

# THE BROOKS COUNTY INDIGENT PROGRAM



**TEXAS**

**Health and Human  
Services**



**If you have any questions, please call**

**The Brooks County Indigent  
Coordinator **Phillip Morones** at**

**(361)-325-0296**



## County Indigent Health Care Program Monthly Income Standard Based on 2025 Federal Poverty Level (FPL)

Effective March 1, 2025

Household	21% FPL Minimum Income Standard	50% FPL Maximum Income Standard
1	\$274	\$652
2	\$370	\$881
3	\$466	\$1,110
4	\$563	\$1,340
5	\$659	\$1,569
6	\$755	\$1,798
7	\$851	\$2,027
8	\$948	\$2,256
9	\$1,044	\$2,485
10	\$1,140	\$2,715
11	\$1,236	\$2,944
12	\$1,333	\$3,173

A household is eligible if its monthly net income, after rounding down cents, does not exceed the monthly income standard for the CIHCP household's size. The FPL is calculated and published each calendar year at [Poverty Guidelines](#).



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### **Important Information for Former Military Services Members**

Women and men who served in any branch of the United States Armed Forces, including Army, Navy, Marines, Air Force, Coast Guard, Reserves or National Guard, may be eligible for additional benefits and services. For more information, please visit the Texas Veterans Portal at <https://veterans.portal.texas.gov>.

### **Información importante para antiguos miembros de las Fuerzas Armadas**

Las mujeres y los hombres que hayan pertenecido a cualquier cuerpo de las Fuerzas Armadas de los Estados Unidos (incluidos el Ejército, la Armada, la Infantería de Marina, la Fuerza Aérea, la Guardia Costera, el cuerpo de reservistas o la Guardia Nacional) podrían recibir beneficios y servicios adicionales. Para más información, visite el Portal de Texas para Veteranos en <https://veterans.portal.texas.gov>.

*Effective March 1, 2018 contractors are required to share this information with program applicants until further notice. For more information, visit program website.*



County Indigent Health Care Program (CIHCP)  
**Application for Health Care Assistance**

**For Office Use Only**

Status <input type="radio"/> Application <input type="radio"/> Review	Date Form 3064 Requested/Issued	Date Identifiable Form 3064 Received	Case Record No.	Appointment Date and Time, if applicable
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Name (Last, First, Middle)	Home Area Code and Phone No.	Other Area Code and Phone No.
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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
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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?
					<input type="radio"/> Yes <input type="radio"/> No
					<input type="radio"/> Yes <input type="radio"/> No
					<input type="radio"/> Yes <input type="radio"/> No
					<input type="radio"/> Yes <input type="radio"/> No
					<input type="radio"/> Yes <input type="radio"/> No
					<input type="radio"/> Yes <input type="radio"/> 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.

<input type="checkbox"/> Own or paying for home	<input type="checkbox"/> Live in a house provided by someone else	<input type="checkbox"/> No permanent residence
<input type="checkbox"/> Live with someone else	<input type="checkbox"/> Rent house or apartment	<input type="checkbox"/> Jail

4. List your average monthly household expenses.

Rent/Mortgage	\$
Phone	\$
Tax and Insurance on Home Per Year	\$
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? \_\_\_\_\_



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.

# Brooks County Indigent Program

## Client Responsibilities

You are eligible for up to six months of assistance from the Brooks County Indigent Program. Client responsibilities are listed below:

Indigent vouchers are needed for the following:

- Doctors / Specialist Visits
- ER Visits
- Prescriptions
- X-rays, MRI, CT, Etc.

Vouchers should be picked up prior to services being performed. Please give the Indigent Coordinator a two-business day advance notice before expecting any kind of assistance.

Clients are eligible to receive no more than three prescriptions per month. The Brooks County Indigent Program has the right to decline any prescriptions when the budget is nearing its end or is seeing certain restraints.

All assistance must be first approved by The Brooks County Indigent Coordinator. If not, client will be responsible for payment.

Clients **MUST** notify the office within fourteen (14) days of any changes such as income, property household members, childcare expenses, application or receipt of SSI / Medicaid, and/or address. If a change occurs that makes you ineligible and you fail to report it, as required by law, you may be held responsible for payment.

I understand my responsibility as an Indigent Client.

X\_\_\_\_\_

Client Name

X\_\_\_\_\_

Date

X\_\_\_\_\_

Client Signature

**Brooks County Indigent Program**  
**Authorization for Release of Information**

Please be aware that all information provided to this department will be kept confidential and used for eligibility purposes only. By signing the Authorization for Release of Information Form, applicants agree to allow The Brooks County Indigent Department staff to release information provided by the applicant to any medical / medical program inquiring information about applicant eligibility status with The Brooks County Indigent Department will use the information provided by the applicant to verify Medicaid eligibility status, residency verification, employment verification, and monthly income received, etc., to determine the eligibility of the household. Personal information on any household member listed on the application will be withheld and kept confidential. Information provided may also be reviewed by the state at any time during an audit that may be performed in this office. If you have any questions on how the information you provide to this department will be used, please feel free to contact The Brooks County Indigent Program office at any time during working hours.

# Brooks County Indigent Program

## Authorization for Release of Information

I, \_\_\_\_\_, authorize The Brooks County Indigent Program to release information provided by me to any medical facility / medical program inquiring about my eligibility with The Brooks County Indigent Program. I understand that my information may be used to: verify Medicaid eligibility, residency verification, employment verification, monthly income received, etc., to determine the eligibility of the household. Personal information on any household member listed in my application will be withheld and kept confidential.

The purpose for my signature has been explained, and I understand and agree to these terms for use of my information.

X \_\_\_\_\_

Client Name

X \_\_\_\_\_

Date

X \_\_\_\_\_

Client Signature

X \_\_\_\_\_

Legal Representative

# **Brooks County Indigent Program**

## **Behavioral Guidelines**

### **BEHAVIORAL**

- All applicants and qualified clients are required to comply with all state and county policies and guidelines to receive services through The Brooks County Indigent Health Care Program (BCIHCP).
- All applicants and qualified clients who are rude and display disruptive or abusive language and behavior will not be seen. Physical and combative confrontations are grounds for immediate termination from The BCIHCP.
- All qualified clients are expected to comply with the medical regime proposed by their physician's or specialist's offices. Clients will be terminated from The BCIHCP for repeated non-compliance.
- No qualified client shall receive any medication without periodic primary care physician evaluation every three to six months.
- Qualified clients will be terminated from The BCIHCP program for illicit drug usage and continued alcohol abuse, if not currently and actively participating in a supervised rehab program.

### **FRAUD/NON COMPLIANCE**

- Fraud is the deliberate misrepresentation of some material fact for the purpose of acquiring benefits.
  1. Making a false and/or misleading statement.
  2. Misrepresenting, concealing, or withholding facts
  3. Violating any provision of the CIHCP Act, The CIHCP regulations or State Statutes relating to the use, or acquisition of CIHCP.
- Non-compliance is the failure to report, whether deliberate or not, the following:
  1. Initial income or change thereof
  2. Resources – currently owned, the selling, trading, or purchasing of,
  3. Change of address,
  4. Change in household members,
  5. Change in marital status,
  6. Application, approval, or denial of Social Security, SSI, or Medicaid,
  7. Eligibility for other medical coverage such as, but not limited to, private insurance, V.A., Worker's Compensation, Crime Victims Assistance,
  8. Failure to comply with work registration requirements, which includes keeping registration active, actively seeking employment, making interviews, accepting reasonable job offers,
  9. Other items as used to determine eligibility

10. In addition, a client is determined to be in non-compliance if he/she fails to apply for a medical coverage program, such as those listed in #7, for which he/she has been determined to be potentially eligible.

- Consequences of Fraud/Non-Compliance

1. Length of suspension is determined by the number of months the infraction covered, in the case of multiple infractions, each infraction will be considered separately.
2. In the case of a second instance of non-compliance eligibility will be suspended for a period of twelve months,
3. Should there be a third instance of non-compliance, the applicant will be **PERMANENTLY** disqualified.
4. It is the responsibility of the client to notify The BCIHCP that he/she wishes to apply for IHC at the end of the suspension period.
5. Clients shall be required to reimburse Brooks to reimburse Brooks County for the cost of benefits they were ineligible to receive,
6. Clients shall be administratively ineligible for BCIHCP benefits in accordance with BCIHCP Policies and Procedures, and
7. Client may be subject to prosecution under the Texas Penal Code.

**I HAVE READ AND UNDERSTAND ALL OF THE ABOVE GUIDELINES.**

X\_\_\_\_\_

Client Name

X\_\_\_\_\_

Date

X\_\_\_\_\_

Client Signature

X\_\_\_\_\_

Legal Representative