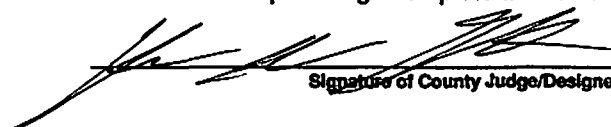


### OPTIONAL HEALTH CARE SERVICES NOTIFICATION

Circle the number of each type of optional health care service the county chooses to provide.

<b>1.</b>	<b>Advanced Practice Nurse (APN)</b> , specifically a nurse practitioner, a clinical nurse specialist, a Certified Nurse Midwife (CNM), and a Certified Registered Nurse Anesthetist (CRNA)
<b>2.</b>	<b>Ambulatory Surgical Center (ASC)</b> , Freestanding
<b>3.</b>	<b>Colostomy Medical Supplies and/or Equipment</b> , namely colostomy bags/pouches, cleansing irrigation kits, paste or powder, and skin barriers with flange/wafers
<b>4.</b>	<b>Counseling Services.</b> Check the ones the county chooses to provide. <input checked="" type="checkbox"/> A. Licensed Clinical Social Worker (LCSW) <input checked="" type="checkbox"/> B. Licensed Marriage Family Therapist (LMFT) <input checked="" type="checkbox"/> C. Licensed Professional Counselor (LPC) <input checked="" type="checkbox"/> D. Ph.D. Clinical Psychologist
<b>5.</b>	<b>Dental Care</b> , namely an annual routine dental exam, an annual routine cleaning, one set of annual x-rays and the least costly service for emergency dental conditions for the removal or filling of a tooth due to abscess, infection, or extreme pain
<b>6.</b>	<b>Diabetic Supplies and/or Equipment</b> , namely test strips, alcohol prep pads, lancets, glucometers, insulin syringes, humulin pens, and the needles required for the humulin pens
<b>7.</b>	<b>Durable Medical Equipment (DME).</b> Check the ones the county chooses to provide. <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> A. Blood Pressure Measuring Appliances  <input type="checkbox"/> B. Canes  <input type="checkbox"/> C. Crutches  <input checked="" type="checkbox"/> D. Home Oxygen Equipment           </div> <div> <input type="checkbox"/> E. Hospital Beds  <input type="checkbox"/> F. Walkers  <input type="checkbox"/> G. Wheelchairs, Standard           </div> </div>
<b>8.</b>	<b>Emergency Medical Services</b> , namely ground transportation only
<b>9.</b>	<b>Federally Qualified Health Center (FQHC)</b>
<b>10.</b>	<b>Home and Community Health Care</b>
<b>11.</b>	<b>Physician Assistant (PA)</b>
<b>12.</b>	<b>Vision Care</b> , namely one exam by refraction and one pair of prescription glasses every 24 months

☐ **CHANGE** Check here if the county decides to discontinue any of the optional services that it is currently providing. Circle the optional service(s) above that the county will continue providing. Complete and fax this form to the TDSHS County Indigent Health Care Program.

 Signature of County Judge/Designee	7-27-08 Date
---	-----------------

Printed Name of Person Signing This Form 120	Title
County	Mailing Address
Telephone Number (Include area code.)	City/State/ZIP