha de la forma, enumere los **ingresos** (vea la información abajo). Ponga la fecha en que recibió cada ingreso, la fuente del ingreso y la cantidad. Sume las cantidades y ponga el total en la caja que dice "total de ingresos del negocio propio". Reste los gastos del total de ingresos del negocio propio y anote sus "ingresos netos del negocio propio".

Los gastos son los costos de un negocio. Algunos ejemplos de posibles gastos son: provisiones, reparaciones, renta, servicios públicos, semilla, forraje, seguro del negocio, licencias, cuotas, pagos del capital de préstamos para propiedades que generan ingresos, compras de bienes de capital (como bienes raíces, equipo, maquinaria y otros bienes duraderos y mejoras de bienes de capital), su aportación al seguro social de las personas que trabajan para usted y sueldos (pero no los que se paga a sí mismo). Si declara el costo de sueldos, ponga el nombre de cada persona y la cantidad que le pagó a cada quien. Si tiene cualquier otro tipo de gastos del negocio, asegúrese de anotarlos y poner la fecha en que los pagó.

No puede declarar:

- El pago de la renta, la hipoteca, los impuestos o los servicios públicos del negocio si lo opera de su casa (a no ser que estos costos son aparte de los costos de la casa);
- El costo de artículos que compra para el negocio pero que usa personalmente;
- La pérdida neta del negocio de un periodo anterior; and
- La depreciación.

Si tiene alguna duda, lleve comprobantes del gasto y consulte con el trabajador.

Los ingresos son, entre otros, el dinero de ventas, el ingreso de caja, las cosechas, las comisiones, las rentas, las cuotas o cualquier cosa que hace o que vende por dinero. Si usted tiene cualquier otro tipo de ingresos del negocio, asegúrese de anotarlos. No olvide poner las fechas en que recibió el ingreso.

Quién debe firmar. El solicitante, su cónyuge o su representante autorizado para firmar la forma. Cualquier persona puede ayudarle a llenar la forma, pero esa persona también tiene que firmar y poner la fecha en la forma. Consulte con el trabajador para saber si alguien más tiene que firmar.

With a few exceptions, you have the right to request and be informed about the information that the county obtains about you. You are entitled to receive and review the information upon request. You also have the right to ask the county to correct information that is determined to be incorrect (Government Code, Sections 552.021, 552.023, 559.004). To find out about your information and your right to request correction, please contact your local county office. / Con algunas excepciones, usted tiene el derecho de saber qué información obtiene sobre usted el condado de pedir dicha información. Si desea recibir y estudiar la información, tiene el derecho de solicitarla. También tiene el derecho de pedir que el condado corrija cualquier información incorrecta (Código Gubernamental, Secciones 552.021, 552.023, 559.004). Para enterarse sobre la información y el derecho de pedir que la corrijan, favor de ponerse en contacto con la oficina local del condado.

PURPOSE

Use to provide a means by which a [household member](#) may report self-employment income and expenses if accurate tax or business records are unavailable.

PROCEDURE

At the top of Form 149, enter the [case record name](#) and the [case record number](#).

Issue Form 149, [including](#) Pages 1 and 2, to the self-employed [person, who](#) completes the rest of the form.

[File the completed Form 149 in the case record.](#)

DETAILED INSTRUCTIONS

Instructions for the [self-employed household member to use in completing](#) Form 149 are on Page 2 of [the Form 149](#).

FORM RETENTION

Maintain the records at least until the end of the third complete state fiscal year following the date on which the application is submitted.

**COUNTY INDIGENT HEALTH CARE PROGRAM
 END OF YEAR REPORT**

Entity Name: _____ **State Fiscal Year:** _____
 (September 1-August 31)

Check below which type of entity you represent:

County Public Hospital Hospital District

I. TOTAL NUMBER OF UNDUPLICATED CLIENTS SERVED: _____

To get the number of unduplicated clients, do not count the same individual more than once.

◆ How many of these clients are SSI appellants? _____

II. TOTAL EXPENDITURES: _____

Break the total expenditures down into the following categories:

1. Physician Services	\$
2. Prescription Drugs	\$
3. Hospital, Inpatient Services	\$
4. Hospital, Outpatient Services	\$
5. Laboratory/X-Ray Services	\$
6. Skilled Nursing Facility Services	\$
7. Family Planning Services	\$
8. Rural Health Clinic Services	\$
9. State Hospital Contracts	\$
10. Optional Health Care Services	\$
11. Reimbursements/Errors	\$

III. TOTAL

DSRIP Projects: _____

Uncompensated Care: _____

Expenditures for 1115 _____

Waiver: _____

IV. DIAGNOSES – List the five top diagnoses of your clients.

1. _____
2. _____
3. _____
4. _____
5. _____

V. FEDERAL POVERTY GUIDELINE % Used to Determine Eligibility: _____

Signature of Person Submitting Form 300: _____

Telephone Number of Person Submitting Form 300: _____

Date: _____

PURPOSE

Use to provide information to HHSC about

- Total number of unduplicated clients served;
- Total expenditures for the state fiscal year for a county, public hospital, or hospital district;
- Top five diagnoses of clients served; and
- Federal Poverty Guideline (FPG) percent the entity used to determine client eligibility.

PROCEDURE

Following the end of each state fiscal year, complete and submit Form 300 to HHSC CIHCP in Austin by the 30th of September. Submit a Form 300 even if no expenditures were made for the state fiscal year.

[Fax the Form 300 to HHSC at 512-776-7203](#)

It is not necessary to submit the Form 300 by mail once it has been faxed and received by HHSC CIHCP.

File the Form 300 for county records.

DETAILED INSTRUCTIONS

I. Total Number of Unduplicated Clients Served. To determine this unduplicated number, do not count the same individual more than once.

How many of these clients are SSI appellants?

II. Total Expenditures. Enter the net total dollar amount spent in the state fiscal year (September 1 – August 31), regardless of the fiscal year in which the entity operates. Exclude the dollar amount spent on 1115 Waiver.

Break the total expenditures down into the following categories:

1. Physician services
2. Prescription drugs
3. Hospital, inpatient services
4. Hospital, outpatient services
5. Laboratory/x-ray services
6. Skilled nursing facility services
7. Family planning services
8. Rural health clinic services
9. State hospital contracts
10. Optional health care services
11. Reimbursements/Review Finding Errors

III. Total. Enter amount of dollars spent if an intergovernmental transfer (IGT) was made to provide health care services as part of the Texas Healthcare Transformation and Quality Improvement Program waiver. Four percent of the General Revenue Tax Levy (GRTL) may be allowed toward eligibility for state assistance.

IV. Diagnoses. List the top five most frequent diagnoses of the entity's clients.

V. Federal Poverty Guideline % Used to Determine Eligibility. Note the FPG % that the entity used to determine eligibility, such as 21%, 25%, 50%, 100%, 150%, etc.

FORM RETENTION

Maintain the records at least until the end of the third complete state fiscal year.

1. State Assistance Request #



Form 500

COUNTY INDIGENT HEALTH CARE PROGRAM
REQUEST FOR STATE ASSISTANCE FUNDS

2. County Name:

3. Payment Address:

4. County Vendor ID #:
(For Payment Address)

5. 100% of County Spending
for this Request: \$

6. Date Paid:

7. Amount Requested
(90% of County Spending) \$

This is a request for reimbursement from the State Assistance Fund for health care services provided under the County Indigent Health Care Program (Chapter 61, Health and Safety Code,) and paid by the end of August 31, 2016. The payee agrees to repay any funds paid in error and acknowledges the state's authority to collect any funds paid in error.

County Judge / Designee

Date

Printed Name of County Judge / Designee

() Telephone Number

PURPOSE

Use to notify the Health and Human Services Commission (HHSC) that the county is requesting state assistance funds for health care assistance reimbursement provided under the County Indigent Health Care Program.

PROCEDURE

Contact HHSC by telephone to request state assistance funds before the Commissioners Court authorizes payment of the health care claims.

Complete and submit Form 500 to the County Indigent Health Care Group in Austin to claim state assistance funds within 30 days from the request for state funds.

File a copy of the Form 500 for county records.

DETAILED INSTRUCTIONS

1. Enter the approval number that was assigned to your request by HHSC.
2. Enter the name of the county.
3. List the address where the county receives payments for services, including the zip code.

4. Enter the county's vendor identification number for the address in item 3.
5. Enter the amount of money for which the county is requesting reimbursement.
6. List the month and year in which the county paid the money listed in #5.
7. Enter 90 percent of the eligible program costs, i. e., 90% of the amount listed in #5.

The County Judge or his designee must sign and date the Form 500. The form and supporting documentation of expenditures may be faxed to HHSC at [512-776-7203](tel:512-776-7203) or mailed to:

Health and Human Services Commission
County Indigent Health Care Group
[MC 2831](#)
[P.O. Box 149347](#)
[Austin, Texas 78714-9347](#)

FORM RETENTION

Maintain the records at least until the end of the third complete state fiscal year.

1. State Assistance Request #



Form 500A

COUNTY INDIGENT HEALTH CARE PROGRAM
REQUEST FOR STATE ASSISTANCE FUNDS

2. County Name:

3. Payment Address:

4. County Vendor ID #:
(For Payment Address)

5. 100% of County Spending
for this Request: \$

6. Date Paid:

7. Amount Requested
(100% of County Spending) \$

This is a request for reimbursement from the State Assistance Fund for health care services provided under the County Indigent Health Care Program (Chapter 61, Health and Safety Code,) and paid by the end of August 31, 2016. The payee agrees to repay any funds paid in error and acknowledges the state's authority to collect any funds paid in error.

County Judge / Designee

Date

Printed Name of County Judge / Designee

() Telephone Number

PURPOSE

Use to notify the Health and Human Services Commission (HHSC) that the county is requesting state assistance funds for health care assistance reimbursement provided under the County Indigent Health Care Program.

PROCEDURE

Contact HHSC by telephone to request state assistance funds before the Commissioners Court authorizes payment of the health care claims.

Complete and submit Form 500A to the County Indigent Health Care Group in Austin to claim state assistance funds within 30 days from the request for state funds.

File a copy of the Form 500A for county records.

DETAILED INSTRUCTIONS

1. Enter the approval number that was assigned to your request by HHSC.
2. Enter the name of the county.
3. List the address where the county receives payments for services, including the zip code.

4. Enter the county's vendor identification number for the address in item 3.
5. Enter the amount of money for which the county is requesting reimbursement.
6. List the month and year in which the county paid the money listed in #5.
7. Enter 100 percent of the eligible program costs, i. e., 100% of the amount listed in #5.

The County Judge or his designee must sign and date the Form 500A. The form and supporting documentation of expenditures may be faxed to HHSC at [512-776-7203](tel:512-776-7203) or mailed to:

Health and Human Services Commission
County Indigent Health Care Group MC 2831
P.O. Box 149347
Austin, Texas 78714-9347

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