C O L L I N C O U N T Y

Collin County Indigent Healthcare Program
825 N. McDonald Street
Suite 110
McKinney, Texas 75069
www.collincountytx.gov
Phone: 972-548-4702
Fax: 972-547-7268

COLLIN COUNTY INDIGENT HEALTHCARE PROGRAM APPLICATION

The Collin County Indigent Healthcare Program helps people pay for medical care on a short-term basis. Whether you are eligible depends on your income, what you own, where you live, help you receive, and other items. To submit an application, please fill out the attached forms and submit them along with copies of all required documentation.

An application may be submitted online or paper applications may be picked up at the Collin County Indigent Healthcare Program office located at 825 N. McDonald Street, Suite 110, McKinney, TX 75069 from 8:00 AM – 4:00 PM, Monday through Thursday. Completed paper applications may be returned by mail or delivered in person to this address.

Once a completed application is received, a decision regarding your eligibility will be made within 14 business days. Collin County Indigent Healthcare Program will notify you if you have been accepted into the program, denied, or if additional information is needed. You will receive this notification by email if the application was submitted online or by mail if a paper application was submitted. Incomplete applications will not be processed until all required information is submitted. Please do not contact Collin County regarding your application until the 14 business day period has passed.

You may be asked to apply for assistance through other programs before your eligibility status for the Collin County Indigent Healthcare Program can be determined. If you are asked to apply for assistance through other programs or you have applied but are awaiting an answer, your application may be held until you are determined to be ineligible for the other assistance programs.

After turning in a completed application, you must report any household changes within 14 business days of the change. Examples of changes that must be reported are address, income, employment, resources, number of people living in the home, and any information from other assistance programs.

If you have any questions, please call (972) 548-4702.

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Indigent Program Required Documentation Checklist

You may be asked to provide additional information during the application review process.
You must provide your own copies of Supporting Documents.

Name: _____ Date: _____/_____/_____

Application: Application pages (3-12) must be completed, signed and returned. Copies or faxes will not be accepted.

Marital status:

□ **Married** □ **Single (never married)** □ **Widowed** □ **Separated**
□ **Divorced** (provide a copy of the Final Decree of Divorce – all pages)

Supporting Documents (You must provide your own copies):

□ N/A □ **All checking account statements** (Applicant/Spouse: Individual/Joint: **for past 90 days**; all pages)
□ N/A □ **All savings account statements** (Applicant/Spouse: Individual/Joint: **for past 90 days**; all pages)
□ N/A □ **Paycheck stubs or Employer Earnings Statements** (past 90 days □ Applicant □ Spouse)
□ N/A □ **Federal Income Tax Return** (current year, **including** if claimed as dependent(s) on another person's tax return)
□ N/A □ **Unemployment compensation award or denial letter** (□ Applicant □ Spouse)
□ N/A □ **Social Security award/denial letter OR proof of SSI filing** (if unemployed □ Applicant □ Spouse)
□ N/A □ **Verification of benefits** □ **Adult Medicaid** □ **Food Stamps** □ **TANF** (award/denial letter OR proof of filing)
□ N/A □ **Verification of benefits from Children's Medicaid** (for anyone in your immediate household)
□ N/A □ **Verification of Veterans Benefits** (□ Applicant □ Spouse)
□ N/A □ **Automobile registration/title** (if the vehicle(s) is in Applicant/Spouse name)
□ N/A □ **Current balance owed on vehicle(s)**, if vehicle(s) is not paid off (if vehicle(s) is in Applicant/Spouse name)
□ N/A □ **Verification of any Retirement Plans, Payments, or Funds** (if not in English, must be translated & notarized)
□ N/A □ **Verification of residence** □ Lease agreement □ Tax assessor statement
□ N/A □ **Social Security Card(s)** (□ Applicant □ Spouse)
□ N/A □ **Texas Driver's License or Texas Identification Card** (Applicant only - must show current address)
□ N/A □ **Passport** (complete copy)
□ N/A □ **Birth Certificate** (Applicant only – US born citizens only)
□ N/A □ **Certificate of Naturalization** (Applicant only)
□ N/A □ **Permanent Resident Card**
□ N/A □ **Refugee/Asylee**
□ N/A □ **Child Support Court Order**

FOR OFFICE USE ONLY / PARA USO DE LA OFICINA				
Status ☐ Application ☐ Review	Date Form 100 is Requested/Issued	Date Identifiable Form100 is Received	Case Record Number	Appointment Date and Time, if applicable

APPLICATION FOR HEALTH CARE ASSISTANCE / SOLICITUD DE ASISTENCIA DE ATENCIÓN MÉDICA

Name (Last, First, Middle)/Nombre (Apellido, primer, segundo)	Home Telephone No./Teléfono de la casa	Other Telephone No./Otro número de teléfono

Have you ever used another name? If so, list other names you have used./¿Ha usado alguna vez otro nombre? Sí es el caso, enumere los nombres que ha usado.

☐Yes/Sí ☐No

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

Home Address, if different from above. If it is rural, give directions. / Domicilio particular, si es diferente a la dirección de arriba. Si es rural, explique cómo llegar.

1. On the chart below, fill in the first line with information about yourself. Fill in the remaining lines for everyone who lives in the house with you, whether or not you consider them household members. / En la tabla a continuación, llene la primera línea con información acerca de usted mismo. Llene las líneas restantes acerca de todos que viven en la casa con usted, los considere miembros de la unidad familiar o no.

Name (Last, First, Middle) Nombre (Apellido, primero, segundo)	Social Security Number **(if available)** Número de Seguro Social (si lo tiene a su disposición)	Sex Sexo Male/ Female Hombre/ Mujer	Date of Birth Fecha de nacimiento	What Relation to you? ¿Parentesco con usted?	Are you a sponsored alien? ¿Es usted un extranjero patrocinado?
				MYSELF Yo mismo	

The word "household" in Questions #2 - #16 refers to: you, your spouse, and anyone else that lives with you and with whom you have a legal relationship. You do not need to include information on people who live with you but are not part of your "household."
Las palabras "unidad familiar" en las preguntas #2- #16 se refiere a: usted, su esposo o esposa, y cualquier otra persona que vive con usted y con quien tiene una relación legal. No necesita incluir información de las personas quienes viven con usted que no son parte de su "unidad familiar."

2. What is your household's county and state of residence (where you make your permanent home)?
¿En qué condado y en qué estado viven (tienen su hogar permanente) usted y las personas de la unidad familiar?

County/Condado _____ State/Estado _____

Do you plan to remain in this county and state?
¿Piensa quedarse en este condado y este estado?..... ☐Yes/Sí ☐No

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

☐ Own or paying for home
Soy dueño de mi casa o la estoy comprando

☐ Live in a house provided by someone else
Vivo en una casa ajena

☐ No permanent residence
No tengo residencia permanente

☐ Live with someone else
Vivo con otra persona

☐ Rent House/Apartment
Rento una casa o apartamento

☐ Jail
Cárcel

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

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

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

   Telephone/Teléfono .....$ _____

   Transportation, such as gas, car payments, bus/Transportación, tal como gasolina, pagos del carro, autobús .....$ _____

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

   Other/Otro.....$ _____

   Other/Otro.....$ _____

   Other/Otro.....$ _____

   Does anyone pay these household expenses for you?
   ¿Hay otra persona que paga estos gastos de la unidad familiar por usted? ..... ☐Yes/Sí ☐No

   If Yes, who?/Si contesta "Sí," ¿ quién? _____

5. Are you – or is anyone in your household – receiving ☐ TANF ☐ Food Stamp ☐ Medicaid benefits?
   ¿Está usted o alguien de la unidad familiar recibiendo beneficios de TANF, estampillas para comida, y/o Medicaid? ..... ☐Yes/Sí ☐No

   If Yes, who?/Si contesta "Sí," ¿ quién? _____

6. Are you – or is anyone in your household – pregnant?
   ¿Está usted o alguien de la unidad familiar embarazada?..... ☐Yes/Sí ☐No
   If Yes, who?
   Si contesta "Sí," ¿ quién? _____

7. Are you – or is anyone in your household – disabled?
   ¿Está usted o alguien de la unidad familiar incapacitada?..... ☐Yes/Sí ☐No
   If Yes, who?
   Si contesta "Sí," ¿ quién? _____

8. Have you – or has anyone in your household – applied for SSI or SSDI?
   ¿Alguna vez usted o alguien de la unidad familiar solicitó beneficios de SSI o SSDI?..... ☐Yes/Sí ☐No

   If Yes, who applied and when?
   Si contesta "Sí," quién los solicitó y cuando? _____

9. Do you – or does anyone in your household – have unpaid health care bills from the last three months?
   ¿Tiene usted o alguien de la unidad familiar cuentas médicas sin pagar de los últimos tres meses? ..... ☐Yes/Sí ☐No

   If Yes, which months?
   Si contesta "Sí," ¿Cuáles meses? _____

10. Do you – or does anyone in your household – have health care coverage (Medicare, health insurance, V. A., Tricare, etc.)?
    ¿Tiene usted o alguien de la unidad familiar la cobertura médica (Medicare, seguro médico, V. A., Tricare, etc.)? ..... ☐Yes/Sí ☐No

    If Yes, who?/Si contesta "Sí," ¿ quién? _____

11. How much money do you have? For example, on your person, in your home, in bank accounts, or other locations?
    ¿Cuánto dinero tiene usted; por ejemplo, en el bolsillo, en la casa, en las cuentas bancarias, o en otros lugares? ..... $

12. How many cars, trucks, or other vehicles do you – and anyone in your household -- have? List the year, make, and model in the chart below./¿Cuántos carros, camionetas u otros vehiculos tienen usted y las personas de la unidad familiar? Anote el año, la marca, y el modelo en la tabla a continuación. .....

	Year/Año	Make and Model/Marca y Modelo
1.		
2.		

	Year/Año	Make and Model/Marca y Modelo
3.		
4.		

13. Do you – or does anyone in your household – own or pay for a home, lot, land, or other things?
    ¿Tiene o paga usted o alguien de la unidad familiar una casa, un lote, un terreno, u otros bienes? ..... ☐Yes/Sí ☐No

14. Did you – or did anyone in your household – sell, trade, or give away any cash or property during the last three months?
    Durante los últimos tres meses, ¿traspasó, vendió o regaló usted o alguien de la unidad familiar dinero o alguna propiedad?..... ☐Yes/Sí ☐No

15. Have you – or has anyone in your household – worked in the last three months?
    ¿Ha trabajado usted o alguien de la unidad familiar en los últimos tres meses?..... ☐Yes/Sí ☐No
    If Yes, who?
    Si contesta "Si," ¿quien? _____

16. List all of your household's income below. Be sure to include the following: Government checks; money from training or work; money you collect from charging room and board; cash gifts, loans, or contributions from parents, relatives, friends, and others; sponsor's income; school grants or loans; **child support and unemployment**./Haga una lista de los ingresos de la unidad familiar a continuación. Asegúrese de anotar: Cheques del gobierno; ingresos de trabajo o de capacitación; dinero que recibe de cobros de cuarto y comida; regalos en efectivo, préstamos, o aportaciones de sus padres, familiares, amigos, y otras personas; los ingresos del patrocinador; becas o préstamos de la escuela; o pagos por desempleo.

Name of person receiving money Nombre de la persona que recibe el dinero	Name of agency, person, or employer who provides the money Nombre del patrón, la persona o la agencia que paga el dinero	Amount received Cantidad recibida	How often received? (daily, weekly, every two weeks, twice a month, monthly?) ¿Con qué frecuencia lo recibe? (¿diariamente, por semana, cada quincena, dos veces al mes, una vez al mes?)

The statements I have made, including my answers to all questions, are true and correct to the best of my knowledge and belief.

I agree to give eligibility staff and the county any information necessary to prove statements about my eligibility.

I agree to report any of the following changes within 14 days:

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

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

A mi leal saber y entender, las declaraciones que he hecho, y mis respuestas a todas las preguntas, son verdaderas y correctas.

Me comprometo a dar al personal que verifica la elegibilidad y al condado toda la información necesaria para comprobar mis declaraciones sobre la elegibilidad.

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

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

Me han dicho y comprendo que esta solicitud será considerada sin discriminación por raza, color, religión, credo, origen nacional, edad, sexo, discapacidad, ni afiliación política; que puedo pedir una revisión de la decisión que se haga acerca de mi solicitud de asistencia o recertificación para asistencia; y que puedo pedir, oralmente o por escrito, una audiencia imparcial sobre cualquier acción que afecte la entrega o la terminación de asistencia de atención médica.

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.

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

Me han dícho y comprendo que si dejo de cumplir con las obligaciones especificadas en ésta podría considerarse como una retención intencional de información y podría dar lugar a la recuperación de pérdidas por medio de la devolución de pagos o por medio de la presentación de cargos criminales en mi contra.

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

Signature – Applicant / Firma – Solicitante	Date / Fecha	Signature – Spouse / Firma – Esposo o Esposa	Date / Fecha

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

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

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

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This form is required to be completed. Please print all information

Medical Questionnaire

What is your **primary** health concern at this time? _____

_____

Please list **all** other ongoing health issues or diagnoses:

_____

_____

Were you referred to our office by another facility? ☐ Yes ☐ No
If yes, what facility? _____

Do you have any unpaid medical bills within the past 95 days? ☐ Yes ☐ No
If yes, please complete the following information:

_____ _____ _____
Facility (Hospital) Admit Date Discharge Date

_____
Reason for visit

Are you currently a LifePath Systems (MHMR) client? ☐ Yes ☐ No
Are you currently receiving assistance through DARS? ☐ Yes ☐ No
Do you have a primary care physician? ☐ Yes ☐ No

Please list **all** medications you are currently taking (if you need extra space please use the back of this form)

Medication	**Reason for medication**	**Daily Dosage**
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____

Emergency Contact: Please provide the name, address and telephone of a relative, or friend, that we may contact in case of an emergency. Name: _____

_____
Address Telephone Relationship to Applicant

_____ _____
Applicant Signature **Date**

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Authorization for Release of Information

Applicant Name: _____

I hereby give permission to the Collin County Indigent Healthcare Program 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 Collin County Indigent Healthcare Program personnel to obtain any information necessary to verify statements about my eligibility. I understand that random home visits will be conducted.

_____ **(Print name of Authorized Representative)** is my representative and I give the Collin County Indigent Healthcare Program permission to speak to them in person or on the phone at any time regarding my eligibility or benefits under the Collin County Indigent Healthcare Program.

I have been told and I understand that my failure to meet the obligations set forth or the unlawful use of ID cards, pharmacy cards, etc. can result in the recovery of any loss by repayment, or by the filing of criminal or civil charges against me.

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

I also give permission for any providers treating me to release my medical records to the Collin County Indigent Healthcare Program for the purpose of determining proper referrals and/or determining whether or not the services provided meet the criteria for payment by the Collin County Indigent Healthcare Program.

Acknowledgment of Receipt of Notice of Privacy Practices

I understand that as part of the provision of healthcare services, Collin County 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.

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 Collin County Health Care Services and its agents (including Collin County Indigent Healthcare Program), of my medical and health information and/or protected health information as is stated in the Notice of Privacy Practices. I understand that Collin County 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 Collin County is not required to agree to the requested restrictions.

This authorization is effective for the duration that the applicant remains in the program.

_____ _____

Applicant Signature **Date**

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Verification Statement

This form is to be completed by any person or persons who are providing any assistance to you.

☐ **Check this box if no one is currently assisting you. Sign and date below.**

Applicant Name: _____

Have you given cash to the above-named person within the past 95 days? ☐ **Yes** ☐ **No**

- If yes, please note the dates and amounts, however small, in the spaces below. You may use the back of this form if you need more space.

Date	Amount	Date	Amount
Date	Amount	Date	Amount

Have you paid any bills directly for the above-named person? ☐ **Yes** ☐ **No**

- If yes, please list below. You may use the back of this form if you need more space.

Date	Name of person or company paid
Date	Name of person or company paid

Is the above-named person currently living with you? ☐ **Yes** ☐ **No**

Are you currently providing room and board for the above-named person? ☐ **Yes** ☐ **No**

I understand that providing any false information can result in a fine or imprisonment. I certify that the above information is correct to the best of my knowledge.

_____
Print Name (person providing the assistance or Applicant, if no one is assisting you)

_____
Address **City** **State** **Zip Code**

(_____)_____ _____
Phone Number **Relationship to Applicant or Self**

_____
Signature **Date**

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Collin County Indigent Health Care Fraud Policy

Definition

Fraud is the deliberate misrepresentation of some material fact for the purpose of acquiring benefits.

Procedure

When the Collin County Indigent Healthcare Program (CCIHP) staff has reason to believe that fraud may have occurred, the following procedures shall be followed:

1. The CCIHP staff shall investigate all cases of suspected fraud and shall collect and document evidence.

2. Upon a finding of fraud, the applicant/client shall be administratively ineligible from CCIHP as follows:
   First offense: 24 months from the date fraud was discovered
   Second offense: 36 months from the date fraud was discovered
   Third offense: 24 months from the date fraud was discovered + 12 months per subsequent offense

3. The CCIHP staff shall contact the applicant/client who is suspected of fraud by sending a certified letter informing the applicant/client of the withdrawal of eligibility and explaining the allegations. If the applicant/client disputes the allegations, the applicant/client will be allowed to submit applicable supporting documents/verifications for further consideration.

4. If the dispute remains unresolved, the CCIHP staff shall schedule an administrative hearing to allow the applicant/client to defend themselves by confronting any adverse witness and by presenting their own argument and evidence. The CCIHP staff must disclose any evidence used to prove its case to the client so they have an opportunity to dispute it. The administrative hearing will be conducted by the CCIHP Coordinator with the CCIHP Eligibility Clerk or designee present. The administrative hearing shall be held at the offices of the CCIHP during normal business hours. The applicant/client shall be given 30 days written notice of the date of the administrative hearing. The burden of proof lies with CCIHP. If the applicant/client does not appear at the administrative hearing, the CCIHP Eligibility Clerk or designee may proceed with presentation of the CCIHP's case only if proof of notice is present. The CCIHP Coordinator must make a decision within ninety (90) days of the hearing.

5. The applicant/client shall have the right to appeal any unfavorable decision to the CCIHP Appeal Authority.

Consequence of Fraud

If, after due process, a person is found to have intentionally misrepresented information in order to receive benefits, that person:

- shall reimburse Collin County for the cost of benefits the applicant/client was ineligible to receive;
- shall be administratively ineligible for CCIHP benefits in accordance with CCIHP Policies and Procedures; and
- may be subject to prosecution under the Texas Penal Code.

_____ _____

Signature **Date**

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Applicant - Affidavit of Assets, Income and Resources

This affidavit is made by the applicant for the purpose of informing the Collin County Indigent Healthcare Program that **I do have access** to the assets, income or resources listed below, either in the United States or any foreign countries.

Check the items that you do have access to:

- ☐ Ownership of any property in the U.S.
- ☐ Ownership of any property in foreign countries
- ☐ Businesses in the U.S. or foreign countries
- ☐ Retirement plans/payments; US/foreign countries
- ☐ Vehicles (Autos, Motorcycles, ATV, Golf Carts, etc.)
- ☐ U.S. bank accounts (checking, savings, IRA, etc.)
- ☐ Foreign bank accounts (checking, savings, IRA, etc.)
- ☐ Medical benefits in the U.S. or foreign countries
- ☐ I do not own, nor are there any assets/income/resources, in my name/ownership

I understand that if I fail to report any of the above information, I will be held responsible for payment of any medical services that I may have received under the Collin County Indigent Healthcare Program, and I will be subject to prosecution under the Texas Penal Code.
I swear (affirm) that the contents of this affidavit signed by me are true and correct.

_____

Applicant Signature **Date**

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 Collin County Indigent Healthcare Program to obtain a background check from the Texas Workforce Commission, Department of Motor Vehicles Registration, LexisNexis Accurint and any other sources that may need to be contacted to determine my eligibility for the Collin County Indigent Healthcare Program. Quarterly background checks are conducted on approved applicants.

_____

Applicant Signature **Date**

_____

Spouse Signature **Date**

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Applicant - Employment Verification Form

If you are not currently employed:

☐ I have not been employed for _____ (months/years) because _____

_____

Last place of employment: _____

☐ Check this box if applicant has **NEVER** worked in the USA and sign and date the bottom of this form

If you are currently employed:

_____ _____
Company Name (Please Print) Supervisor (Please Print)

_____ _____
Company Address Telephone

Employee (Applicant) Information:

☐ Full time ☐ Part time Pay Period: ☐ Weekly ☐ Bi-Weekly ☐ Monthly

_____/_____/_____ _____ _____
Hire Date Hourly wage Hours worked weekly

☐ **Check this box if you are Self Employed and/or own your own business:**

_____
Occupation/Trade Name of Business Start Date

_____ _____
Employee/Applicant Signature Date

Collin County Indigent Health Care Public Notice
September 1, 2025 - August 31, 2026

All residents over the age of 18 who reside in Collin County and who fall within 100% of Federal Poverty Level Income, resource, residency, citizenship and household composition criteria established in the Collin County Indigent Care Program and who have no other equivalent public or private health care benefits, may be eligible for medically necessary health care benefits as mandated by the State of Texas pursuant to the programs and services offered by Collin County Indigent Program.

Potentially eligible residents may include:

- US Citizens
- Permanent Residents
- Individuals whose household composition makes them ineligible for Medicaid through the State of Texas
- Individuals who countable gross income minus work deductions does not exceed the minimum Federal Poverty Income Level (FPIL) of 100%
- Individuals whose resource standards approximate the State of Texas' TANF standards

Eligibility determination will be made within 14 (fourteen) business days after the date a completed application and all required documentation is received by Collin County Indigent Program office.

A complete application will include but may not be limited to the following types of verification:

- Identification for each member of the applying household
- Proof of marital status
- Resources identification, to include automobile registration or title, property tax statement, savings account/CD statements, etc.
- If applicant is a sponsored immigrant, a copy of the I-864 affidavit of support, name and address of the sponsor, proof of resources provided to applicant from the sponsor, the date the sponsored immigrant became a permanent resident, alien registration number, address, and date of birth
- Income and resources of all sponsors (and the sponsor's spouse if applicable) who executed an affidavit of support on behalf of a sponsored alien will be used to determine applicant's eligibility
- Proof of income or lack of income to include verification of support by friends, family or other sources, pay stubs, food stamp printout, self-employment records, etc.
- Proof of County residency
- Proof of registration with Texas Workforce Commission (some exemptions may apply)

Applicants must provide all requested information and documentation in order to determine eligibility or applicant will be denied eligibility for assistance. Background checks will be completed. Applicants have the right to appeal adverse decisions regarding eligibility.

Additional information applicable to sponsored immigrants: Collin County considers the benefits given to applicants to be a means-tested public benefit. Therefore, Collin County reserves the right to seek reimbursement from a Sponsor who signed an I-864 or any Affidavit of Support on behalf of an immigrant who receives any benefits from Collin County. Collin County shall use all legal rights available to seek reimbursement from the Sponsor.

Collin County Indigent Program
825 N. McDonald Street, Suite 110
McKinney, Texas 75069
Phone: (972) 548-4702

Applications can be mailed directly to you by calling the phone number listed above. Additionally, applications can be found on the Collin County website at www.co.collin.tx.us by clicking on the County Directory and choosing Health Care Services and refer to Indigent Program Application under Links and Resources.

Collin County Indigent Program does not discriminate on the basis of age, race, or gender in administering the Indigent Health Care Program.

Applicant (print name) Applicant signature Date