WINNIE STOWELL HOSPITAL DISTRICT

PO BOX 1997, WINNIE, TX 77665 PHONE: (409)296-1003 FAX: (409)400-4023

Application Appointment Hours are 8:00am-2:00pm, Monday - Friday

The following items are needed to complete your case:

2 forms of identification for everyone in the household:

- Drivers' license or state issued ID card
- Social Security card
- Birth Certificate
- Voter Registration Card
- Shot Record
- School Record

Proof of Residency (ALL that apply)

- **Last 3 months** of consecutive utility bills (Entergy/TBCD)
- **Last 3 months** rent/mortgage receipt
- Statement from landlord or another person that can attest to your residency

Proof of Income (ALL that apply)

- **Last 3 months** payroll check stubs
- **Earnings verification** from your employer
- **If Self-Employed**, current year Federal Tax Return
- **Award letter** or current application status from SSI and/or RSDI
- **Award letter** or current application status for Unemployment Benefits
- **Statement of Support** from whoever is paying your living expenses

Additional Information

- **Medical Insurance card** (Medicaid, Medicare, Medicare Advantage plan, Medcare Part D Prescription coverage, private insurance, or any other medical insurance) for you and/or your household members
- **Award letter** (Medicaid, Medicare, TANF, Food Stamps or any other state assistance)
- **Denial letter** (Medicaid, Medicare, TANF, Food Stamps or any other state assistance)
- **Last 3 months** of Bank statements (Checking and Savings)
- **Vehicle Registration** or title for **ALL** vehicles and any balance owed on financed vehicles
- **If Unemployed**, Verification of Registration with the Texas Workforce Commission

If you have any questions, please contact the WSHD Indigent Care Office

TEXAS Health and Human Services

Form 3064
January 2020-E

Clinic Choice:
- ○ **RMC**
- ○ **TOPC**

Pharmacy Choice:
- ○ **BBS**
- ○ **WLX**

County Indigent Health Care Program (CIHCP)

Application for Health Care Assistance

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

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

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

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

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

1. On the chart below, fill in the first line with information about yourself. Fill in the remaining lines for everyone who lives in the house with you, whether or not you consider them household members.

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

Note: The word “household” in Questions 2 through 16 refers to you, your spouse and anyone else who lives with you and with whom you have a legal relationship. You do not need to include information on people who live with you but are not part of your “household.”

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

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

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

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

☐ Live with someone else ☐ Rent house or apartment ☐ Jail

4. List your average monthly household expenses.

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

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

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

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

If Yes, who? _____

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

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

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

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

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

If Yes, which months? _____

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

◯ Yes ◯ No If Yes, who? _____

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

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

	Year	Make and Model	+
1			−

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

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

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

16. List all of your household's income below. Include the following: government checks; money from training or work; money you collect from charging room and board; cash gifts, loans or contributions from parents, relatives, friends and others; sponsor's income; school grants or loans; child support; and unemployment.

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

The statements I have made, including my answers to all questions, are true and correct to the best of my knowledge and belief. I agree to give eligibility staff and the county any information necessary to prove statements about my eligibility. I agree to report any of the following changes within 14 days:

- Income
- Resources
- Number of people who live with me
- Address
- Application for or receipt of SSI, TANF or Medicaid

I have been told and understand that this application will be considered without regard to race, color, religion, creed, national origin, age, sex, disability or political belief; that I may request a review of the decision made on my application or recertification for assistance; and that I may request, orally or in writing, a fair hearing about actions affecting receipt or termination of health care assistance.

I understand that by signing this application, I am giving the county the right to recover the cost of health care services provided by the county from any third party.

I agree to give the county any information it needs to identify and locate all other sources of payment for health care services.

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

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

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

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

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

The County Indigent Health Care Program (CIHCP) helps people pay for needed health care. Whether you can get this help depends on your income, what you own, where you live, other help you receive or could receive and other items. Be sure to:

1. Complete your name and address;
2. Sign and date Page 3 of the application; and
3. Answer as many questions as you can on this application.

Turn in or mail back your application today even if you cannot answer all the questions.

Your Responsibilities

You may be asked to bring proof of what you write on your application or what you tell the person interviewing you. If you need help getting proof, the person interviewing you will help. Examples of some of the items you may be asked to prove and documents you can use for proof are listed below.

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

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

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

Other Health Care Coverage – Award or claim letters; insurance policies; court documents; and other legal papers.
Information regarding Social Security numbers should be given if this information is available. Information regarding sex (male/female) is voluntary. This information will not affect your eligibility.

You must give information about health care insurance and any other third party financially liable for health care services paid by the county for yourself and members of your household. By signing and submitting this application, you are agreeing to give the county the right to recover the cost of health care services provided by the county from any third party.

You may be asked to apply for Medicaid, Temporary Assistance for Needy Families (TANF) or Supplemental Security Income (SSI) benefits. If you are asked to apply for one of these programs, or have applied but are waiting for an answer, your CIHCP application may be pended until you are determined ineligible for the other program. If you are not eligible for these other programs and if you have answered all the questions on the application and have given all the proof asked for, your application can be processed. Then, the CIHCP must determine if you are eligible within 14 days.

After turning in your application, you must report within 14 days any changes in your address, income, resources, people living with you, or application for or receipt of Medicaid, TANF or SSI.

WINNIE STOWELL HOSPITAL DISTRICT

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WINNIE STOWELL HOSPITAL DISTRICT PRIVACY PRACTICES POLICY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATIN ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE READ IT CAREFULLY

If you have any questions about this notice, please contact the WSHD Indigent Care Director by calling 409-296-1003.

We are required by law to maintain the privacy of protected health information and to provide patients with notice of our legal duties and privacy practices with respect to protected health information. This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by either mailing the revised Notice to an address you provide or by delivering a revised Notice to you at our office.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Uses and Disclosures of Protected Health Information for Treatment, Payment and Health Care Operations

We are permitted to use and disclose your protected health information for treatment, payment and health care operations as described in this Section 1. Your protected health information may be used and disclosed by us and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to facilitate payment of your health care bills and to support our operations.

Following are examples of the types of uses and disclosures of your protected health care information that we are permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

- **Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians and health care providers who may be treating you: i.e. your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

  In addition, we may disclose your protected health information from time-to- time to another physician or health care provider (e.g., a specialist or laboratory) who, at our request, becomes involved in your care by providing assistance with your health care diagnosis or treatment.

- **Payment:** Your protected health information may be used, as needed, to obtain payment for your health care services. This may include certain activities that a payor (whether a governmental entity or private insurance or other health plan) may undertake before it approves or pays for the health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. Your protected health information may be used, as needed, to obtain reimbursement from a sponsor who signed an I-864 affidavit of support on your behalf.

- **Healthcare Operations:** We may use or disclose, as needed, your protected health information in order

to support the business activities of our office. These activities include but are not limited to: quality assessment activities; employee review activities; training of medical students, other practitioners, or non-health care professionals; accreditation; certification; licensing; credentialing; and conducting or arranging for other business activities. For example, we may use and disclose your protected health information when training and reviewing our staff. We may use or disclose your protected health information, as necessary, to contact you to remind you of upcoming appointments.

If you are a job applicant, existing employee, or a family member of an employee covered by the County's health insurance, we will share your protected health information with the Collin County Human Resources Department, and/or supervising department as part of routine business operations. Some examples of situations where your information would be shared are: post-offer/pre-employment health screening outcomes; wellness screening outcomes; random drug screening outcomes; and Department of Transportation physical outcomes.

We will share your protected health information with third party "business associates" that perform various activities (e.g., auditing, legal) for us. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information. This requirement will not apply if the business associate is a "health care component" designated by our governing body.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services we offer that may be of interest to you. You may contact our Privacy Official to request that these materials not be sent to you.

- **Emergencies:** We may use or disclose your protected health information in an emergency treatment situation.

  a) Other Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

  Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that we have taken an action in reliance on the use or disclosure indicated in the authorization.

  b) Other Permitted Uses and Disclosures to Which You May Agree or Object

  We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then we may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

- **Others Involved in Your Healthcare:** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are not present or unable to agree or object to such a disclosure because of your incapacity or an emergency circumstance, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

  c) Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

  We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

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- **Required By Law:** We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. If required by law, you will be notified of any such uses or disclosures.
- **Public Health:** We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.
- **Communicable Diseases:** We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.
- **Abuse or Neglect:** We may disclose your protected health information to a public health authority or other government authority that is authorized by law to receive reports of child abuse or neglect. In addition, if we believe that you have been a victim of abuse, neglect or domestic violence we may disclose your protected health information to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.
- **Health Oversight:** We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
- **Food and Drug Administration:** We may disclose your protected health information to a person or company required by the Food and Drug adverse events, product defects or problems, biological product deviations; to track products; to enable product recalls; to make repairs or replacements; or to conduct post marketing surveillance, as required.
- **Legal Proceedings:** We may disclose protected health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), and in response to a subpoena, discovery request or other lawful process as permitted by law. We may disclose protected health information in the course of any legal proceedings which seek reimbursement from a sponsor who signed an I-864 affidavit of support on your behalf.
- **Law Enforcement:** We may disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. Such disclosures include (1) the reporting of certain physical injuries; (2) responding to legal processes; (3) providing limited information for identification and location purposes, (4) providing law enforcement officials with information pertaining to victims of a crime; (5) reporting deaths possibly resulting from criminal conduct; (6) reporting a crime that occurs on our premises; and (7) reporting criminal activity outside our premises that results in emergency medical services.
- **Coroners, Funeral Directors, and Organ Donation:** We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out his/her duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.
- **Research:** We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

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- **Serious Threat to Health or Safety:** Consistent with applicable federal and state laws, we may disclose your protected health information if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.
- **Military Activity and National Security:** When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or certain other individuals.
- **Inmates:** We may use or disclose your protected health information if you are an inmate of a correctional facility and we created or received your protected health information in the course of providing care to you.
- **Workers' Compensation:** Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally established programs.
- **Sponsored Immigrant (I-864 Affidavit of Support):** Your protected health information may be disclosed as part of a request for reimbursement from a person who sponsored your admissibility into the United States by signing an I-864 on your behalf. Additionally, your protected health information may be disclosed in public legal proceedings if we pursue legal proceedings against a sponsor who signed an I-864 affidavit of support on your behalf.
- **Project Access-Collin County, Inc.:** Your protected health information may be disclosed in order to provide continuity of care through Collin County's participation in the Project Access—Collin County, Inc. program.
- **Required Uses and Disclosures:** Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Title 45, Code of Federal Regulations, Parts 160 and 164.

2. YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

- **You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

  We are not required to agree to a restriction that you may request. If we believe it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If we agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. Additionally, if you are a sponsored immigrant and we need to use your protected health information in order to seek reimbursement from the person who sponsored you with an I-864 affidavit of support, your protected health information will not be restricted when communicating with your sponsor or pursuing legal action against your sponsor. With this in mind, please discuss any restriction you wish to request with your health care provider. You may request a restriction by completing a "Restriction of use and Disclosures Request Form," which you may obtain from our Privacy Official.
- **You have the right to request to receive confidential communications from us by alternative means or at an alternative location.** We will accommodate reasonable requests. We may also condition

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this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Official.

- **You have the right to inspect and copy your protected health information.** This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that we use for making decisions about you.

  Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to any law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. Please contact our Privacy Official if you have questions about access to your medical record.

- **You may have the right to have us amend your protected health information.** This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. Requests for amendment must be in writing and must provide a reason to support each requested amendment. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Official if you have questions about amending your protected health information.

- **You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.** This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, for notification purposes, and for other purposes, as permitted by law. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003 and during the six years prior to your request. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

- **You have the right to obtain a paper copy of this notice.** Upon request, even if you have agreed to accept this notice electronically.

3. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying the person named below of your complaint. We will not retaliate against you for filing a complaint.

For further information about the complaint process, or to file a complaint, contact:

- **WSHD Indigent Care Director**
- Phone: 409-296-1003
- Fax: 409-400-4023

For further information about filing a complaint with the Secretary of Health and Human Servers, or to file a complaint, contact:

U.S. Dept. of Health & Human Services, Office for Civil Rights
Medical Privacy, Complaint Division 200 Independence Avenue, SW HHH Building, Room 509H Washington, D.C. 20201
Phone: 866-627-7748, TTY: 886-788-4989

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WINNIE STOWELL HOSPITAL DISTRICT
FRAUD/MISREPRESENTATION & DISRUPTIVE BEHAVIOR POLICY

Definition

1. Fraud/Misrepresentation" is the deliberate misrepresentation of a material fact for the purpose of acquiring benefits. Fraud/Misrepresentation includes the failure to notify the Winnie Stowell Hospital District ("WSHD") of changes that affect an applicant's ability to participation in the WSHD's Indigent Care Assistance Program ("ICAP").
2. Arrest for Drug or Alcohol Offenses: Failure to report any drug or alcohol arrest or convictions at the time of filing an application to participate in the ICAP or after constitutes Fraud/Misrepresentation.
3. At Fault Injuries: Failure to notify the District of injuries sustained due to a motor vehicle accident or an assault in which medical expenses are incurred by the District related to that accident or assault, unless proper documentation is provided showing no other liability, constitutes Fraud/Misrepresentation.
4. Notice of Lawsuit: Failure to give notice of any personal injury lawsuit or settlement in which medical expenses are incurred by the District and the ICAP client has the chance to receive or receives a monitory award is Fraud/Misrepresentation.
5. "Disruptive Behavior" is any inappropriate language or behavior that is rude; disruptive; combative; threatening, or abusive to the WSHD staff or staff of any healthcare provider while participating in the WSDH's ICAP.

Procedure

When the Winnie Stowell Hospital District ("WSHD") staff has reason to believe that an applicant for the Indigent Care Assistance Program ("ICAP") has committed Fraud/Misrepresentation or displays Disruptive Behavior, the following procedures shall be followed:

1. Immediately upon receiving knowledge of any Fraud/Misrepresentation or Disruptive Conduct, WSHD staff shall notify the ICAP client, in writing, of the alleged violation of the ICAP.
2. During any investigation of Fraud/Misrepresentation and/or Disruptive Conduct, the ICAP client shall be administratively ineligible to participate in the ICAP.
3. Staff shall investigate all cases of suspected fraud and shall collect and document evidence.
4. During the investigation, the client shall be administratively ineligible from ICAP.
5. Staff shall issue its findings in writing.
6. If the Client disputes the decision of the WSHD staff, the Client can the decision within ninety (90) days of the issuance of staff's findings.
    a. Appeals shall be submitted to the WSHD or the Agent of the WSHD, Indigent Care Director with the Winnie-Stowell Hospital District Indigent Health Care Department and state the reason(s) why the applicants should be considered eligible.
    b. The Chair of the Board of Directors of WSHD or his/her appointed designee serve as the Hearing Officer.
    c. The Hearing Officer shall have the authority to hold an evidentiary hearing or decide the case from the case file and documentation provided including any and all documents presented with the appeal.
    d. The Hearing Officer's decision is administratively final and non-appealable.
    e. In the event that the District and the Applicant or Client cannot resolve the dispute, the District must submit a Form 106, Eligibility Dispute Resolution Request, within ninety (90) days to the Texas Commission on Health and Human Services Commission.

Consequence of Fraud

If the WSHD staff determines that the allegations Fraud/Misrepresentation or Disruptive Conduct have merit, staff of the WSHD has discretion to discipline the Client in a manner consistent with violation of the ICAP, including but not limited to:

1. Termination from the ICAP;
2. The repayment of ICAP benefits; and
3. Criminal prosecution under the Texas Penal Code.

WINNIE STOWELL HOSPITAL DISTRICT

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WINNIE-STOWELL HOSPITAL DISTRICT INDIGENT HEALTHCARE POLICY & PROCEDURE STATEMENT

MISSION STATEMENT

To attend to and balance the healthcare needs of the community with fiscal responsibility.

PURPOSE

To establish rules and procedure that will allow ***any*** qualified resident of Winnie-Stowell Hospital District (WSHD) with: 1) a gross yearly income of less than or equal to 150% of the Federal Poverty Income Level per Household; and 2) Resources of less than $2,000, and $3,000 for certain elderly or disabled residents, to temporarily participate in the Indigent Care Assistance Program (”ICAP”).

POLICY

A. The WSHD is liable for health care services as provided by the Texas Constitution and the statute creating the WSHD.

B. In the event that any provision of this Policy and Procedure Statement is more restrictive than Chapter 61 of the Texas Health and Safety Code, it is the intent of the WSHD for Chapter 61 to supersede this Statement

C. The WSHD is the payor of last resort pursuant to Section 61.060(c) of the Health and Safety Code (i.e., Indigent Healthcare Act) 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. The applicant must not be eligible for, or potentially eligible for any other medical coverage. *Example: Medicaid or any other source that has no cost to the applicant.* WSHD’S Indigent Care Assistance Program is payor of last resort!

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.

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MEDIAL SERVICES BENEFITS:

BASIC SERVICES:

1. The services to be provided ICAP are the basic services required by Section 61.028 of the Indigent Health Care Act that include the following:
2. Physician services include services ordered and performed by a physician that within the scope of practice of their profession as defined by state law.
3. Annual physical examinations once per calendar year by a physician or a physician assistant. Associated testing, such as mammograms, can be covered with a physician referral.
4. Immunizations that are administered by healthcare providers within the WSHD.
5. Medical screening services include blood pressure, blood sugar, and cholesterol screening.
6. Laboratory and x-ray services ordered and provided under the personal supervision of a physician in a setting other than a hospital (inpatient or outpatient).
7. Family planning services or preventive health care services that assist an individual in controlling fertility and achieving optimal reproductive and general health.
8. Medically necessary Skilled Nursing Facility (SNF) services ordered by a physician and provided in a SNF that provides daily services on an inpatient basis.
9. Prescriptions. This service includes up to three prescription drugs per month. New and refilled prescriptions count equally toward this three (3) prescription drugs per month total. Drugs must be prescribed by a physician or other practitioner within the scope of practice under law.
10. Rural Health Clinic services must be provided in a freestanding or hospital-based rural health clinic by a physician, a physician assistant, an advanced practice nurse, or a visiting nurse.
11. Medically necessary inpatient hospital services provided in an acute care hospital to hospital inpatients, by or under the direction of a physician, and for the care and treatment of patients.
12. Medically necessary outpatient hospital services must be and provided in an acute care hospital to hospital outpatients, by or under the direction of a physician, and must be diagnostic, therapeutic, or rehabilitative. Outpatient hospital services include hospital-based ambulatory surgical center (HASC) services.
13. Winnie-Stowell Hospital District ICAP shall provide for prescription medications purchased from contract providers within the boundaries of the WSDH (*See* XI(D). Prescription Drug Information).

EXTENDED HEALTHCARE SERVICES:

In addition to the Basic Service requirements set forth pursuant to Section 61.028 of the Texas Health and Safety Code, the WSHD may provide other established optional health care services that the WSHD determines to be cost-effective. The extended healthcare service(s) provide is(are):

1. Emergency Medical Services are defined as a medical services whose purpose is to provide immediate assistance to a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: 1) placing the patient's health in serious jeopardy; 2) serious impairment of bodily functions; or serious dysfunction of any bodily organ or part.

   The Winnie Stowell EMS ("EMS") is the WSHD's mandated provider for EMS services to patients in the WSHD's ICAP. However, EMS is independently responsible in determining the most appropriate course of treatment and healthcare provider for the ICAP client as set forth by its policies and procedures for all transported patients, including ICAP client patients.
2. Psychological Counseling Services shall be available to residents of the WSHD who qualify to attend a school in the East Chambers Independent School District. The mandated provider for the counseling service shall be provided for by a Board approved Licensed Professional Counselor or Licensed Professional Counselor-Intern.

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SERVICE RESTRICTIONS AND EXCLUSIONS:

1. Medically Necessary Procedures
   a. Within WSHD: Healthcare providers within the WSHD are the WSHD's mandated providers and all medically necessary inpatient and/or outpatient procedures shall be performed within the boundaries of the WSHD unless specifically provided otherwise by the WSHD in this policy.
   b. Outside WSHD: Medically necessary inpatient and outpatient procedures that cannot be performed by a hospital or medical provider inside the WSHD boundaries may be treated outside of the WSHD subject to the following requirements:
      i. Procedure declared "medically necessary" by a healthcare provider inside the WSHD's boundaries;
      ii. Procedure referred by the WSHD Indigent Care Director, with consideration given toward healthcare provider's recommendation; and
      iii. Procedure paid for by the WSHD subject to the rules set forth in this Policy; Chapter 61 of the Texas Health & Safety Code, and the Texas Administrative Rules.
2. Unless specifically approved by the Indigent Care Director, subject to the Board's approval and oversight, the Winnie-Stowell Hospital District ICAP shall not provide, nor be financially responsible for any other services no matter where nor by whom provided, included but not limited to:
   a. Any healthcare services resulting directly or indirectly from drug or alcohol abuse;
   b. Abortions; unless the attending physician certifies in writing that, in his professional judgment, the mother's life is endangered if the fetus were carried to term or unless the attending physician certifies in writing that the pregnancy is related to rape or incest;
   c. Air conditioners, humidifiers and purifiers, swimming pools, hot tubs, or waterbeds, whether prescribed by a physician;
   d. Air Medical Transport;
   e. Ambulation aids unless they are authorized by WSHD ICAP;
   f. Autopsies;
   g. BiPAP (Bi-level Positive Airway Pressure);
   h. Charges made by a nurse for services which can be performed by a person who does not have the skill and training of a nurse;
   i. Chiropractors;
   j. Cosmetic (plastic) surgery to improve appearance, rather than to correct a functional disorder; here, functional disorders do not include mental or emotional distress related to a physical condition. All cosmetic surgeries require WSHD ICAP authorization;
   k. Cryotherapy machine for home use;
   l. Custodial care;
   m. Dental care; except for reduction of a jaw fracture or treatment of an oral infection when a physician determines that a life-threatening situation exists and refers the patient to a dentist;
   n. Dentures;
   o. Drug or alcohol rehabilitation program or treatments.
   p. Drugs, which are:
      i. Not approved for sale in the United States, or
      ii. Over-the-counter drugs (except with WSHD ICAP authorization)
      iii. Outpatient prescription drugs not purchased through the prescription drug program, or
      iv. Not approved by the Food and Drug Administration (FDA), or
      v. Dosages that exceed the FDA approval, or
      vi. Approved by the FDA but used for conditions other than those indicated by the manufacturer;

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q. Durable medical equipment supplies unless they are authorized by WSHD ICAP;
r. Exercising equipment (even if prescribed by a physician), vibratory equipment, swimming or therapy pools, hypnotherapy, massage therapy, recreational therapy, enrollment in health or athletic clubs;
s. Experimental or research programs;
t. Family planning services are not payable if other entities exist to provide these services in the WSHD;
u. For care or treatment furnished by:
    i. Christian Science Practitioner
    ii. Homeopath
    iii. Marriage, Family, Child Counselor (MFCC)
    iv. Naturopath.
v. Genetic counseling or testing;
w. Hearing aids;
x. Hormonal disorders, male or female;
y. Hospice Care
z. Hospital admission for diagnostic or evaluation procedures unless the test could not be performed on an outpatient basis without adversely affecting the health of the patient;
aa. Hospital beds;
bb. Hospital room and board charges for admission the night before surgery unless it is medically necessary;
cc. A hysterectomy shall only be performed for other medically necessary reasons, not sterilization;
dd. Immunizations and vaccines that are unable to be administered by a healthcare provider within the WSHD;
ee. Infertility, infertility studies, invitro fertilization or embryo transfer, artificial insemination, or any surgical procedure for the inducement of pregnancy;
ff. Legal services;
gg. Medical services, supplies, or expenses as a result of a motor vehicle accident or assault unless WSHD is the payor last resort;
hh. More than one physical exam per year per active client;
ii. Obstetrical Care;
jj. Oriental pain control (Acupuncture or Acupressure);
kk. Other CPT codes with zero payment or those not allowed by county indigent guidelines;
ll. Parenteral hyperalimentation therapy as an outpatient hospital service unless the service is considered medically necessary to sustain life. Coverage does not extend to hyperalimentation administered as a nutritional supplement;
mm. Podiatric care unless the service is covered as a physician service when provided by a licensed physician;
nn. Private inpatient hospital room except when:
    i. A critical or contagious illness exists that results in disturbance to other patients and is documented as such,
    ii. It is documented that no other rooms are available for an emergency admission, or
    iii. The hospital only has private rooms.
oo. Prosthetic or orthotic devices;
pp. Recreational therapy;
qq. Routine circumcision if the patient is more than three days old unless it is medically necessary. Circumcision is covered during the first three days of his newborn's life;
rr. Separate payments for services and supplies to an institution that receives a vendor payment or has a reimbursement formula that includes the services and supplies as a part of institutional care;
ss. Services or supplies furnished for the purpose of breaking a "habit", including but not limited to overeating,

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smoking, thumb sucking;

tt. Services or supplies provided in connection with cosmetic surgery unless they are authorized for specific purposes by the WSHD or its designee before the services or supplies are received and are:
   i. Required for the prompt repair of an accidental injury; or
   ii. Required for improvement of the functioning of a malformed body member

uu. Services provided by an immediate relative or Household member;

vv. Services provided outside of the United States;

ww. Services rendered as a result of (or due to complications resulting from) any surgery, services, treatments or supplier specifically excluded from coverage under this handbook;

xx. Sex change and/or treatment for transsexual purposes or treatment for sexual dysfunctions of inadequacy which includes implants and drug therapy;

yy. Sex therapy, hypnotics training (including hypnosis), any behavior modification therapy including biofeedback, education testing and therapy (including therapy intended to improve motor skill development delays) or social services;

zz. Social and educational counseling;

aaa. Spinograph or thermograph;

bbb. Surgical procedures to reverse sterilization;

ccc. Take-home items and drugs or non-prescribed drugs;

ddd. Transplants, including Bone Marrow;

eee. Treatment of flat foot (flexible pes planus) conditions and the prescription of supportive devices (including special shoes), the treatment of subluxations of the foot and routing foot care more than once every six months, including the cutting or removal of corns, warts, or calluses, the trimming of nails, and other routine hygienic care

fff. Treatment of obesity and/or for weight reduction services or supplies (including weight loss programs);

ggg. Vision Care, including eyeglasses, contacts, and glass eyes except as can be provided by

hhh. Vocational evaluation, rehabilitation or retraining;

iii. Voluntary self-inflicted injuries or attempted voluntary self-destruction while sane or insane;

jjj. Whole blood or packed red cells available at no cost to patient.

MAXIMUM HOSPITAL DISTRICT LIABILITY:

MAXIMUM BENEFIT AMOUNT PER FISCAL YEAR (JANUARY 1ST THROUGH DECEMBER 31ST)

To the extent the WSHD is financially able to do so, the maximum amount paid by WSHD for an ICAP recipient ("Client") for each Fiscal Year for health care services provided by all assistance providers, including hospital care is whichever occurs first:

1. $30,000; or
2. The payment of thirty (30) days of hospitalization and/or treatment in a skilled nursing facility, if the WSHD provides hospital or skilled nursing facility services to the resident.
3. Outpatient Referrals to University of Texas Medical Branch-Galveston ("UTMB"): The maximum annual WSHD liability per Client referred to UTMB pursuant to the Interlocal Agreement between UTMB and WSHD shall be $30,000 for services provided by UTMB.
4. The payment standard is determined by the day the claim is paid. WSHD ICAP approved providers must dispense services and supplies.

PRESCRIPTIONS DRUG INFORMATION:

1. WSHD prescription drug service includes a minimum of three medications per month regardless of the price of the medication, excluding experimental or cancer medications. In the alternative, if a Client has more than three medications and the cost of the three medications is less than $150.00, the WSHD will pay up to a total of $150.00 for the Client's medications. For example, if a Client has six (6) prescriptions that need to be filled each month and three

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prescriptions cost $25.00 each (or $75.00 total), the Client would have $75.00 left over each month to use on other prescriptions.

2. The quantity of drugs prescribed depends on the prescribing practice of the provider and the needs of the Client. However, each prescription is limited to a thirty (30) day supply. New and refilled medications count equally toward the three medications 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 Client.

EXCLUSION AND LIMITATIONS:

Basic and Extended Health Care Services do not Include Services and Supplies that are:

1. Provided to a Client before or after the time period that Client is eligible for the WSHD ICAP;
2. Payable by or available under any health, accident, or other insurance coverage; by any private or governmental benefit system; by a legally liable third party, or under other contract;
3. Provided by military medical facilities. Veterans Administration facilities, or United State public health service hospitals;
4. Related to any condition covered under the worker's compensations laws or any other payor source.

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ACKNOWLEDGMENT FOR RECEIPT OF WSHD POLICIES

WSHD NOTICE OF PRIVACY PRACTICES POLICY

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I have read and understand that document. I consent to the use and disclosure, by WSHD and its agents of my medical and health information and/or protected health information as is stated in the Notice of Privacy Practices. I understand that WSHD reserves the right to change its Notice and practices with regard to the use and disclosure of health information. I understand that I have the right to request restrictions as to how my health information may be used or disclosed for treatment, payment, or healthcare operations, but that WSHD is not required to agree to the requested restrictions. My initials indicate I have received, read, and understand the following sections of this policy.

_____ (Initial) 1. Uses and Disclosures of Protected Health Information

_____ (Initial) 2. Your Rights

_____ (Initial) 3. Complaints

By signing below, I acknowledge I have received and read a copy of the Winnie-Stowell Hospital District's Notice of Privacy Policy, and I understand its purpose. I understand that as part of the provision of healthcare services, WSHD creates and maintains health records and other information describing, among other things, my health and medical history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment, which may be shared with my healthcare providers for the purpose of the provision of my healthcare.

This authorization is effective for one (1) year from the date of signature below.

Signature: _____ Signature Date: _____

WSHD INDIGENT CARE FRAUD/MISREPRESENTATION & DISRUPTIVE BEHAVIOR POLICY

By signing below, I acknowledge I have received and read a copy of the Winnie-Stowell Hospital District's Fraud, Misrepresentation & Disruptive Behavior Policy. I understand that if the WSHD staff determines that allegations against me of Fraud/Misrepresentation or Disruptive Conduct have merit, the staff of WSHD has the discretion to discipline me in a manner consistent with violation of the ICAP, including but not limited to:

1. Termination from the ICAP;
2. The repayment of ICAP benefits; and
3. Criminal prosecution under the Texas Penal Code.

Signature: _____ Signature Date: _____

WSHD INDIGENT CARE POLICY & PROCEDURE SATEMENT

By signing below, I acknowledge I have received and read a copy of the Winnie-Stowell Hospital District's Indigent Care Policy and Procedure Statement. I have read and understand the Winnie Stowell Hospital District's ("District") dated June 20, 2019. As such, I understand the scope of the healthcare services provided by the District in its Policy and Procedures Statements and understand that any healthcare services provided must be administered by a hospital and/or skilled nursing facility within the boundaries of the WSHD or owned by the WSHD.

In the event that the required healthcare services provided for in the Policy and Procedures Statement cannot be provided for by the hospital or skilled nursing facility within the boundaries of the WSHD, I agree to get prior written consent from the District's Indigent Care Director before obtaining healthcare services outside of the WSHD Boundaries. I also agree that if I fail to get this consent, I am responsible for any financial obligations resulting from the receipt of healthcare services outside of the WSHD boundaries without the written consent of the District's Indigent Care Director. Your initials indicate you have received, read, and understand the following sections of this policy.

_____ (Initial) 1. Policy statements

_____ (Initial) 2. Basic Services

_____ (Initial) 3. Extended Healthcare Services

_____ (Initial) 4. Service Restrictions and Exclusions

_____ (Initial) 5. Maximum Benefit Amount per Fiscal Year (January 1st through December 31st)

_____ (Initial) 6. Prescriptions Drug Benefits Information

_____ (Initial) 7. Exclusion and Limitations

Signature: _____ Signature Date: _____

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AUTHORIZATION FOR RELEASE OF INFORMATION

This authorization describes the information that may be released to or from Winnie Stowell Hospital District (WSHD) to verify the statements you have made on your application, and to determine your eligibility for the Indigent Care Assistance Program. ***Please read each point carefully.*** Your initials indicate you have received, read, and understand each point of this authorization.

_____ (Initial) 1. I _____, hereby give permission to the Winnie Stowell Hospital District ("WSHD") to contact any source to verify the statements I have made in my application. I understand that a background check company and the Texas Workforce Commission will be contacted. I will cooperate fully with the WSHD personnel to obtain any information necessary to verify statements about my eligibility.

_____ (Initial) 2. I understand that random home visits will be conducted.

_____ (Initial) 3. I designate _____ (____) ____-_____
Authorized Representative Name & Relationship Phone Number
as my authorized representative, and I give the WSHD permission to speak to them in person or on the phone at any time regarding my eligibility or benefits under the WSHD Indigent Care Assistance Program ("ICAP").

_____ (Initial) 4. I give permission for my legal counsel or the Social Security Administration to release information regarding my application or appeal for SSI Disability benefits.

_____ (Initial) 5. I also give permission for any providers treating me to release my medical records to the WSHD for the purpose of determining proper referrals and/or determining whether or not the services provided meet the criteria for payment by the WSHD ICAP.

_____ (Initial) 6. I have been told and I understand that my failure to meet the obligations set forth or the unlawful use of ICAP benefits can result in the recovery of any loss by repayment, or by the filing of criminal or civil charges against me.

This authorization is effective for one (1) year from the date of signature below.

Signature: _____

Printed Name: _____

Signature Date: _____

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AUTHORIZATION FOR BACKGROUND CHECKS

Applicant (Print Name)	Social Security Number	Date of Birth
		/ /

Spouse (Print Name)	Social Security Number	Date of Birth
		/ /

I hereby give permission to the Winnie Stowell Hospital District to obtain a background check from the Texas Workforce Commission, Department of Motor Vehicles Registration, Credit Bureau, LexisNexis, Accurint and any other sources that may need to be contacted to determine my eligibility for the Indigent Care Assistance Program

Applicant Signature **Date**

Spouse Signature **Date**

Subscribed and sworn to (affirmed) before me this_____day of_____, _____
(Day) (Month) (Year)

at_____. Notary Public in and for the State of Texas. (Place of Notary)

My commission expires on_____.

(MM/DD/YY)

_____

Notary Signature

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CONSENT TO RECEIVE EMAIL AND/OR TEXT MESSAGES

Clients approved for the WSHD (Winnie Stowell Hospital District) Indigent Care program may be contacted via email and/or text messaging to remind them of an appointment or to communicate other healthcare information.

By signing this form, you consent to receive email and/or text messages for appointment reminders or other Healthcare communications.

_____ (Initial) 1. I understand that if at any time, I provide the WSHD Indigent Care Director with an email address and/or text capable phone number, I give my full consent to receive electronic messages from WSHD Indigent Care regarding an appointment reminder and/or to communicate other healthcare information to my email address or my text number.

_____ (Initial) 2. I consent to receive emails and/or text messages from WSHD Indigent Care to my cellphone and any other phone number that may be forwarded or transferred to that number, for the purpose of an appointment reminder and/or other healthcare communications and/or information.

_____ (Initial) 3. The cell phone number I authorize to receive text messages for an appointment reminder and/or other healthcare communications and/or information is _____.

_____ (Initial) 4. The email address I authorize to receive email messages for an appointment reminder and/or other healthcare communications and/or information is _____.

_____ (Initial) 5. I understand that in the event my phone number and/or email address changes, it is my responsibility to provide the WSHD Indigent Care Director with my new phone number and/or email address. ***Not receiving an email or text message appointment reminder does not excuse you from attending your scheduled appointment.***

_____
Client's Printed Name

_____ _____ / _____ / _____ _____:_____am/pm
Client's Signature Date Time

REVOCATION OF MY ABOVE CONSENT:

_____ (Client's Initials) I hereby revoke my consent for future communications via email regarding any appointment reminders and/or any other important healthcare communications/information.

_____ (Client's Initials) I hereby revoke my consent for future communications via text messaging regarding any appointment reminders and/or any other important healthcare communications/information.

_____
Client's Printed Name

_____ _____ / _____ / _____ _____:_____am/pm
Client's Signature Date Time