(Para espanol vea el dorso)

GOLDEN PLAINS COUMMUNITY HOSPITAL
100 Medical Drive, Borger, TX 79007
(806) 273-1100

Date:_____

Patient:_____

Hospital Account #:_____

Dear Patient:

Attached you will find the Golden Plains Community Hospital Charity Care Program Application and the application for Hutchinson County Indigent Care Program. Completion of these applications will enable us to present your account for consideration of financial assistance for your hospital bill(s). The discount, if approved, is applied after any insurance(s) have paid in full.

We understand your desire for privacy. Accordingly, except for verification purposes, the information included in your application will be treated as confidential information. It will only be shared within GPCH Resources on a need to know basis.

Please complete each item on each of the applications. If you need additional space for any explanations, please utilize the back of the application.

Please provide copies of the following:

1. Proof of income and/or 3 prior weeks pay stubs for ALL adults in the home
2. Copy of Drivers License for ALL adults in the home
3. Copy of social security cards for ALL adults in the home
4. Copy of insurance cards, Medicaid / Medicare cards of anyone in the home
5. Copy of utility bills (gas, water, electric)
6. 2 prior months bank statements (checking, savings, cd's, ira's)
7. Copy of denial letter from Medicaid
8. Federal Income Tax Return for the previous year
9. Household Letter *

After processing your application you will be notified in writing as to the status of your request for assistance.

Thank you for cooperation in this matter.

Latisha Scott
Indigent Care/Financial Assistance Coordinator
806-467-5730

*If someone assists you with your household bills, please have them write a letter regarding what they pay, how much they pay, how often they pay the bills for you and to whom they give the money to (example they give the money to you to pay the bills or they give the money to the utility company).

(Para espanol vea el dorso)

Golden Plains Community Hospital
100 Medical Drive
Borger, TX 79007
Phone: (806) 273-1209 Fax: (806) 467-5726

Patient Name:_Last_____First_____MI_____

Physical Address:_____City_____State_____Zip_____

Social Security#_____DOB:_____Hospital Acc#_____

Married_____Single_____Divorced_____Widowed_____Separated_____

Do you have minor children (under 18yrs)?	Yes	No	
Do they live with you?	Yes	No	
Is the patient employed?	Yes	No	
Spouse employed?	Yes	No	N/A
Do you have medical insurance?	Yes	No	
Are you on disability?	Yes	No	

Family Members

Spouses Name_____ Date of birth_____

Child:_____Date of birth_____

Child:_____Date of birth_____

Child:_____Date of birth_____

Child:_____Date of birth_____

(Para espanol vea el dorso)

Income (Monthly Amount):	Gross	Net
Patient	$_____	$_____
Spouse	$_____	$_____
Dependants	$_____	$_____
Public Assistance	$_____	$_____
Food Stamps	$_____	$_____
Social Security	$_____	$_____
Unemployment	$_____	$_____
Worker's Compensation	$_____	$_____
Child Support	$_____	$_____
Total	**$**_____	**$**_____

Assets

Checking Account	$_____
Savings Account	$_____
Other Investments	$_____

Are you currently applying for Medicaid Benefits?	Yes	No
Are there any potentially liable third-parties responsible for your accident/injury/illness?	Yes	No
Is anyone assisting you with payment of your hospital bills?	Yes	No

Who is assisting you? _____

How much assistance are you receiving? _____

(Para espanol vea el dorso)

I understand that Golden Plains Community Hospital (GPCH) is under no legal obligation to provide Financial Assistance. It doses so in order to help members of the community who are actively trying to help themselves. I understand that GPCH may verify the financial information contained in this application in connection with the hospital's evaluation of this application. I am aware that this information will be used to determine my eligibility for charity assistance and that the falsification of information in this application may result in denial of charity care assistance. I affirm that the above information is true and correct to the best of my knowledge. I have not made any false statements, error or omissions. If any information I have given proves to be untrue, I understand that this constitutes fraud and that the hospital will seek legal action as deemed necessary.

_____ _____

Signature of Person Making Request, if patient Date

_____ _____

Signature of Person Making Request, If NOT Patient Relationship

_____

Home Telephone Number

(used only if we need to clarify information)

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? Si 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 vehículos 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 "Sí," ¿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; manutención de niños, 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.

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

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

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

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**

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.

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.

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.

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.

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.

Me han dicho 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 must 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, se requiere 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

APPLICATION FOR HEALTH CARE ASSISTANCE

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:

Where You Live and Plan To Continue Living
Possible Proof: Mail that you received at your address; school records; voting records; property tax, rent or mortgage receipts; Texas driver's license; other official identification.

What You Own and What It Is Worth
Possible Proof: Property tax appraisals, estimates from car dealers, ads selling similar items, statements from real estate agents, bank statements.

Your Income
Possible Proof: Pay check stubs, pay checks, W-2 tax forms or income tax returns, sales records, statements from employers, award letters, legal documents, statements from persons giving you money.

Other Health Care Coverage
Possible Proof: Award or claim letters, insurance policies, court documents, other legal papers.

Information on social security numbers should be given if this information is available. Information on sex (Male/Female) is voluntary. These types of 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, if you have answered all the questions on the application, and if you 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.

SOLICITUD DE ASISTENCIA DE ATENCIÓN MÉDICA

El Programa de Atención Médica para Indigentes del Condado (CIHCP) ayuda a la gente a pagar los servicios médicos que necesita. La elegibilidad para esta ayuda depende de los ingresos del solicitante, sus posesiones, el lugar donde vive, otra ayuda que recibe o que podría recibir, y otras consideraciones. Asegúrese de:

1.) Poner su nombre y dirección;
2.) Firmar y fechar la tercera página de la solicitud; y
3.) Conteste tantas preguntas que pueda sobre esta solicitud.

Entregue su solicitud, o échela al correo, hoy mismo aun si no ha podido contestar todas las preguntas.

SUS RESPONSABILIDADES

Puede que le pidan pruebas de lo que escriba en su solicitud o de lo que diga en su entrevista. Si necesita ayuda para obtener las pruebas, la persona que le haga la entrevista le puede ayudar. Estos son algunos ejemplos de información que puede que tenga que probar y de documentos que le puede servir de prueba:

El Lugar Donde Vive O Donde Tiene Su Hogar Permanente
Posibles Pruebas: Correo que recibió en esa dirección; expedientes de de la escuela; registros de votante; recibos de impuestos, renta o hipoteca; la licencia para manejar de Tejas; otra identificación oficial.

Las Posesiones Que Tiene Y Cuanto Vale Cada Una
Posibles Pruebas: El avalúo para impuestos sobre la propiedad, avalúos hechos por vendedores de carros, anuncios de la venta de artículos parecidos, declaraciones de agentes que venden propiedades, estado de cuentas del banco.

Los Ingresos Que Tiene
Posibles Pruebas: Talones del cheque de paga, cheque de paga, comprobante de salaries e impuestos (Forma W-2), declaración de impuesto federal, el historial de ventas, declaraciones de empleadores, carta de concesión, documentos legales, declaraciones de personas que le dan dinero.

Otra Cobertura Para Gastos Médicos
Posibles Pruebas: Cartas de reclamación o de concesión, pólizas de seguros, papeles de la corte u otros documentos legales.

Si tiene a su disposición los números de seguro social, debe darlos. La información sobre el sexo (Hombre/Mujer) es voluntaria. Esta información no afectará su elegibilidad.

Debe dar información sobre seguros médicos y de cualquier tercero que tenga la responsabilidad de pagar los servicios médicos pagados por el condado en beneficio de usted y miembros de la unidad familiar. Al firmar y presentar esta solicitud, usted se compromete a darle al condado el derecho de recuperar el costo de servicios de un tercero.

Pueden pedirle que solicite Medicaid, Asistencia Temporal a Familias Necesitadad (TANF), o Seguridad de Ingreso Suplemental (SSI). Si le han pedido que solicite beneficios de alguno de estos programas o si usted ya los solicitó y está esperando la respuesta, su solicitud de CIHCP puede ser detenida hasta que decidan que no es elegible para los programas mencionados. Si no es elegible para estos programas, si ha contestado todas las preguntas de la solicitud, y si ha dado todos los comprobantes que piden, ya pueden procesar su solicitud. Entonces, el CIHCP tiene un plazo de 14 dias para determinar su elegibilidad.

Después de entregar su solicitud, usted debe reportar dentro de un plazo de 14 dias cualquier cambio de dirección, ingreso, recursos, el número de personas que viven con usted, o si solicita o recibe Medicaid, TANF, o SSI.

I understand that the indigent care program will not pay for the following treatments.

1. Elective Surgeries
2. Prosthetic and orthopedic devices
3. Social and Educational counseling
4. Diet consults
5. Hearing aids
6. Chiropractors
7. Outpatient Home oxygen
8. Dental
9. Vision
10. Mental disorder
11. Birth control (can obtain for free at United Pharmacy)
12. Home health
13. Physical therapy (one time visit only, must have a referral for you primary care physician)
14. Braces, Crutches, or Slings (foot, ankle, leg, knee, waist, back, shoulder, arm, elbow, wrist, hand, neck, or head)

***<u>**Patients presenting to his or her emergency room with non-emergent conditions will be held financially responsible for treatment without regard to Indigent eligibility status.**</u> ***

Signature Date

HUTCHINSON COUNTY HOSPITAL DISTRICT INDIGENT CARE PROGRAM GUIDELINES

In order for the Indigent Care Program (ICP) to be cost effective and assure non-discriminatory administration, the following guidelines MUST be adhered to:

- All clinic and physician office visits must be medically necessary. Routine services (i.e. physicals, exams, pap smears, and breast exams) are NOT covered under the ICP.
- A primary clinic will be assigned to each ICP client (Golden Plains Rural Health Clinic or Fritch Medical Clinic). Services by another healthcare provider, including another clinic, are allowed only by assigned clinic referral AND approved by the ICP coordinator. The clinic PA or physician reserves the right to refuse service to any ICP client. Clients are not allowed to go back and forth between clinics unless reassigned by the ICP coordinator, and the client is issued a new ICP card.
- The ICP Program is a Hutchinson County Hospital District (HCHD) based program and all medical services must be obtained within the HCHD if possible. Any healthcare services obtained outside the HCHD will be denied unless PRIOR approval is obtained.
- The ICP will cover visits to the Golden Plains Community Hospital (GPCH) Emergency Department or nearest hospital Emergency Room available only if the reason for the visit is an emergent condition. The ICP will NOT cover non-emergent visits.
- All lab work, x-rays, EKGs and any other diagnostic services must be performed at GPCH. Any medical service available within the HCHD must be performed within the HCHD. Services not available within the HCHD MUST have prior approval by the ICP coordinator and be of an emergent basis.
- A drug voucher must be obtained prior to going to the pharmacy for medications. The client is limited to no more than three prescriptions vouchers within a 30 day period. Drugs are prescribed by the primary clinic or an approved referral. A drug voucher can be obtained from the ICP coordinator.
- MRIs, CT scans, sonograms, Lithotripsy and all surgeries, etc, must have PRIOR approval by the ICP coordinator. If prior approval is not obtained, the client will be responsible for payment in full.
- Failure to adhere to the ICP requirements/mandates or abusive utilization practices will result in disciplinary action up to and/or including discharge from the program.
- The maximum liability for each fiscal year for health care services provided is:
    - $30,000; or
    - The payment of 30 days of hospitalization or treatment in a skilled nursing facility, or both, or $30,000, whichever occurs first.

Please call the ICP coordinator if you have any questions about these guidelines (806)467-5730.

HUTCHINSON 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 Indigent Health Care (IHC) staff has reason to believe that fraud may have occurred, the following procedures shall be followed:

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

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

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

4. If the dispute remains unresolved, the IHC staff shall schedule an administrative hearing to allow the client to defend himself/herself by confronting any adverse witness and by presenting his/her own argument and evidence. The IHC staff must disclose any evidence used to prove its case to the client so he/she has an opportunity to dispute it. The client shall be given 30 days written notice of the date of the administrative hearing. The burden of proof lies with the IHC program. If the client does not appear at the administrative hearing, the IHC program coordinator may proceed with presentation of her case only if proof of notice is present.

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 Hutchinson County for the cost of benefits they were ineligible to receive.
- Shall be administratively ineligible for Hutchinson County (IHC) benefits in accordance with the IHC handbook.
- May be subject to prosecution under the Texas Penal Code.

Signature

Date

Golden Plains Community Hospital

100 Medical Drive

Borger, TX 79007

Charity Discount Program for Non-Insured Patients PRIOR to Services rendered

It is the policy of Golden Plains Community Hospital that for all NON-emergent services, the patient and/or responsible party is required to pay the total ESTIMATED charges **PRIOR TO OR AT THE TIME OF SERVICE**. The minimum acceptable deposit for NON-insured patients is:

50% of the ESTIMATED charges

However, the charity program helps those NON-insured patients. After filling out the appropriate forms and all the supporting documents are obtained, the charity program coordinator will be able to discount your account based on your income, family size and estimated charges. You will be required to pay 50% of YOUR portion **PRIOR TO OR AT THE TIME OF SERVICE.**

Total **ESTIMATED** cost for your Procedure is: ___$_____

The charity program coordinator has reviewed your account and found that you qualify for a discount of _____%.

Your ESTIMATED portion of the procedure will be (after the discount): _____.

I understand that I will owe $_____ (which is 50% of my ESTIMATED portion) **PRIOR TO OR AT THE TIME OF SERVICE.** The remaining balance must be set up on a payment plan and be paid within a year to two years. Monthly payments MUST be made to the remaining balance or the **entire balance (before the discount)** for your procedure will go to collections.

_____ _____

Patient/Responsible Party

Latisha Scott, Charity Program Coordinator – (806) 467-5730

_____

Date