

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, 2014. 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