LONE STAR
FAMILY HEALTH CENTER
CONROE FAMILY MEDICINE RESIDENCY PROGRAM

605 South Conroe Medical Drive, Conroe, TX 77304
Main: 936-539-4004 & Fax: 936-521-5997

Requirements for Sliding Fee Scale Applications

The information below is required by the Eligibility Department at Lone Star Family Health Center to determine if you qualify to receive discounted services that can be provided under the Sliding Fee Scale program:

1. Completed application that includes the names of all persons living at the address.
2. A copy of a current driver's license, birth certificate, passport, voter registration card, and/or other ID card from your country of origin.
3. Three (3) months of bank statements (checking and/or savings).
4. A copy of most recent light bill
5. Proof of income (even if not currently employed). This can be given through the following documents:
    a. 2-3 current paycheck stubs
    b. A typed and notarized letter from the applicant stating your current wages per week if you are paid cash for services and not able to provide paycheck stubs
    c. A typed and notarized letter from your employer stating your dates of employment and wages if you are paid cash and not able to provide paycheck stubs
    d. The previous year tax return submitted to the IRS – if self employed
    e. If unemployed, please provide earning record
    f. Income of the person(s) who are 18 years or older who live with you
    g. A pre-paid paycard statement or transaction record if you are paid by paycards
    h. Food stamp award letter and award letter for social security, disability, and retirement
    i. Child support letter

Please note that we follow the Federal guidelines established by the U.S. Government to determine your eligibility. ***Falsification of any information and/or documentation will disqualify you from receiving any services under Sliding Fee Scale.*** Please sign and date below stating that you understand the requirements of this program.

By signing this document I authorize Lone Star Family Health Center to obtain a credit report to assist in determining Sliding Fee Scale Eligibility.

_____ _____

Applicant's Signature Date

_____ _____

Applicant's Printed Name Applicant's Date of Birth

Name:
Address:
City, State:
Zip Code:
Telephone:
Social Security #:
Date of Birth:
Chart Number:

Lone Star Community Health Center
605 S. Conroe Medical Dr
Conroe, TX 77304

Sliding Fee Eligibility Form

It is necessary for Lone Star Community Health Center to collect the requested information so a discount on your medical expenses can be provided. This information will be kept on file in strict confidence. You must renew your application every six months. Your household size and annual household income will be used to calculate the level of your discount based on the Federal Poverty Income Level guidelines.

Today's Date: _____ Number of people living at your address? _____

What is your marital status? ☐ Married ☐ Widow(er) ☐ Single ☐ Divorced ☐ Separated

Presumptive Income	You	Your Spouse	Your Children	Other Person	Total Household Income

Amount of Household Income?	You	Your Spouse	Your Children	Other Person	Total Household Income

Place of Employment?	You	Your Spouse	Your Children	Other Person

Do you have a savings account? Yes ☐ No ☐

Do you have a checking account? Yes ☐ No ☐

Do you receive any income from any of the following sources, and if so, how much?

Sources	You	Your Spouse	Your Children	Other Person	Total Sources
Social Security					
Public Assistance					
Retirement Pension					
Food Stamps/ SNAP					
Rental Income					
Child Support					
Other (Specify)					

Give Names, DOB, and SSN of all individuals living at the address.

Name:	Sex	Age	Date of Birth:	Social Security Number:

I declare the above information is true and have given Lone Star Family Health Center permission to investigate any information given in this application. I understand that this information will be kept in strict confidence.

Signature:	Date:	*Clinic Purpose Only* Income Code:

LONE STAR
FAMILY HEALTH CENTER
CONROE FAMILY MEDICINE RESIDENCY PROGRAM

SLIDING FEE SCALE APPLIACTION FORM
APPROVAL/DENIAL FORM

_____ _____
Applicant/ Patient Name **Date**

APPROVED APPLICATION

Application Approved On: _____ _____ **Medical** _____ **Dental** _____ **Prescription**

SFS% _____ **COPAY** _____ **Comments:** _____

Recertification Date: _____ _____

☐ **Medicaider** _____

DENIED APPLICATION

Application Denied On: _____

Reason for Denial:
_____ **Exceeds Income Requirements**

_____ **Additional Information Required**

_____ **Lack of Cooperation**

☐ **PRESUMPTIVE**

SFS% _____ **COPAY**_____

Recertification Date _____

APPROVAL/ DENIAL REVIEW BY:

_____
Eligibility Coordinator **Date**

_____
Karrie Golden, Chief Operating Officer **Date**

TEXAS Department of State Health Services

Texas Department of State Health Services
Breast and Cervical Cancer Control Program
Comprehensive Case Management Form

Contractor, Clinic Name:	Case Manager:	Patient ID Number:	Chart Number:

CLIENT INFORMATION

Name:	Date of Birth:	Social Security No.:	Daytime Phone:

Screening/Diagnosis results:	Other Contact Information:			
	Name:	Address:	Phone:	Relationship:

ASSESSMENT DATE

Social Resources Assessment	Medical Care/Service Status	Education and Counseling Assessment
☐ Social Support (e.g., Family, Church, Friends) ☐ Other	☐ Medical Home ☐ Transportation ☐ Language Barrier ☐ Unable to leave work ☐ Child Care ☐ Making Appointment ☐ Financial Resources ☐ Alternative Healing ☐ Other	☐ Concern about procedure (e.g., discomfort, pain) ☐ Embarrassment ☐ Fear of cancer ☐ Overwhelmed by information ☐ Feelings of anger, sadness ☐ Relationship with spouse/friends ☐ Intimacy/sexual concerns ☐ Body image ☐ Cost of procedures ☐ Loss of employment ☐ Other

SERVICE PLAN DATE

Identified Need	Service/Referral	Provider	Date of Initial Svc./Ref.	F/U Date	Outcome of Service/Referral

STATEMENT OF UNDERSTANDING

I understand that my participation in the BCCS means that I agree to additional evaluation and/or treatment if any of my test results are abnormal.

(Signed):_____ Date:_____

F04-11953

BREAST AND CERVICAL CANCER SERVICES (BCCS)
ENROLLMENT AND AUTHORIZATION FORM

New to the BCCS program: Yes / No

PATIENT INFORMATION

LAST NAME _____ FIRST NAME _____ MI _____ DATE OF BIRTH _____ SOCIAL SECURITY # _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

COUNTY OF RESIDENCE _____ HOME PHONE NUMBER _____ CELL PHONE NUMBER _____

ELIGIBILITY INFORMATION

Household Income before Taxes: $_____ annual/monthly

Number o f People living in the household: _____ Do have Medical Insurance: Yes / No

PERSONAL INFORMATION

Best time to call: Morning / Afternoon May we leave a message? Yes / No

Birth County: USA / Other (please specify):_____ Are you Latina or Hispanic: Yes / No

Primary Language Spoken: English / Spanish / Other (please specify):_____

What race are you: White / Pacific Islander / Black or African American / Asian / Native American

What is the highest grade of school you have completed? (number of years in school):_____

PATIENT CONSENT

I, _____, HEREBY AUTHORIZE MY INFORMATION TO BE ENTERED INTO THE MED-IT DATA COLLECTION SYSTEM. I CONSENT TO TREATMENT AT THE AGENCY. I ALSO UNDERSTAND THAT MY PARTICIPATION IN THE BCCS MEANS THAT I AGREE TO ADDITIONAL EVALUATION AND/OR TREATMENT IF ANY OF MY TEST RESULTS ARE ABNORMAL.

PATIENT SIGNATURE _____ DATE _____

FOR OFFICE USE ONLY

BCCS AGENCY AND CLINICAL SITE: 078—LONE STAR FAMILY HEALTH CENTER
DATE OF COMPLETED APPLICATION:_____

DSHS Family & Community Health Services Division
INDIVIDUAL Eligibility Form Instructions

PART I - APPLICANT INFORMATION

Fill in the boxes with your information.

a) Check all the boxes that apply.

b) Check *yes* or *no*.

c) Check all the boxes that apply:

- *CHIP (Children's Health Insurance Program) Perinatal*
- *Medicaid for Pregnant Women*
- *SNAP (Supplemental Nutrition Assistance Program)*
- *WIC (Special Supplemental Nutrition Program for Women Infants and Children)*
- *None*

If you selected one of these benefits or health care coverage programs and you are able to provide proof of current enrollment, you may be adjunctively (automatically) eligible for a DSHS Family & Community Health Services Division program and able to skip Part II and III on this application, if your agency does not collect a co-pay. (Exception -- Adjunctive eligibility does not apply to applicants seeking Title V services.)

PART II – HOUSEHOLD INFORMATION

Fill in the box with the number of people in your household. This number will include you and anyone who lives with you for whom you are legally responsible.

How to determine your household:

- If you are married (including common-law marriage), include yourself, your spouse, and any mutual or non-mutual children (including unborn children).
- If you are not married, include yourself and your children, if any (including unborn children).
- If you are not married and you live with a partner with whom you have mutual children, count yourself, your partner, your children, and any mutual children (including unborn children).

Applicants 18 years and older are adults. Do not include any children age 18 and older, or other adults living in the house, as part of the household. Minors should include parent(s)/legal guardian(s) living in the house.

PART III - INCOME INFORMATION

List all of your household's income in the table. Include the following: government checks; money from 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 benefits.

Fill in the table with the following information:

1st column: The name of the person receiving the money.
2nd column: The name of the agency, person, or employer who provides the money.
3rd column: The amount of money received per month.

PART IV - APPLICANT AGREEMENT

Rights and Responsibilities:

If the applicant omits information, fails or refuses to give information, or gives false or misleading information about these matters, he/she may be required to reimburse the State for the services rendered if the applicant is found to be ineligible for services. The applicant will report changes in his/her household/family situation that affect eligibility during the certification period (changes in income, household/family members, and residency). *(MBCC clients are not required to report changes in income, household, and residency)*

The applicant understands that, to maintain program eligibility, he/she will be required to reapply for assistance at least every twelve months *(not applicable to MBCC)*.

The applicant understands he/she has the right to file a complaint regarding the handling of his/her application or any action taken by the program with the HHSC Civil Rights Office at 1-888-388-6332.

The applicant understands that criteria for participation in the program are the same for everyone regardless of sex, age, disability, race, or national origin.

With few exceptions, the applicant has the right to request and be informed about information that the State of Texas collects about him/her. The applicant is entitled to receive and review the information upon request. The applicant also has the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 522.023 and 559.004)

Read the **Rights and Responsibilities** above. Check *yes* or *no*.
Sign and date on the lines. If a person helped you complete the application, he/she should sign, state the relationship to you, and date on the lines.

PART V – PROVIDER ELIGIBILITY CERTIFICATION (to be completed by provider)

(1) Check the appropriate box (*yes* or *no*) for Texas resident. (2) Total the *amount received per month* to fill in the *Total monthly household income* box. (3) Calculate the client's household FPL using the applicable DSHS program policy (include applicable deductions) and fill in the *Household FPL* box. Check the appropriate box (*yes, no, waived,* or *n/a*) for (4) *Proof of* income and (5) *Verification of adjunctive eligibility*.

If client is presumptively eligible, fill in the light gray box. (6a) Check the appropriate box (*yes, no,* or *n/a*) for *Presumptively eligible*. Once the client completes the requirements for full eligibility, (6b) check *Yes* for *Full eligibility met* and fill in the (6c) *Full eligibility met date* box.

(7) Check the appropriate box (*yes*, *no*, or *n/a*) for each program regarding the client's eligibility. If yes, fill in the client's co-payment amount for the program based on their household and income information.

Use the space provided in *Notes* to document other appropriate information concerning eligibility and screening.
Fill in the *Eligibility effective date* box in the top right corner of Part V. Fill in the *Name of Agency*, sign, and date.

DSHS Family & Community Health Services Division
INDIVIDUAL Eligibility Form

TEXAS Department of State Health Services

PART I - APPLICANT INFORMATION

Name (Last, First, Middle)	Telephone Number		Email Address		
Texas Residence Address (Street or P.O. Box)	City	County	State	ZIP	
SSN (optional)	Date of Birth	Age	Race	Ethnicity	Sex

a) Please contact me by: (check all that apply) ☐ Mail ☐ Phone ☐ Email

b) Do you have comprehensive health care coverage (Medicaid, Medicare, CHIP, health insurance, VA, TRICARE, etc.)? ☐ Yes ☐ No

**If yes, DSHS' authorized representative will submit a claim for reimbursement from your insurer for any benefit, service or assistance that you have received.*

c) Which benefits or health care coverage do you receive? (check all that apply)

☐ CHIP Perinatal ☐ SNAP ☐ None

☐ Medicaid for Pregnant Women ☐ WIC

PART II – HOUSEHOLD INFORMATION

Fill in the box with the number of people in your household. This number will include you and anyone who lives with you for whom you are legally responsible. Minors should include parent(s)/legal guardian(s).

How many people are in your household? ☐

PART III - INCOME INFORMATION

List all of your household's income below. Include the following: government checks; money from 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 benefits.

Name of person receiving money	Name of agency, person, or employer who provides the money	Amount received per month

PART IV - APPLICANT AGREEMENT

I have read the **Rights and Responsibilities** statements in the *instructions* section of this form. ☐ Yes ☐ No

The information that I have provided, including my answers to all questions, is true and correct to the best of my knowledge and belief. I agree to give eligibility staff any information necessary to prove statements about my eligibility. I understand that giving false information could result in disqualification and repayment.

I authorize release of all information, including income and medical information, by and to the Texas Department of State Health Services (DSHS) and Provider in order to determine eligibility, to bill, or to render services to me.

Signature – Applicant _____ Date _____

Signature – Person who helped complete this application _____ Relationship to Applicant _____ Date _____

PART V – PROVIDER ELIGIBILITY CERTIFICATION (to be completed by provider)

Eligibility effective date / /

1. Texas resident	☐ Yes	☐ No	
2. Total monthly household income	$		
3. Household FPL	%		
4. Proof of income	☐ Yes	☐ Waived	
5. Verification of adjunctive eligibility	☐ Yes	☐ No	☐ n/a
6a. Presumptively eligible	☐ Yes	☐ No	☐ n/a
6b. Full eligibility met	☐ Yes		
6c. Full eligibility met date	/ /		

7. Is the client eligible for the following program(s)?

	Yes	No	n/a	Co-payment amount (if applicable)
BCCS	☐	☐	☐	$
DSHS FP	☐	☐	☐	$
EPHC	☐	☐	☐	$
PHC	☐	☐	☐	$
Title V/MCH	☐	☐	☐	$

Notes:

Name of Agency _____ Signature – Agency / Staff Member _____ Date _____