CIHCP Outreach Days and Times

Dias y las horas en que puede contactarse con CIHCP son

Killeen

Monday: By Appointment

Tuesday: 9 a.m. to 2 p.m.

Wednesday: By Appointment

Thursday: By Appointment

Friday: By Appointment

Closed: Saturdays, Sundays, Holidays

309 Priest Drive, Killeen

Temple

Tuesday

9 a.m. to 2 p.m.

Temple Community Clinic
1905 Curtis B Elliott Drive

Call 1-877-516-8593
254-519-1229

To request an Appointment or a CIHCP Application for Assistance

Phone: 254-519-1229; 254-618-4165 Fax: 254-618-4179
Reception Desk: 254-618-4141
Toll Free: 1-877-516-8593
Email: cihcp.eligibility@bellcounty.texas.gov
Webpage: www.bellcountytx.com/departments/indigent_health_services

Application for Assistance and/or all Request for Information can be submitted via:

Aplicaciones para asistencia / y informacion requerida por su trabajador social pueden ser sometidas via:

P.O. Box 880, Killeen, TX 76540

Or

Dropped off in the **secured drop box** located in front of the CIHCP Office at 309 Priest Drive, Bldg 3, Killeen

Or

In person at the following locations

Killeen

Tuesday
309 Priest Drive, Bldg 3
9 a.m. to 2 p.m.

Temple

Tuesday
Temple Community Clinic
1905 Curtis B Elliott Drive
9 a.m. to 2 p.m.

Bell and Mills CIHCP Applicants/Recipients

Your responsibilities:

You must notify this office within 14 days of any changes in your situation, such as changes in:

- **Address**
- **Household members**
- **Property**
- **Income**
- **Application for or receipt of SSI/SSDI/RSDI/SS, TANF or Medicaid**.

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.

Sus Responsabilidades:

Tiene que avisar a esta oficina dentro de 14 dias de cualquier cambio in su situacion, como, por ejempo, cambios en:

- **Su direccion**
- **El numero de miembros de su casa**
- **Propiedades que tenga**
- **Sus ingresos**
  Solicitud de SSI/SSDI/RSDI/SS, TANF, o Medicaid o recibo de cualquier de estas

Si ocurre un cambio que lo descalifica, y usted deja de cumplir con su deber de reportar el cambio, puede ser responsible de pagar cualquier servicio medico que reciba despues de su descalificacion o puede ser sujeto a procescucion bajo las leyes de Texas Pena.

Bell County Indigent Health Services/Servicios Humanos del Condado Bell

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 Page 4 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. **Send to: P.O. Box 880, Killeen, Texas 76540 (254) 618-4165 / Toll Free: 1-877-516-8593.**

SOLICITUD DE ASISTENCIA DE ATENCION MEDICA

El Programa de Atencion Medica paraindigentes del Conedado (CIHCP) ayuda a la gente a pagar los servicios medicos 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 podria recibir, ;y otras consideraciones. Asegurese de:

1.) Poner su nombre y direccion;
2.) Firmar y fechar la tercera pagina de la solicitud; y
3.) Conteste tantas preguntas que pueda sobre esta solicitud.

Entregue su solicitud, o echela al correro, hoy mismo aun si no ha podido contester todas las preguntas.

SUS RESPONSABILIDADES

Pued\e que le pidan pnuebas de lo que escriba en su solicitud o de to 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 ejemptos de informacion que puede que tenga que probar y de documentos que le puede server de prueba:

El Lugar Donde Vive O Donde Tiene Su Hogar Permanente
Posibles Pruebas: Correro que recibio en esa direccion; expedients de de la escuela; registros de votante; recibos de impuestos, renta o hipoteca; la licencia para manegar de Tejas; otra identificacion official.

Las Posesiones Que Tiene y Cuanto Vale Cada Una
Posibles Pruebas: El avaluo para impuestos sobre la propiedad, avaluos hechos por vendedores de carros, anuncios de la venta de articulos parecidos, declaraciones de agents que venden propiedades, estado de cuentas del banco.

Los Ingresos Que Tiene
Posibles Pruebas: Talones del cheque de paga, cheque de paga, comprobante de safaris e impuestos (Forma W-2), declaracion de impuesto federal, el historial de ventas, declaracdiones de empleadores, carta de concesion, documentos legales, declaraciones de personas que le dan dinero.

Otra Cobertura Para Gastos Medicos
Posibles Pruebas: Cartas de reclamacion o de concesion, polizas de seguros, papeles de la corte u otros documentos legales.

Si tiene a su disposicion los numeros de seguro social, debe darlos. La informacion sobre el sexo (Hombre/Mujer) es voluntaria.Esta informacion no afectara su elegibilidad.

Debe dar informacion sobre seguros medicos y de cuakquier tercero que tenga la responsabilidad de pagar los servicios medicos pagados por el condado en beneficio de usted ymiembros de la unidad familiar. Al firmar y presenter 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 Necesitadad (TANF), o Seguridad de Ingreso Suplemental (SSI). Si le han pedido que solicite beneficios de alguno de estos programas o si usted ya los solicito y esta esperando la respuesta, su solicitud de CIHCP puede ser deterida hasta que decidan que no es elegible para los programas mencionados. Si no es elegible para estos programas, siha 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 dias para determiner su eligibilidad.

Despues de entregar su solicitud, usted debe reporter dentro de un plazo de 14 dias cualquier cambio de direccion, ingreso, recursos, el numero de personas que viven con usted, o si solicita o recibe Medicaid, TANF, o SSI.

Bell County Indigent Health Services/Servicios Humanos del Condado Bell

FOR OFFICE USE ONLY / PARA USO DE LA OFICINA				
Status ☐ Application ☐ Review	Date Form 100 Is Requested/Issued	Date Identifiable Form 100 Is Received	Case Record Number	Appointment Date and Time, if applicable

APPLICATION FOR HEALTH CARE ASSISTANCE / SOLICITUD DE ASISTENCIA DE ATENCION MEDICA

Name (Last, First, Middle)/Nombre (Apelido, primer, segundo)	**Home Telephone No.**/Telefono de la casa	**Other Telephone No.**/Otro numero de telefono

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.

☐ Yes/Si ☐ No

Mailing Address (Street or P.O. Box)/Direccion Postal (Calle o Apdo.)	**Apt.#**/Apto.#	**City**/Ciudad	**State**/Estado	**ZIP**

Home Address, if different from above. If it is rural, give directions. / Domicillio particular, si es diferente a la direccion de arriba.; Si es rural, explique como 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 continuacion, llene la primera linea con informacion acerca de usted mismo. Llene las lineas 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, Nombres)	**WHAT KIN TO YOU?** RELACION DE BABENTESCO	**DATE OF BIRTH** FECHA DE NACIMENTO	**SEX** SEXO	**RACE** RAZA	**U.S. CITIZEN** CIUDADANO DE LOS EUA		**LEGAL ALIEN** RESIDENTE LEGAL		**IN SCHOOL** ESTA EN LA ESCUELA		**SOCIAL SECURITY NUMBER** NUMERO DE SEGURO SOCIAL
					YES SI	**NO**	**YES** SI	**NO**	**YES** SI	**NO**	

1b. **If you or anyone in your household is a legal alien, do you or they have a sponsor?** / ?Si usted o otra persona de su hogar es un extranjero legal, tiene usted o el/ella un patrocinador?

☐ **YES** / SI ☐ **NO**

Sponsor Name
Nombre del patrocinador: _____

The word "household" in Questions #2—#16 refers to: you, your souse, 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 esposo. Y cualquier otra persona que vive con usted y con quien tiene una relacion legal. No necesita incluir informacion 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 que condado yen que 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**/Si ☐ **No**

3. **Living Arrangements**/Viyienda
Check all boxes that apply to your household./Marque todas las cajitas que se apliquen a su caso.

☐ **Own or paying for home** Soy dueno de mi casa o la estoy comprando
☐ **Live in a house provided by someone else** Vivo en una casa ajena
☐ **No permanent residence** No tengo residencia permanente
☐ **Live with someone else** Vivo con otra pesona
☐ **Rent House/Apartment** Rento una casa o apartamento
☐ **Jail** Carcel

4. List your average monthly household expenses./Enumere los gastos mensuales de la unidad familiar.

Rent/Mortgage/Renta/hipoteca.....$_____

Utilities (gas, water, electric)/Servicios publicos (gas, agua,luz).....$_____

Telephone/Telefono.....$_____

Transportation, such as gas, car payments, bus/Transportacion, tal como gasoline, pagos del carro, abobus..$_____

Tax and Insurance on home per year/Impuesto y seguro annual de la casa.....$_____

Credit, Store, Charge Cards.....$_____

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/**Si ❑ **No**

If Yes, who?/Si contesta "Si," ¿quien?_____

5. Are you—or is anyone in your household—receiving ❑ TANF, ❑ Food Stamp, ❑ and/or Medicaid benefits?
¿Esta usted o alguien de la unidad familiar recibiendo beneficios de TANF, estampillas para comida, y/o Medicaid? ..... ❑ **Yes/**Si ❑ **No**

If Yes, who?/Si contesta "Si," ¿quien?_____

6. Are you—or is anyone in your household pregnant? **If Yes, who?**
¿Esta usted o alguien de la unidad familiar embarazada? .....❑ **Yes/**Si ❑ **No** Si contesta "Si," ¿quien? _____

7. Are you—or is anyone in your household disabled? **If Yes, who?**
¿Esta usted o alguien de la unidad familiar incapacitada? .....❑ **Yes/**Si ❑ **No** Si contesta "Si," ¿quien? _____

8. Have you—or has anyone in your household—applied for SSI or SSDI?
¿Alguna vez usted o alguien de la unidad familiar solicito beneficios de SSI or SSDI? ..... ❑ **Yes/**Si ❑ **No**

If Yes, who?
¿Si contesta "Si," ? _____

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 medicas sin pagar de los ultimos tres meses? ..... ❑ **Yes/**Si ❑ **No**

If Yes, which months?
Si contesta "Si," ¿Cuales 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 medica (Medicare, seguro medico, V.A., Tricare, etc.)?..... ❑ **Yes/**Si ❑ **No**

If Yes, who?/Si contesta "Si," ¿quien? _____

11. How much money do you have? For example, on your person, in your home, in bank accounts, or other locations?
¿Cuanto dinero tiene usted; porejemplo, 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, model in the chart below./ ¿Cuantos carros, camionetas u otros vehiculos tienen usted y las personas de la unidad familiar? Anote el ano, la marca, y el modelo en la tabla a continuacion. .....

	Year/Ano	Make and Model/
1.		
2.		

	Year/Ano	Make and Model/
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/**Si ❑ **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 ultimos tres meses, traspaso, vendio o regalo usted o alguien de la unidad familiar diner o alguna propiedad?..... ❑ **Yes/**Si ❑ **No**

15. Have you—or has anyone in your household—worked in the last three months? **If Yes, who?**
Ha trabajado usted o alguien de la unidad familiar en los ultimos tres meses?.....❑ **Yes/**Si ❑ **No** Si contesta "Si," ¿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; child support; and unemployment.**/Haga una lista de los ingresos de la unidad familiar a continuacfion. Asegurese de anotar: Cheques del gobiemo; ingresos de trabajo o de capacitacion; dinero que recibe de cobros de cuarto y comida; regales en efectivo, prestamos, o aportaciones de sus padres, familares, amigos, y otras personas; los ingresos del patrocinador; becas o prestamos de la escuela; manutencion de ninos, 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 patron, 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 que frecuencia to recibe? (diariamente, por semana, cada quicena, 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.

I understand that by signing this application, I am giving the county the right to recover the cost of health care services provided by the county from any third party. I agree to give the county any information it needs to identify and locate all other sources of payment for health care services.

I have been told and understand that my failure to meet the obligations set forth may be considered intentional withholding of information and can result in the recovery of any loss by repayment or by filing civil or criminal charges against me.

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 condado toda la informacion necesaria para comprobar mis dedaraciones sobre la elegibilidad.

Me comprometo a avisar, dentro de los 14 dias, de cualquier cambio de:

- Ingresos
- Recursos
- Numero de personas que viven conmigo
- Direccion
- Solicitud de SSI, TANF, o Medicaid o la entrega de cualquiera de estas.

Me han dicho y comprendo que esta solicitud sera considerada sin discriminiacion por raza, color, religion credo, origin national, edad, sexo, discapacidad, ri afiliacion politica; que puedo pedir una revision de la decision que se haga acerca de mi solicitud de asistencia o recertificacion para asistencia; y que puedo pedir, oralmente o por escrito, una audiencia imparcial sobre cualquier accion que afecte la enfrega o la terminacion de asistencia de atencion medica.

Comprendo que al firma esta solicitud, doy al condado el derecho a recuperar de cualquier tercero el costo de los servicios medicos proporcionados por el condado. Me comprometo a dar al condado la informacion necesaria para identificar y localizer cualquier otro fuente de pagos por mis servicios medicos.

Me han dicho y comprendo que si dejo de cumplir con las obligaciones especificadas en esta podria considerarse como una retencion intencional de informacion y podria dar lugar a la recuperacion de perdidas por medio de la devolucion de pagos o por medio le la presentacion de cargos criminals en mi

BEFORE YOU SIGN, BE SURE EACH ANSWER IS COMPLETE AND CORRECT.
ANTES DE FIRMAR, ASEGURESE DE QUE CADA RESPUESTA SEA COMPLETA Y CORRECTA.

Signature—Applicant / Firma—Solicitante	**Date /** Fecha	**Signature—Spouse /** Firma—Esposo o Espos	**Date /** Fecha

If the applicant is married and his/her spouse is a household member, the spouse must also sign and date this Form 100 if the spouse is a disqualified household member./Si el/la solicitante esta casado/a y su esposo o esposa vive en la misma casa, se require que su esposo o esposa tambien firme esta Forma 100, aunque no tenga derecho de recibir asistencia.

Signature—Person Who Helped Complete This Application / Date Firma—Persona que ayudo a llenar esta solicitud / Fecha	**Signature—Applicant's Representative / Date** Firma—Representante del solicitante / Fecha	**Signature—Witness (if signed with "X") / Date** Firma—Testigo (si9 firma con "X") / Fecha

Address (Street, City, State, ZIP) and telephone number of anyone who helped complete this Form 100 / Direccion (Calle, Ciudad, Estado, ZIP) y telefono de la persona que ayudo a llenar esta Forma 100

APPLICATION FOR ASSISTANCE/*SOLICITUD DE ASISTENCIA*
ADDENDUM FOR/ *ADICIÓN PARA*
BELL & MILLS CIHCP

1. AUTHORIZED REPRESENTATIVE
If you want someone besides the head of your household , your spouse, or a responsible member to apply for benefits, obtain information or report changes for you, give his or her name and address. This person MUST sign on the "Authorized Representative" line below.

REPRESENTANTE AUTORIZADO
Si quiere que alguien que no sea la cabeza de la casa, su esposo/a ni otro adulto responsable de la casa, le haga la solicitud de beneficios, obtenga información or avise de cambios, prevea el nombre y dirección de esa persona. Esa persona debe firmar sobre "Representante Autorizado"

Name of Authorized Representative/*Nombre de Representante Autorizado*	Telephone/*Teléfono*
Address (Street, City, State, Zip)/*Dirección (Calle, Ciudad, Estado, Código Postal)*	

Signature – Applicant/*Firma-Solicitante* Date/*Fecha*

Signature-Spouse/ *Firma Esposo/a* Date/*Fecha*

Signature-Witness(if signed with "X") Date/*Fecha*
Firma-Testigo(si la firma es con "X")

Signature-Authorized Representative Date/*Fecha*
Firma-Representante Autorizado

2. OTHER SERVICES YOU HAVE APPLIED FOR OR YOU ARE CURRENTLY RECEIVING/*OTROS SERVICIOS DE LOS CUALES A SOLICIDADO O ESTA ACTUALMENTE RECIBIENDO*

a) Has anyone in your household applied OR does anyone plan to apply for DARS (Department of Assistive & Rehabilitative Services)?
¿A solicitado alguien en su hogar o hay planes para solicitor al DARS (Departamento de Servicios de Asistencia y Rehabilitación)?

_____Yes/*Si* _____ No/*No* If "Yes", complete all questions below/*Si contesta "Si", complete todas las preguntas bajo.*

Name of Person seeking DARS/*Nombre de la persona solicitando DARS*	Date of application/*Fecha de solicitud*
Status of claim (please circle)/ *Estado de su petición(circunde)* PENDING/*PENDIENTE* RECEIVING BENEFITS/*RECIBIENDO BENEFICIOS* IN APPEAL/*EN APELACIÓN*	Name, address and phone of Case Worker *Nombre, dirección y teléfono del Trabajador del Caso*

b) Is anyone in your household seeking Worker's Compensation?/*Alguien en su hogar esta solicitando Remuneración de Trabajadores?*

_____Yes/*Si* _____ No/*No* If "Yes", complete all questions below/*Si contesta "Si", complete todas las preguntas bajo.*

Name of Person seeking Worker's Compensation/*Nombre de la persona solicitando Remuneración de Trabajadores*	Date of application/*Fecha de solicitud*
Status of claim (please circle)/ *Estado de su petición(circunde)* PENDING/*PENDIENTE* RECEIVING BENEFITS/*RECIBIENDO BENEFICIOS* IN APPEAL/*EN APELACIÓN*	Name, address and phone of legal counsel *Nombre, dirección y teléfono del abogado*

c) Is anyone in your household seeking Crime Victim's Compensation? *¿Alguien en su hogar esta solicitando Remuneración de Victimas de Crimen?* _____Yes/*Si* _____No/*No* If "Yes", who/*Si contesto "Si", quien?*

Name of Person seeking Crime Victim's Compensation /*Nombre de la persona solicitando Remuneración para Victimas de Crimen*	Date of application/*Fecha de solicitud*
Status of claim (please circle)/ *Estado de su petición(circunde)* PENDING/*PENDIENTE* RECEIVING BENEFITS/*RECIBIENDO BENEFICIOS* IN APPEAL/*EN APELACIÓN*	Name, address and phone of legal counsel *Nombre, dirección y teléfono del abogado*

d) Is anyone in your household applying for or seeking any other type of assistance or compensation (i.e. MHMR, Commission for the Blind or Deaf, Sickle Cell, State TB services, insurance settlement, etc.)?/ *¿Alguien en su hogar esta solicitando otra ayuda (MHMR, Comisión para la Ceguera o Sordera , Anemia del Sickle Cell, Servicios Estatales de TB, pago de Seguros)* _____Yes/*Si* _____No/*No* If "Yes" complete the questions below/*Si contesto "Si" complete las preguntas bajo.*

Name of Person seeking other services/*Nombre de la persona solicitando otros servicios*	Date of application, lawsuit/*Fecha de solicitud, petición legal*
Status of claim (please circle)/ *Estado de su petición(circunde)* PENDING/*PENDIENTE* RECEIVING BENEFITS/*RECIBIENDO BENEFICIOS* IN APPEAL/*EN APELACIÓN*	Type of assistance/services being saught/*Tipo de asistencia o servicios que esta solicitando*

e) Is anyone in your household a veteran? Yes_____No_____If yes, who?_____

¿Alguien en su hogar un veterano? Si_____No_____ En caso afirmativo, ¿Quien?_____

f) Is anyone in your household associated with the military, either as a dependent or receiving military retirement or veterans benefits?
¿Alguien en su hogar tiene asociación militar, como dependiente o recibiendo benficios de jubilación o de veteranos?

Name of Person/ *Nombre de Persona*	Status/ *Estado*: ☐ Dependent/ *Dependiente* ☐ Retired/ *Jubilado* ☐ Receiving Veterans Benefits/ *Recibiendo Beneficios de Veterano*

3. MARITAL STATUS Please complete the following/ *ESTADO CIVIL Favor de contestar lo siguiente:*

Are you currently married (please circle)/ ¿Es actualmente casada/o? (*circunde)* YES/SI NO/NO	If you are married, what is your spouse's name?/ *¿Si es casada/o, que es el nombre de su esposo/a?* Where does your spouse live?/ *¿En donde vive su esposo/a?*
If not married check the correct answer Si no es casada/o marque lo correcto _____ Never married/*Nunca casada/o* _____ Separated from/*Separada/o de* _____	_____ My spouse is deceased/*Mi esposo/a es difunto/a* _____ I am divorced from/*Estoy divorciada/o de* _____
If you are divorced, separated, or if your spouse is deceased, please give the date or length of time since this occurred (i.e. 2 months, 3 years, etc.) *Si usted es divorciada/o, separada/o, o si su esposo/a es difunto/a, favor de dar la fecha o la longitud del tiempo desde que ocurrió (ejemplo, 2 meses, 3 años…)*	

4. Please include anything else you feel the CIHCP case worker should know about you and your household (i.e. applying for dependent status with the U.S military)/*Favor de incluir alguna otra información que usted sienta que el/la Trabajador/a del Caso del CIHCP debe saber de usted o su hogar (ejemplo, si esta aplicando para estado de dependiente del servicio militar):*

_____

_____

_____

_____

_____

_____

_____

_____

INCOME/RESOURCES CHECKLIST
LISTA PARA VERIFICAR INGRESOS/RECURSOS

Have you received or expect to receive money from any of the following sources this month or during the last 3 months? (Please respond to each item.) **Usted o alguna persona en su casa ha recibido sigulente lista durante este mes o los ultimos 3 meses? (Favor de responder en cada item).**

	Yes Si	No No		Yes Si	No No
Employment or Self-Employment **Empleo o Negocio Independiente**			Child Support **Pagos de Sostanimiento para Ninos**		
Contract Work/**Trabajo por Contrato**			Alimony / **Compensacion por Separacion o Divorcio**		
Tips or Commissions **Propinas o Comisiones**			Dividends from Stocks, Bonds or Bank Accounts **Dividendos de Acciones, Bonos o Cuentas Bancarias**		
Worker's Compensation Benefits **Compensacion del Seguro Obrero**			Interest or Royalties **Intares o Derachos de Propledad**		
Unemployment Benefits **Compensacion de Desempleo**			Money or Royalties from Oil, Gas or ineral Leases **Dinero o Derechos de Propiedad de Contratos de Petroleo, Gas, o Minerales**		
Educational Grants, Scholarships or Loans **Donaciones Educatives, Becas, o Prestamos Educativos**			Money from Rent of Houses or Apartments **Dinero de Renta de Casas o Apartamentos**		
Loans (from any other source) **Prestamos(algun otro origin)**			Money from roomers or Boarders **Dinero que Recibe de Inquilliones o Huespedes**		
Cash Gifts or Contributions **Donaciones de Dinero o Contribuciones**			Payments from Private Insurance **Pegos de Seguranza Privada**		
Refunds or Lump Sum Payments **Reembolsos o Pagos de Suma Total**			Union Benefits (including strike benefits) **Beneficios de Union (incluyendo beneficios de huelga)**		
Supplemental Security Income (SSI) or Social Security **Seguridad de Ingreso Supplemental (SSI) o Seguro Social**			Military Allotments **Repartido de Sueldo Militar**		
Veteran's Benefits or Pensions **Beneficios y/o Pensiones de Veterano**			TANF **Asistencia a Famillias con Ninos Dependientas**		
Railroad Retirement or Other Pensions **Pension de Ferrocarril u Otros Beneficios de Retiro o Pensiones**			Money from Other Public or Private Welfare AGencies **Dinero de Otras Agencias de Welfare Publicas o Privades**		
Babysitting or Cleaning Houses **Culder Ninos o LImpieza de Casas**			Flea Market or Arts and Crafts Sales **La Pulga o Venta de Artes**		
Animal or Pet Breeding and/or Sales **Generador y Ventas de Animales Caseros**			Home Sales: Avon, Mary Key, Tupperware, Amway, Etc. **Venta en su Casa de: Avon, Mary Kay, Tupperware, Amway, etc.**		
Money from Farm (including pasture rental, ASC payments Livestock or other related money) **Dinero de Agricultura (incluyendo renta de pasture, Pados de ASC, ganaderia, u otro origin paracido)**			Miscellaneous: Yard Work, Painting, Sale of Cans or Scrap Metal, wood Cutting, Ironing, Sewing, Carpentry, Mechanical Work, Hauling Hay, Fence Building, Meals for the Elderly, etc. **Miscelanco—Trabajo de: Yards, Pintor, Venta de Aluminio o Metal, Lenardo, Planchados,Costurers, Acarreando Heno, Carpinteria, Mecanico, Construyendo Cercas, Comida para los Ancionos, etc.**		

Have you received, or expect to receive income, cash or any other type of assistance from any other source NOT listed above this month or the last 3 months? **Usted recibio o espera recibir ingresos, dinero o otro tipo de asistencia de sigun otro origin que no fue include en la lista durante este mas o los ultimos 3 meses?** If yes, please sources and amounts. **(Si es al, favor de alistar ol origin yla cantidad.):** _____		
Have you received or expect to receive any assistance from any source in exchange for work instead of receiving money? **Usted recibio o espera recibir siguna salestencia de un origin en camblo de trabajo en vez de recibir ingresos?** If yes, please list source. **(Si es al, favor de allstar el origin y la cantidad.):** _____		
Does anyone help you or any person in the home by paying any of your expenses or bills? **Hay una persona que la ayuda a usted o siguna persona en su casa pagar sus gastos o cuentas?**		

Do you own, have, or are buying any of the following: (Please respond to each item)
Usted tienen o handan comprando de la lista en seguida? (Favor de responder a cada item.)

	Yes Si	No No
Cars or Trucks/**Carros o Camiones (trocas)**		
Motorcycles/**Motocicietas**		
Boats or Other Vehicles/**Barcos o Otros Vehiculos**		
Equipment of any kind (such as tools or farm equipment)/**Equipo o Herramienta**		
Houses, Land or Lots (in Texas or anywhere else)/**Casas, Solares, o Propiedad (En Texas o en algun otro lugar**		
Livestock or Cattle/**Ganado o Aves**		
Life Insurance/**Seguranza de Vida**		
Burial Insurance or Burial Plots/**Seguro deEntierro o Terreno de Supultura**		
Real Estate (in Texas or anywhere else)/**Bienes raices (En Texas o en algun otro lugar)**		
Rental Property/**Propiedad oCasas de Renta**		
Checking or Savings Accounts/**Cuentas de cheques o Ahorros**		
Credit Union Accounts/**Cuentas en Banco Cooperativo**		
Individual Retirement Accounts (IRA)/**Cuentas de Retiro Individuo lIRA)**		
401(K) or Keogh Plans/**Fondos de Retiro (401K o Keogh)**		
Certificates of Deposit (CDs)/**Certificados de Deposito (CDs)**		
Trust Funds/**Fondosde Deposito**		
Pension Funds/**Fondos de Pension**		
Stocks, Bonds, or Mutual Funds/**Acciones, Bonos o Mutual Funds**		
Savings Bonds/**Bonos de Ahorro**		
Oil or Mineral Rights/**Derechos de Petroleo o Minerales**		
Do you or any person in the home have any cash, checks or money that is NOT in a bank or credit union? **Usted o alguna persona en su casa tiene dinero en efectivo, cheques o dinero que no esta depositado en banco o banco cooperative?** If Yes, how much **(Si es si, que tanto)? $** _____		
Have you or any person in the home received any settlements, refunds, or lump sum payments within the last 3 months? **Usted o alguna persona en su casa ha recibido un arregio de pago de seguro o pagos de suma total en este mes o Durante los ultimos tres meses?** If Yes, how much **(Si es si, que tanto)? $** _____		
Do you or any person in the home own, have, or are buying anything NOT listed above? **Usted o siguna persona en su casa tienan o handan comprando cualguier cosa que no fue mencionada en la lista?** If Yes, please list each item and the value. **(Si es si, favor de alistar cada item y el valor):** _____ _____		

Social Security Administration
Consent for Release of Information

Form Approved
OMB No. 0960-0566

*SSA will not honor this form unless all required fields have been completed (*signifies required field).*

TO: Social Security Administration

*Name | *Date of Birth | *Social Security Number

I authorize the Social Security Administration to release information or records about me to:

*NAME	*ADDRESS
Bell County Indigent Health Services	P.O. Box 880
	Killeen, TX 76540

*I want this information released because: it is necessary to complete my County Indigent Health Care Program Application for Assistance.

There may be a charge for releasing information.

*Please release the following information selected from the list below:

You must check at least one box. Also, SSA will not disclose records unless applicable date ranges are included.

- [X] Social Security Number
- [X] Current monthly Social Security benefit amount
- [X] Current monthly Supplemental Security Income payment amount
- [X] My benefit/payment amounts from _____ to _____
- [X] My Medicare entitlement from _____ to _____
- [ ] Medical records from my claims folder(s) from _____ to _____
  If you want SSA to release a minor's medical records, do not use this form but instead contact your local SSA office.
- [ ] Complete medical records from my claims folder(s)
- [X] Other record(s) from my file (e.g. applications, questionnaires, consultative examination reports, determinations, etc.) determinations, pending applications

I am the individual to whom the requested information/record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury in accordance with 28 C.F.R. § 16.41(d)(2004) that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that any applicable fees must be paid by me.

*Signature: _____ *Date: _____

Relationship *(if not the individual)*: _____ *Daytime Phone: _____

Social Security Administration
Consent for Release of Information

Form Approved
OMB No. 0960-0566

Instructions for Using this Form

Complete this form only if you want us to give information or records about you, a minor, or a legally incompetent adult, to an individual or group (for example, a doctor or an insurance company). If you are the natural or adoptive parent or legal guardian, acting on behalf of a minor, you may complete this form to release only the minor's non-medical records. If you are requesting information for a purpose not directly related to the administration of any program under the Social Security Act, a fee may be charged.

NOTE: Do not use this form to:

- Request us to release the medical records of a minor. Instead, contact your local office by calling 1-800-772-1213 (TTY-1-800-325-0778), or
- Request information about your earnings or employment history. Instead, complete form SSA-7050-F4 at any Social Security office or online at www.ssa.gov/online/ssa-7050.pdf.

How to Complete this Form

We will not honor this form unless all required fields are completed. An asterisk (*) indicates a required field. Also, we will not honor blanket requests for "all records" or the "entire file." You must specify the information you are requesting and you must sign and date this form.

- Fill in your name, date of birth, and social security number or the name, date of birth, and social security number of the person to whom the information applies.
- Fill in the name and address of the individual (or organization) to whom you want us to release your information.
- Indicate the reason you are requesting us to disclose the information.
- Check the box(es) next to the type(s) of information you want us to release including the date ranges, if applicable.
- You, the parent or legal guardian acting on behalf of a minor, or the legal guardian of a legally incompetent adult, must sign and date this form and provide a daytime phone number where you can be reached.
- If you are not the person whose information is requested, state your relationship to that person. We may require proof of relationship.

PRIVACY ACT STATEMENT

Section 205(a) of the Social Security Act, as amended, authorizes us to collect the information requested on this form. The information you provide will be used to respond to your request for SSA records information or process your request when we release your records to a third party. You do not have to provide the requested information. Your response is voluntary; however, we cannot honor your request to release information or records about you to another person or organization without your consent.

We rarely use the information provided on this form for any purpose other than to respond to requests for SSA records information. However, in accordance with 5 U.S.C. § 552a(b) of the Privacy Act, we may disclose the information provided on this form in accordance with approved routine uses, which include but are not limited to the following: 1. To enable an agency or third party to assist Social Security in establishing rights to Social Security benefits and/or coverage; 2. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; 3. To comply with Federal laws requiring the disclosure of the information from our records; and, 4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of SSA programs.

We may also use the information you provide when we match records by computer. Computer matching programs compare our records with those of other Federal, State, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

Additional information regarding this form, routine uses of information, and other Social Security programs are available from our Internet website at www.socialsecurity.gov or at your local Social Security office.

PAPERWORK REDUCTION ACT STATEMENT

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 3 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U.S. Government agencies in your telephone directory or you may call 1-800-772-1213 (TTY 1-800-325-0778).** *You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***

AUTHORIZATION TO OBTAIN INFORMATION

In order to determine eligibility for the Bell or Mills County Indigent Health Care Program certain information about your income, assets, household composition, residency, and other health care coverage to household members must be made available to Bell County Indigent Health Services. Also, in the course of the determination process, it may become evident that you could benefit from other services that may be available to you within the community.

I, _____ and _____
Applicant Spouse

Living at _____
Street Address City State Zip

AUTHORIZATION TO OBTAIN:

_____do hereby authorize persons, organizations, or establishments having information or records related to my household income, residency, household composition, assets, and health status & to furnish such information to the Bell County Indigent Health Services which administers the County Indigent Health Care Program (CIHCP) for Bell and Mills Counties.

_____understand that this information is necessary to determine if I meet the criteria of eligibility for the CIHCP; and that health status is necessary to determine whether I might be eligible for any other resources to include but not limited to those provided by the State of Texas, the Veteran's Administration, the local Mental Health Authority, and /or the Social Security Administration,

_____I/We further authorize Bell County Indigent Health Services to utilize a subscription data base to search for any possible assets, income, relationships, and other data that may have bearing on my/our eligibility for the CIHCP; and that my case worker may require further documentation to verify or discredit information that may be received from the search report.

The following agencies may be contacted:

Immigration Neutralization Services	**Insurance Settlements**	**Other:** _____
Central Counties Services	**Deaf, Sickle Cell, State TB Services**	_____
DARS (Dept. of Assist & Rehab Services)	**Texas Commission for the Blind**	_____
CTHAP Section 8/HUD	**Heritage House Central Texas**	_____
Killeen Housing Authority	**Bell County Health District**	_____
Families Crisis	**Greater Killeen Free Clinic**	_____
Veterans Administration	**Temple Community Clinic**	_____
Cedar Crest	**Body of Christ Community Clinic**	
Texas Health and Human Services (All eligibility based programs such as SNAP, Breast and Cervical Cancer, Medicaid, TANF, and etc.)	**Bell County Mental Health Indigent Defense**	

I/We understand that information will be obtained as needed and as appropriate to my circumstances in order to determine eligibility for the CIHCP. And that all information will be managed and protected in accordance with HIPPA and relevant state confidentiality guidelines.

I understand that the obtaining the information is valid for a period of (2) years from the date of the signature unless I/We revoke all or part of it in writing prior to that date.

Applicant or Designated Representative Signature	Date	Signature of Spouse	Date
CIHCP Caseworker Signature	**Date**	**Print Name-CIHCP Caseworker**	