PROCESSING PROCEDURES
INDIGENT HEALTH CARE

Application Process

1. Receive request for application (referrals from hospitals, phone calls, walk-ins)
2. Mail application (letter, application, return envelope and business card); make copy of cover letter, attach hospital face sheet or other available information and file in pending temporary folder.
3. Leave file open for 30 days or until application is received back. (include all face sheets, pending bills, faxes, etc. in file). After 30 days, pull copies from pending folder and place name on "Closed Files" list. Return any bills received to vendor stating "Not an IHC client. No application received". File application letter with any attachments in Closed Files.
4. When application is received:
    a. Assign case #
    b. Create permanent file
    c. Assign appointment interview date and time and send notice
    d. Place copy of notice in permanent file
    e. Place file in date file tickler
5. At interview:
    a. Do Worksheet entry and place copy in file
    b. Create eligibility verification form for required documentation
    c. Internal forms required for processing:
        i. HIPAA compliance
        ii. Fraud Policies and Procedures
        iii. Client responsibility
        iv. Verification of support (if applicable)
        v. Form 113 (if disabled)
    d. Assign 2-week deadline for submission of documents
6. For regular processing, attach blue round sticker to file
7. Place file in date tickler by document submission due date
8. If applicant is applying for SSI or SSDI, place yellow sticker on file and put in pending file (must receive denial letter before applicant can be approved for IHC. This often takes 120-160 days)
9. When all required documentation has been received, applicant file can be reviewed for eligibility. Must be reviewed within 14 days of receipt of all documents.
10. Send applicant notice of eligibility or ineligibility within 14 days. If eligible, include list of covered services, orange ID card, and HEB RX Advantage drug prescription card.
11. Place green sticker on file folder and file in active client file.
12. Place ½ green and ½ yellow sticker on file if the applicant is an SSI Appellant.
13. Applicant's eligibility is good for 6 months and must go through review process at least every 6 months. Some applicants that are accepted on a short-term eligibility may be for only 2-3 months.
14. If applicant does not submit required documentation by the end of the 14 day period, the day after the "due date", send ineligibility statement. Extensions to the due day may be granted upon request by the applicant.
15. If applicant does not appear for required intake interview appointment, after 10 days, send ineligibility statement. I give them 10 days to call and reschedule.
16. If applicant is denied (through qualifications, no documentation, or no-show for interview), place red sticker on file and place in File cabinet with other ineligible clients.

17. For eligible clients, create an additional file folder for copies of all paid bills and monthly client EOB statements. Keep separate from active client files.

Bill Processing

1. Date stamp all bills on date received.
2. Enter for processing as quickly as possible (same day received, if possible).
3. Check bills for:
    a. Eligible client status
    b. Signature of Dr. or representative
    c. Receipt of bill within 95 days of date of service.
4. Enter eligible bills into system for payment.
5. Return ineligible bills to vendors with explanation of reason for non-payment. Note if they can be re-submitted and a date to be returned.
6. Write amount of each charge that is payable, including total of the bill, on the face of the invoice.
7. Note Invoice # (assigned by system) on face of bill and batch date bill is to be paid.
8. File until day before bill cut-off date (set by Treasurer's office...noon Wednesday before Commissioners Court day).
9. After bills are cleared for payment on the Invoice Listing (generated by the system by batch date), make a copy of each bill. File originals in "Check Date" file. (I do not copy hospital attached itemized statements).
10. Attach copies of all bills to back of Client EOB statement and file in individual client folders for paid bills.
11. Submit GL Ledger Report for each Vender, and Vendor EOB statements to County Treasurers office on the day before Bill cut-off date.
12. Date checks are approved and delivered to you (day after Commissioners Court meets), enter check # for each vendor paid bill into system, and mail check with Vendor EOB.

Prescription Approval

1. Active clients are allowed 3 prescriptions per month. They are issued an HEB RXAdvantage card when they are issued their eligibility letter and orange card.
2. Approved pharmacies: HEB Burnet, HEB Marble Falls.
3. Prescriptions must be no more than a 30 day supply
4. Prescriptions cannot be for restricted pain and narcotic drugs, lifestyle drugs, or psychotropic meds (see restricted drug list)
5. Over the counter drugs are not eligible (even if they have a prescription), unless they are diabetic supplies. Diabetic supplies are covered over and above 3 scripts per month.

Provider/Service Notification

1. All clients or physicians/hospitals are required to give 72 hour notice of service(s) being rendered.
2. Record Client name, date called, date of scheduled service, and place of service in spiral notebook.

To: County Judge and Commissioners

Re: UPDATED Burnet County Indigent Health Care Internal Forms and Policies

Completed by or delivered to applicant at eligibility interview:

1. Client Responsibility
2. Fraud Policies & Procedures
3. Authorization of Background Checks
4. HIPAA Compliance (Policy, Release, and Receipt)
5. Verification of Support
6. Verification of Disability
7. Social Security Consent for Release of Information

Delivered to Approved IHC Applicants:

8. What you need to know about Burnet County IHC
9. Services Covered by Burnet County IHC
10. Restricted Drug List (not all inclusive)
11. IHC ID Card
12. HEB Prescription Card

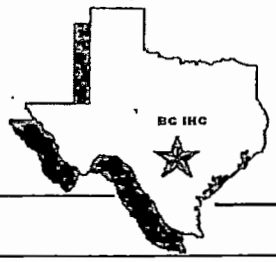
Other Pertinent IHC Documents:

13. Public Notice (Required to be published before Sept. 1st each year)
14. Burnet County Internal Policies
15. IHC Appeal Process
16. Certification and Approval page for packet

Respectfully Submitted,

IHC Coordinator
Seton Highland Lakes/Burnet County Indigent

Burnet County Indigent Health Care



IHC Coordinator James Oakley County Judge

I understand as a client of Indigent Health Care Program (IHC) I must:

- Report to the IHC Coordinator in less than 14 days if my income changes, if I move, or if there are new members in my household (for example getting married, or a child or spouse moving back in with me). Any new job, new income, or money received must be reported. I understand that failure to report changes that may disqualify me for services, I will have to pay for those services or I could face legal charges.
- Report if I apply for Social Security Disability, or if there are any changes in my SSI or SSDI case.
- Go only to the primary care physician (PCP) assigned to me by this program. I will only visit specialists referred by my physician. I understand that the program may not pay for a specialist if the referral is not from my assigned physician.
- See my assigned primary care physician for non-emergency situations.
- Always call ahead to make an appointment with my physician and to follow physician orders.
- I will take my medication as instructed by my physician.
- I will follow recommended diet and restrictions from my physician (i.e. no smoking, tobacco products, or alcohol).
- Carry my BCI eligibility cared when I go to the doctor, hospital, or pharmacy. I may not receive services without presenting my card.
- Notify or have my physician notify the IHC Coordinator of any procedures or appointments that I have scheduled.
- Contact the IHC coordinator for a replacement card should my card becomes lost.
- I must call the IHC coordinator and request to **reapply for BCI assistance <u>2 weeks prior</u>** to the end of my eligibility.
- Use HEB pharmacy in Burnet or Marble Falls for prescriptions. I understand that BCI will only pay for three prescriptions each calendar month for a 30 day supply. Some medications are restricted.
- If I receive bills for physician, hospital, or pharmacy services I will request that those be sent to Burnet County IHC immediately.

I also understand that:

- Claims for medical services provided outside the State of Texas will not be paid by Burnet County IHC, unless prior arrangements have been made and services pre-approved by program administrators.
- Burnet County IHC does not pay for treatment of, or hospital stays related to drug, alcohol abuse or overdose.
- Burnet County IHC does not cover self-inflicted injuries or abuse.
- Burnet County IHC does **NOT** pay for any medications that can be bought without a prescription, restricted medications (pain, psychiatric, lifestyle), ambulance services, major dental, vision, prenatal care, or any immunizations that are available at State Health clinics.
- The program covers up to $30,000 in medical bills or up to 30 days of hospitalization each fiscal year (September 1st through August 31st); whichever occurs first.

I have read (__) or have had read to me (__) the above information and my questions have been answered. I understand and agree to these terms.

Signature Date Witness Date

Approved by Burnet County Commissioner's Court

Date: _____

FRAUD POLICIES AND PROCEDURES

COUNTY INDIGENT HEALTHCARE PROGRAM

The following Fraud Policy and Procedures have been adopted for County Indigent Health Care Program (CIHCP).

James Oakley, Burnet County Judge

1/23/18
Date

General Provisions

I. Indication of fraud-intention program violation consists of intentionally committing any of the following actions:
   a. Making a false and/or misleading statement;
   b. Misrepresenting, concealing, or withholding facts;
   c. Violating any provision of the CIHCP Act, the CIHCP regulations, or State Statues relating to the use, or acquisition of CIHCP

II. Possible Misrepresentations-Situations are varied in which an applicant or recipient might intentionally withhold information or present false information to obtain assistance or benefits to which he/she is not entitled. Examples include, but are not limited to:
   a. Information misrepresented or concealed the time any of the Burnet County IHCP forms are completed;
   b. Information misrepresented at the time legal requirements (CIHCP Eligibility) are tested for initial certification or recertification;
   c. Information misrepresented concerning income or resources;
   d. Information misrepresented concerning composition of family group:
   e. Information misrepresented concerning county of residency;
   f. Information misrepresented concerning some element of need;
   g. Information misrepresented to obtain prescribed drugs over the authorized limit
   h. Information misrepresented or concealed regarding concerning incapacity;
   i. Information misrepresented or concealed by a member of the recipient's family, authorized representative or any other individual(s) who assists recipient in obtaining medical services via CIHCP;
   j. Information misrepresented concerning child support payments, including payments being paid in arrears;
   k. Use of fictitious names and/or sources of identification;
   l. Misrepresentation on guardianship or custody of children in the household;
   m. Misrepresentation of dependent status for adults in the household, to include but not limited to military dependents status and alien sponsorship;
   n. Misrepresentation of employment status.

III. The IHC refers any case to the County Judge or County Attorney for investigation of suspected fraud in which there has been an intentional falsification or omission, which was material in obtaining assistance.
The IHC will evaluate all situations in which a recipient failed to report changes in circumstances between reviews. If IHC changes were intentionally concealed, a referral to the County Judge or County Attorney will be completed.

IV. If evidence of fraud is confirmed an applicant/client will be determined ineligible for the IHC program.

Acknowledged:

IHC Client Signature | Printed Name | Date

Approved by Burnet County Commissioner's Court

Date: _____

BURNET COUNTY INDIGENT HEALTH CARE PROGRAM
AUTHORIZATION FOR BACKGROUND CHECKS

Name: _____ SSN: _____

Address: _____ DOB: _____

_____

I understand that as part of the application process for benefits from the Burnet County Indigent Health Care Program (IHC), I am required to provide certain written documents to the IHC office. I realize that my failure to provide such documents will delay the receipt of benefits, if any, I might receive.

I hereby give my permission to the Burnet County Indigent Health Care Program to obtain a background check from the Texas Workforce Commission, Department of Motor Vehicle Registration, Credit Bureau, and any other sources or databases that may need to be contacted to determine my eligibility for the IHC program.

I, _____, hereby authorize any public agency including the Social Security Administration, Medicaid and Medicare to furnish to Burnet County, or its agent, information related to assets or any sources of income to me held in my name and/or my criminal history. I hereby release Burnet County and all of its agents and employees, the public agencies providing such information and all employees of public agencies furnishing information, from all liability resulting from the furnishing of this information to Burnet County. I certify that the statements made by me on this form and on my application for health services are true, complete and correct to the best of my knowledge and belief, and are made in good faith. I understand that any false statements made herein or on my application for health services from Burnet County will void further consideration for eligibility in Burnet County's IHC program as it relates to my application for such health services. I have read and understand the Burnet County IHC Program Fraud Policy and Procedures.

I am aware that I must reapply for IHC benefits every six (6) months and that if I do not reapply I will lose any benefits I might have been receiving. Deadline to reapply is two weeks prior to end of current eligibility.

I have read (or have had read to me) all of the above and I understand it.

_____ _____
Applicants Signature Date

Subscribed and Sworn to (affirmed) before me this _____ day of _____, 20__.

_____
Notary Public

Approved by Burnet County Commissioner's Court

Date: _____

BURNET COUNTY INDIGENT HEALTH CARE OFFICE
NOTICE OF PRIVACY PRACTICES
"HIPAA"

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION
ABOUT YOU MAY BE USED AND DISCLOSED AND HOW
YOU CAN GET ACCESS TO THIS INFORMATION
PLEASE REVIEW CAREFULLY

Each time you visit or communicate with the Burnet County Indigent Health Care Program (BCIHCP), the staff makes a record of this communication. Typically, this record contains information needed to determine and/or continue eligibility, i.e., residency, household status, income, potential eligibility for other programs. However, your files also contain Protected Health Information. Protected Health Information is information created or received by a health care provider, health plan, employer, or health care clearinghouse that relates to your past, present or future physical or mental health or condition; the provision of health care to you; or the past, present or future payment for the provision of health care to you and that identifies you or with respect to which there is a reasonable basis to believe the information can be used to identify you. BCIHCP is required by the privacy regulation issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to maintain the privacy practices with respect to your Protected Health Information. This document is notice to you of BCIHCP's privacy practices. BCIHCP is required to abide by the terms of the notice currently in effect.

Indigent Health Care caseworkers and business associates contracted to maintain your health case records are usually the only individuals with access to these records. However, we may use or disclose your Protected Health Information without your written authorization for the following reasons:

- For treatment or payment for treatments authorized or to conduct health care operations of the BCIHCP.

  Treatment: For example, BCIHCP must disclose diagnosis and test results from the referring primary care physician. When BCIHCP obtains appointments or authorizes payments with specialty clinics.

  Payment: For example, in order to pay for direct care, BCIHCP must have dates of service, ICD-9 diagnosis, and CPT procedure codes on all bills.

  Health Care Operations: For example, in coordinating with other agencies to provide service to our clients, BCIHCP provides identification information and medical history.
- To individuals involved in your care such as a family member or other relative, a close personal friend, or any other person you identify to us;
- To our Business Associates. In order to conduct our operations, it is sometimes necessary for BCIHCP to share Protected Health Information with third parties with which we contract for services. We will not disclose your Protected Health Information to our Business Associates without assurance from them that they will safeguard the confidentiality of the information;
- If the disclosed is required by law;
- To a health oversight agency for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations, inspections, licensures or disciplinary actions, civil administrative, or criminal proceedings or actions; or other activities necessary for appropriate oversight of the health care system, government benefit programs for which health information is relevant to beneficiary eligibility, entities subject to government regulatory programs for which health information is necessary for determining compliance with program standards, or entities subject to civil rights laws for which health information is necessary for determining compliance;
- If BCIHCP has reason to believe that an individual is a victim of abuse, neglect, or domestic violence, to a government authority including a social service or protective agency authorized by law to receive reports of abuse, neglect or domestic violence;
- In connection with administrative or judicial proceedings;
- To a law enforcement official for law enforcement purposes;
- To a public health authority for public health activities as required or authorized by law;
- To a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties authorized by law;

Approved by Burnet County Commissioner's Court

Date:

- To organ procurement organizations or others engaged in the procurement, banking or transplantation of cadaveric organs, eyes or tissue:
- For research as authorized by the privacy regulation;
- To avert a serious threat to health or safety of a person or the public;
- For specialized government functions such as for national security and intelligence activities or for the protection of the President or other persons authorized by 18 U.D.C. 3056 or to foreign heads of state or other persons authorized by 22 U.S. C. 2709 (a)(3) or for the conduct of investigations authorized by 18 U.S. C. 871 and 879.
- To you or to your personal representative upon written request;
- To provide appointment reminders to you.

This office does not keep a copy of your medical records. These are kept by your treating physicians/facilities and would have to be requested from them. Our office only maintains your eligibility file, which also includes billing information.

Your Privacy Rights Regarding Protected Health Information

Your eligibility records and the Protected Health Information contained therein are the physical property of Burnet County Health Care Program. However, you have the following rights with respect to your own Protected Health Information.

- The right to request restrictions on uses and disclosures of your Protected Health Information to family members or personal representatives as otherwise permitted by law or to carry out treatment, payment, or health care operations. BCIHP is not required to agree to the requested restriction. If BCIHCP agrees to a restriction, it will not use or disclose your Protected Health Information in violation of the restriction. Either you or BCIHCP has the right to terminate an agreed upon restriction at any time. A request for a restriction on the uses and disclosures of your Protected Health Information must be in writing and must provide adequate detail of the restriction you are requesting.
- The right to receive confidential communications of your Protected Health Information by alternative means or at an alternative location (for example, at an address other than your home address) if you provide a clear statement that the disclosure of all or part of your Protected health Information could endanger you.
- The right to inspect and copy your Protected Health Information except for the following:
  - Psychotherapy notes.
  - Information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding, and
  - Protected Health Information that is subject to the Clinical Laboratory Improvements Amendments of 1988, 42 U.S.C. 263a, to the extent the provision of access would be prohibited by law or is exempt from the Clinical Laboratory Improvements Amendments of 1988, pursuant 42 CFR 493.3(a)(2).

  Requests to inspect and copy Protected Health Information must be in writing and signed by you or by your representative. If BCIHCP denies a request for access to Protected Health Information, in whose or in part, it will notify you in writing of the denial. If we grant access, we will tell you what, if anything, you have to do to get access. We reserve the right to charge a reasonable, cost-based fee for making copies.
- The right to request an amendment of your Protected Health Information. Such request must be in writing and must provide a reason to support the requested amendment. BCIHCP may deny a request for amendment of Protected Health Information. If it does so, it will notify you in writing of the reason for the denial. Requests for amendment of Protected Health Information should be directed to: IHC Coordinator, Burnet County Indigent Health Care Program, 220 S. Pierce, Burnet, TX 78611. The right to receive an accounting of disclosures of your Protected Health Information covering six years prior to the date of a request for disclosure. However, BCIHCP does not have to provide an accounting for the following types of disclosures:
  - Disclosures to carry out treatment, payment and health care operations;
  - Disclosures to you of your own Protected Health Information;
  - Disclosures incident to a use or disclosure otherwise permitted or required by law;
  - Disclosures made pursuant to an authorization signed by you;

Approved by Burnet County Commissioner's Court

Date: _____

- Disclosures to persons involved in your care or for other authorized notification purposes;
- Disclosures for national security of intelligence purposes;
- Disclosures to correctional institutions or law enforcement officials as required or authorized by law;
- Disclosures as part of a limited date set; or
- Disclosures made prior to April 14, 2003.

- The right to receive a copy of this Notice of Privacy Practices upon request. The law requires us to ask you to acknowledge receipt of your copy.

We will not disclose your Protected Health Information except as described in this notice without your written authorization. Your written authorization may be revoked by you in writing at any time by sending a written notice of revocation to Indigent Health Care Coordinator, Burnet County Indigent Health Care Program., 220 S. Pierce St., Burnet, TX 78611.

How to Get More Information or to File a Complaint

If you have any questions and/or would like additional information, you may contact the Coordinator of the Burnet County Indigent Health Care Program at 512 756-5404.

If you believe your privacy rights have been violated, you may file a complaint with BCIHCP and with the Secretary of the U.S. Department of Health and Human Services. Complaints filed with BCIHCP should be in writing and directed to Indigent Health Care Coordinator, Burnet County Indigent Health Care Program, 220 S. Pierce, Burnet, TX 78611.

Complaints to the Burnet County Judge and Secretary of U.S. Department of Health and Human Services must be in writing, must specify the entity that is the subject of the complaint, and must describe the acts or omissions believe to be in violation of your privacy rights.

BCIHCP will not intimidate or retaliate against any person who files a complaint about the treatment of his or her Protected Health Information.

BURNET COUNTY INDIGENT HEALTH CARE PROGRAM
RESERVES THE RIGHT TO CHANGE
ITS PRIVACY PRACTICES AND TO MAKE THE NEW PROVISIONS
EFFECTIVE FOR ALL PROTECTED
HEALTH INFORMATION WE MAINTAIN.
SHOULD WE CHANGE OUR PRIVACY PRACTICES,
WE WILL MAIL A REVISED NOTICE TO THE ADDRESS
YOU HAVE SUPPLIED US ON YOUR APPLICATION.

This notice is effective on Date: _____

Please verify by signing the attached form that you have received a copy of this NOTICE of PRIVACY PRACTICES.

Approved by Burnet County Commissioner's Court

Date: _____

BURNET COUNTY INDIGENT HEALTH CARE PROGRAM
Authorization Form for the Use or Disclosure
of Protected Health Information
"HIPAA"

Name:_____ Social Security #_____

Address:_____

Phone Number:_____ Date of Birth_____

I understand that, by my signature below, I am authorizing the use and/or disclosure of my Protected Health information.

Description of the Protected Health Information for which I am authorizing use and/or disclosure.

_____
_____

Person or organization authorized to use and/or disclose the above-described Protected Health Information:
Burnet County Indigent Health Care Program

Person or organization to which I authorize disclosure for the above-described Protected Health Information:

Name	Address/Phone	Relation
_____	_____	_____
_____	_____	_____
_____	_____	_____

The purpose for the authorized use and/or disclosure of my Protected Health Information is:_____
_____
_____.

This authorization expires on:_____.

Signed:_____ Date: _____

This authorization may be revoked in writing by the individual at any time by providing a written notice of revocation to Burnet County Indigent Health Care, 220 S. Pierce, Burnet, TX 78611. Burnet County Indigent Health Care may rely on this authorization until it receives the written notice of revocation or until the authorization expiries. If the authorization has been provided in order to obtain insurance coverage and other law provides the insurer with the right to contest a claim under the policy or the policy itself, the notice of revocation of the authorization will not be effective.

Be aware that there is a risk that the person or organization to which your Protected Health Information is disclosed pursuant to this authorization will disclose this information to another party and that the information will no longer be subject to Burnet County IHC privacy protections.

Approved by Burnet County Commissioner's Court

Date: _____

BURNET COUNTY INDIGENT HEALTH CARE PROGRAM
Authorization Form for the Use or Disclosure
of Protected Health Information
"HIPAA"

I have received a copy of the Burnet County Indigent Health Care Program's Notice of Privacy Practices.

Signed:_____

Printed Name:_____

Date:_____

Approved by Burnet County Commissioner's Court

Date: _____

BURNET COUNTY INDIGENT HEALTH CARE

Verification of Support/Verificación de Apoyo

I/We _____ assist: _____
(Person providing support – Please print) (Applicant)

by providing the following: (check ONLY those that apply)

_____ CASH If yes, how much per month? $_____
_____ Payment of Medical bills and/or Prescription needs.
_____ Payment of Utilities
_____ Food and/or Clothing
_____ Payment of House Loan or Rent
_____ This person is supported by me in that I pay for his/her expenses, but do not provide cash assistance
_____ Other If yes, please explain _____

The above person(s) live with me/us Yes _____ No _____

_____ _____
(Signature) (Address)

_____ _____
(Phone Number) (Date)

****

Yo/Nosotros _____ ayudamos a _____
(persona dando la ayuda) (solicitante)

con lo siguiente: (marque SOLAMENTE los que apliquen)

_____ Dinero en efectivo Cantidad emnsual? $_____
_____ Pago de cuentas médicas y/o medicinas
_____ Pago de servicios públicos
_____ Comida y/o ropa
_____ Pago de prestamo de casa o renta
_____ Esta persona es apoyada por mi en que yo le pago sus gastos pero no le doy dinero en efectivo
_____ Otro Por favor de explicar: _____

La persona/familia nombrada arriba vive con migo/nosotros: Si _____ No _____

_____ _____
(firma) (dirección)

_____ _____
(teléfono) (fecha)

Approved by Burnet County Commissioner's Court

Date: _____

VERIFICATION OF DISABILITY / HANDICAPPED STATUS

CIH-FRM-DIS 3/01

To Physician:

I would like the requested information concerning my handicap/disability status to be furnished to the Burnet County Indigent Health Care Dept. at 220 S. Pierce St., Burnet, TX 78611 as soon as possible.

Signed:_____Date:_____

This is to certify that in my opinion _____

(Please check the statement that applies)

☐ Is disabled to such an extent that the following applies to his/her condition: "Inability to engage in any substantial activity or employment by reason of any medically determinable physical or mental impairment which can be expected to last for a continuous period of not less than twelve (12) months."
The above handicap began about_____Nature of handicap:_____

_____

_____

☐ Is disabled to such an extent that the following applies: "Inability to engage in any substantial activity or employment by reason of any medically determinable physical or mental impairment which can be expected to last at least from:_____to _____."
Nature of handicap:_____

_____

OR

☐ Does not demonstrate a physical or mental impairment that would cause long term inability to engage in any substantial activity or employment and is/will be medically released to return to work on_____. (Please give date of expected medical release)

_____

This is to certify that I am a practicing physician duly licensed by the State of Texas.

Physician Printed Name	Address	City	State	Zip
Physician Signature	Phone #		Date	

Burnet County Indigent Health Care
220 S. Pierce St., Burnet, TX 78611 (512) 756-5404 Fax: (512) 756-4213
Approved by Burnet County Commissioners Court
Date: July 21, 2009

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 child, you may complete this form to release only the minor's non-medical records. We may charge a fee for providing information unrelated to the administration of a program under the Social Security Act.

NOTE: Do not use this form to:

- Request the release of medical records on behalf of a minor child. Instead, visit your local Social Security office or call our toll-free number, 1-800-772-1213 (TTY-1-800-325-0778), or
- Request detailed information about your earnings or employment history. Instead, complete and mail form SSA-7050-F4. You can obtain form SSA-7050-F4 from your local Social Security office or online at _____ .

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 "any and all records" or the "entire file." You must specify the information you are requesting and you must sign and date this form. We may charge a fee to release information for non-program purposes.

- 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 requested information pertains.
- Fill in the name and address of the person or organization where you want us to send the requested information.
- Specify the reason you want us to release the information.
- Check the box next to the type(s) of information you want us to release including the date ranges, where applicable.
- For non-medical information, you, the parent or the legal guardian acting on behalf of a minor child or legally incompetent adult, must sign and date this form and provide a daytime phone number.
- If you are not the individual to whom the requested information pertains, 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. We will use the information you provide to respond to your request for access to the records we maintain about you or to process your request to 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, the Privacy Act (5 U.S.C. § 552a(b)) permits us to disclose the information you provide 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. We use information from these matching programs to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of incorrect payments or overpayments under these programs. Additional information regarding this form, routine uses of information, and other Social Security programs is available on our Internet website, _____ , 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 _____ . Offices are also listed under U.S. Government agencies in your telephone directory or you may call 1-800-772-1213 (TYY 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.***

Social Security Administration

Form Approved
OMB No. 0960-0566.

Consent for Release of Information

You must complete all required fields. We will not honor your request unless all required fields are completed. *(*Signifies a required field. **Please complete these fields in case we need to contact you about the consent form).*

TO: Social Security Administration

***My Full Name**	***My Date of Birth (MM/DD/YYYY)**	***My Social Security Number**

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

***NAME OF PERSON OR ORGANIZATION:**	***ADDRESS OF PERSON OR ORGANIZATION:**
BURNET COUNTY INDIGENT HEALTH SERVICES	220 S. PIERCE ST.
	BURNET, TEXAS 78611

***I want this information released because:**

We may charge a fee to release information for non-program purposes.

It is necessary to complete my County Indigent Health Care Program Application for Assistance.

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

Check at least one box. We will not disclose records unless you include date ranges where applicable.

1. ☒ Verification of Social Security Number
2. ☒ Current monthly Social Security benefit amount
3. ☒ Current monthly Supplemental Security Income payment amount
4. ☐ My benefit or payment amounts from date _____ to date _____
5. ☐ My Medicare entitlement from date _____ to date _____
6. ☐ Medical records from my claims folder(s) from date_____ to date_____

   If you want us to release a minor child's medical records, do not use this form. Instead, contact your local Social Security office.
7. ☐ Complete medical records from my claims folder(s)
8. ☒ Other record(s) from my file (We will not honor a request for "any and all records" or "the entire file." You must specify other records; e.g., consultative exams, award/denial notices, benefit applications, appeals, questionnaires, doctor reports, determinations.)

   Determinations, Pending Accounts

I am the individual, to whom the requested information or 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 (28 CFR § 16.41(d)(2004) that I have examined all the information on this form 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 I must pay all applicable fees for requesting information for a non-program-related purpose.

***Signature:** _____ ***Date:** _____

****Address:** _____ ****Daytime Phone:** _____

Relationship (if not the subject of the record): _____ ****Daytime Phone:** _____

Witnesses must sign this form ONLY if the above signature is by mark (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

1.Signature of witness	2.Signature of witness
Address(Number and street,City,State, and Zip Code)	Address(Number and street,City,State, and Zip Code)

WHAT YOU NEED TO KNOW ABOUT
YOUR BURNET COUNTY IHC BENEFITS

1. You must present the enclosed **orange** Health Care card whenever you receive services from any IHC provider. You must also present your **red** H.E.B prescription card when filling or picking up prescriptions. This is your eligibility identification and you cannot receive services without it. You may also be asked to present a picture ID to confirm that you are the eligible client and cardholder.

2. If you lose your card, only ONE replacement will be available within a six month eligibility period. Prescriptions will be verified with your pharmacy before a replacement is issued.

3. ***IMPORTANT***. Please note the expiration date on your card. ***YOU*** are responsible for notifying this office 14 days prior to its expiration to request a review application for continued eligibility.

4. You will be assigned a Primary Care Physician (PCP). No payments will be made to any other physicians for services unless they are referred directly by your Primary Care Physician. This includes hospital, emergency room, lab, and x-ray services.

5. You must notify (or have the provider notify) the IHC Coordinator of any appointments or services you have scheduled.

6. IHC will require a $20 co-pay (payable in advance to the hospital) for all Emergency Room visits except those referred directly by your PCP or determined to be TRUE emergencies (i.e. heart attacks, accidents involving broken bones, lacerations requiring sutures, seizures, diabetic or anaphylactic shock). See your PCP for all non-emergency services.

7. Claims for medical services provided outside of the State of Texas will not be paid by the Burnet County Indigent Health Care Program, unless prior arrangements have been made and services pre-approved by the program administrators

8. Reminder: You must follow physician recommended diets and restrictions (such as no smoking, tobacco products or alcohol).

9. You must register, and show proof of registration, with Prescription Assistance program as your first source for medications.

10. Prescription Benefits (H.E.B. pharmacies only):
    a. You are restricted to 3 prescriptions per month, 30 day supply only.
    b. On prescription medicines where a name brand is designated, but a generic is available, the IHC Client will be responsible for the difference in price, if the client chooses the brand name.
    c. Benefits do not cover drugs or medicines available over the counter.
    d. Some of are restricted drugs and are not covered by IHC: **(see attached list)**
    e. Someone else may pick up the prescription for you, but they must be in possession of your red H.E.B ID card and the name on the card must agree with the name on the prescription.

11. If at any time the Administrators of the Burnet County Indigent Health Care Program are aware of abuse of the privileges of this program, the client's IHC services will be suspended pending an investigation and fair hearing.

Approved by Burnet County Commissioner's Court

Date: _____

SERVICES COVERED BY BURNET COUNTY IHC

BASIC SERVICES

- Hospital
  - Inpatient
  - Outpatient
  - Emergency
- Physicians and Physician Assistants
- 3 Prescriptions per month (**H.E.B. Pharmacies-Burnet & Marble Falls ONLY**)
- Laboratory
- X-Rays
- Immunizations
- Medical Screening Services
- Annual Physical Examinations
- Ambulatory Surgical Centers
- Certified Registered Nurse Anesthetist (CRNA)
- Diabetic Medical Supplies and Equipment

TYPE OF SERVICES

1. Non-Surgical
2. Surgical
3. Consultation
4. Radiological
5. Laboratory
6. Radiation Therapy
7. Anesthesia
8. Assistant Surgeon
9. Interpretation
10. Technical

SERVICES NOT COVERED

1. Dental
2. Transportation (ambulance, etc..)
3. Psychiatric Services
4. Sleep Studies
5. DME (Durable Medical Equipment)
6. Results of self-inflicted injuries or wounds, overdose/abuse of drugs or alcohol

Approved by Burnet County Commissioner's Court

Date: _____

BURNET COUNTY
INDIGENT HEALTH CARE
Mail: **220 S. PIERCE ST.**
Office Location: **133 E. JACKSON**
BURNET, TX 78611
(512) 756-5404 FAX (512) 756-4213

NOTIFICATION OF SERVICES REQUIRED WITHIN 72 HOURS

BILLS MUST BE SUBMITTED TO BCIHC WITHIN 95 DAYS OTHERWISE PAYMENT WILL BE DENIED

Unauthorized use of this card is prohibited
Any sign of alteration voids this card

BURNET COUNTY
INDIGENT HEALTH CARD

Name_____

Street_____

City_____

Client #_____

D.O.B._____

Pharmacy_____

PCP _____

Expires: _____

Authorized by:_____

_____
IHC Coordinator

_____
County Judge

H-E-B Pharmacy

Welcome to My HEB Rxtra Advantage Community Choice!

Use your card below to help you save money on your prescriptions. Your card can be used for savings on both brand name and generic prescriptions. Additionally, the first three prescriptions per month are available at no cost to you.

Saving is easy, all you need to do is:

1. Cut out your card below.
2. Save instantly by presenting your card at either of these participating HEB pharmacies for any of your prescription fills or refills.

Burnet HEB #433
105 S. Boundary, Burnet, TX 78611
Pharmacy Hours: M - F 9:00am - 7:00pm,
Sat 9:00am - 5:00pm, Sun 11:00am - 3:00pm
Phone: 512-715-0701

Marble Falls HEB #284
1503 Hwy 1431 W, Marble Falls, TX 78654
Pharmacy Hours: M - F 8:00am - 9:00pm,
Sat 8:00am-7:00pm, Sun 10:00am-6:00pm
Phone: 830-693-4810

Program Benefits:

- ✓ First 3 prescriptions per month at no cost to you
- ✓ Savings on both brand and generics
- ✓ 500 select generic medications in a 30 days supply for $5 (at commonly prescribed dosages)

Use Your Card to Start Saving!

┌ - FOLD

My H-E-B Rxtra Advantage
COMMUNITY CHOICE

Group # 809

Customer Care: 1-877-432-6979

Bin 006053 PCN MSC
PRESCRIPTION DRUG DISCOUNT CARD
DISCOUNT ONLY - NOT INSURANCE

└ - FOLD

This program is not an insurance policy and does not provide insurance coverage. Discounts are available exclusively through participating pharmacies. Pain medications, lifestyle drugs and psychotropic medications are not covered. A 30-day supply limitation applies to all prescriptions.

This program is administered by Medical Security Card Company (MSC) of Tucson, Arizona. By using your card, you acknowledge and agree that MSC may have access to and use your prescription drug data to administer the program.

PUBLIC NOTICE

INTENT OF IMPLEMENTATION OF COUNTY INDIGENT HEALTH CARE PROGRAM (AS MANDATED UNDER SENATE BILL 1 – INDIGENT HEALTH CARE AND TREATMENT ACT)

Effective September 1, 2009, Burnet County will be providing any health care, which is deemed medically necessary, to eligible residents as specifically provided by the County Indigent Health Care Program.

The Burnet County Indigent Health Care Program will follow the established eligibility and services standards, application, documentation, and verification procedures contained in the County Indigent Health Care Handbook provided by the Texas Department of Health. Applications will be available upon request at the following location:

Burnet County Indigent Health Care Program
Burnet County Annex on the Square
133 E. Jackson St.
Burnet, TX 78611
(512) 756-5404
FAX (512) 756-4213

Assistance will be available upon request for completing applications. Applicants are responsible for providing information, for correctly filling out the application, and providing all requested verification. The county will notify the applicant's eligibility. Applicant has the right to appeal eligibility decisions within 90 days from the receipt of written notice of eligibility.

Burnet County is liable for 8% of the General Revenue Tax Levy and 10% of all expenditures exceeding that amount as long as state matching funds are available. In the event that Burnet County spends 8% of its G.R.T. L. and State funds are exhausted, the program will be discontinued until such time that further state funds are available or until September 1 of the next fiscal year.

James Oakley
County Judge

Approved by Burnet County Commissioner's Court

Date: _____

BURNET COUNTY
INDIGENT HEALTH CARE
INTERNAL POLICIES

1. Primary Care Physician (PCP) will be assigned to each IHC client. No payments will be made to any other physicians for services unless they are referred directly by the Primary Care Physician. This includes hospital, emergency room, lab and x-ray services.

2. IHC will require a $20 co-pay (payable in advance to the hospital) for all Emergency Room visits except those referred directly by your PCP or determined to the TRUE emergencies (ie. heart attacks, seizures, strokes, diabetic or anaphylactic shock, accidents involving broken bones, or lacerations requiring sutures). See your PCP for all non-emergency services.

3. IHC clients must be compliant with all physician instructions/directions, including taking prescribed medications, following recommended diets, and instruction to cease alcohol and tobacco usage.

4. On prescription medicines where a name brand is designated, but a generic is available, the IHC Client will be responsible for the difference in price, if the client chooses the name brand.

5. Some drugs are restricted and will not be covered by IHC. (see attached list)

6. Payments for hospitalization (emergency, in-patient, or out-patient services) due to alcohol or drug abuse/overdose, will be denied. Self-inflicted injuries or suicide attempts are not covered.

7. A valid social security number and/or proof of citizenship will be required for all applicants.

8. Claims for medical services provided outside of the State of Texas will not be paid by the Burnet County Indigent Health Care Program, unless prior arrangements have been made and services pre-approved by the program administrators

Approved by Burnet County Commissioner's Court

Date: _____

BCIHC Household/Client Appeal Process

(to an IHC eligibility denial)

- The Household/Client may appeal any eligibility decision by signing the bottom of CIHCP Form 117, Notice of Ineligibility, within 30 days from the date of the denial.

- Burnet County will have 14 days from the date Form 117 was received in the IHC eligibility office, with the appropriate signature, to respond to the client to let them know that IHC received their appeal. A detailed explanation as to the denial will be stated. The client will be notified as to the next step in the appeal process, either:

  1. An appeal hearing is not necessary as a mistake or reconsideration has been made by Burnet County IHC. Burnet County IHC and the client will take the appropriate steps required to remedy the situation;
     or
  2. With 14 days of receipt the appeal, a Hearing Officer will be appointed by the County Judge. On review of the case:
     - If the Hearing Officer rules in favor of the client/appellant, a hearing will not be scheduled and the client/appellant will be notified of the favorable decision.
     - If the Hearing Officer determines a hearing is necessary, Burnet County will have 30 days in which to schedule the appeal hearing. Client/appellant will be notified in writing on the date, time, and place of the hearing.

- Anytime during the appeal process further information may be requested from the client/appellant by Burnet County IHC or the Hearing Officer.

- Burnet County IHC will call the client/appellant to remind the client of appeal hearing.

- Should a client/appellant choose not to attend their scheduled appeal hearing, leave a hearing, or become disruptive during a hearing, the case will be dropped and the appeal denied.

- After the date of the appeal hearing, the Hearing Officer will have 30 days to decide. The client will be notified of the decision in writing.

- Ruling of the Hearing Officer is final.

James Oakley, County Judge

Commissioner, Pct. 1

Commissioner, Pct. 2

Commissioner, Pct. 3

Commissioner, Pct. 4

Attested to:

Janet Parker, County Clerk

1-23-18

Date

BURNET COUNTY
INDIGENT HEALTH CARE PROGRAM

The following internal documents and policies have been reviewed and adopted:

1. Client Responsibility
2. Fraud Policies & Procedures
3. Authorization of Background Checks
4. HIPAA Compliance (Policy, Release, and Receipt)
5. Verification of Support
6. Verification of Disability
7. What you need to know about Burnet County IHC
8. Services Covered by Burnet County IHC
9. Restricted Drug List (not all inclusive)
10. IHC ID Card
11. HEB Prescription Card
12. Public Notice (Required to be published before Sept. 1st each year)
13. Burnet County Internal Policies
14. IHC Appeal Process

Burnet County Commissioner's Court

Approved this _____ day of _____, 2018.

James Oakley, County Judge

Commissioner, Pct. 1

Commissioner, Pct. 2

Commissioner, Pct. 3

Commissioner, Pct. 4

Attested to:

Janet Parker, County Clerk

1-23-18
Date