Tom Green County

Indigent Health Care

Procedures and Guidelines

Effective September 1, 2019

Commissioners' Court Reviewed/Approved

TOM GREEN COUNTY TREASURER

Tom Green County Indigent Health Care Procedure & Guidelines

SECTION 1
PLAN ADMINISTRATION

INTRODUCTION

Tom Green County Indigent Health Care (TGC IHC) program is governed by the Texas Chapter 61, *Health and Safety Code*.

TGC Commissioners' Court, and the TGC Treasurer acting as IHC Director, is committed to ensure that the needy inhabitants of the county receive quality health care services in an equitable and non-discriminatory manner through the county indigent care plan. In addition, we believe quality medical care services can be provided to the county's needy inhabitants in a manner that is fair and equitable, efficient and without undue expense of local taxpayer dollars, which fund such care.

These indigent care plan policies are approved annually by TGC Commissioners' Court and intended to provide guidelines and rules for the qualification and enrollment of participants into the county's indigent care plan, per the guidelines provided by the Texas Department of State Health Services (TDSHS) and pursuant to the Indigent Health Care and Treatment Act (Texas Chapter 61, *Health and Safety Code*). In addition, these policies are intended to ensure the delivery of quality and medically necessary health care services to plan participants in a fair and non-discriminatory manner.

These policies are not intended to apply to persons who do not qualify for the program pursuant to Chapter 61, *Health and Safety Code*.

These indigent care plan policies are intended to cover the delivery of health care services to indigent residents of the county. Employees of TGC are not eligible for the plan; therefore, these policies do not create benefits or rights under ERISA, COBRA or other employment-related statutes, rules or regulations. These policies are intended to comply with medical privacy regulations imposed under HIPAA and other state regulations, but are superseded by such statutes to the extent of any conflict. Compliance with ADA and other regulations pertaining to disabled individuals shall not be the responsibility of the county, but shall be the responsibility of those medical providers providing services to the county's needy inhabitants. As a county, only certain provisions of the Indigent Health Care and Treatment Act apply to services provided by the county, including these policies.

These policies may be amended from time to time by official action of the TGC Commissioners' Court. Chapter 61, *Health and Safety Code*, may be found online at: http://www.statutes.legis.state.tx.us/Docs/HS/htm/HS.61.htm

Guidelines

The purpose of the guidelines is to establish the eligibility standards and application, documentation, and verification procedures for basic and extended health care services.

TECHNICAL ASSISTANCE

Tom Green County Indigent Health Care Office
19 N. Irving St., San Angelo, Texas 76903
Office: (325) 659-6504
Fax: (325) 655-4863
Public Email: indigenthealthcare@co.tom-green.tx.us
Provider Email: IHCNotify@co.tom-green.tx.us

Public Office Hours

Monday – Thursday	8:00 a.m. to 11:30 a.m. and 1:00 p.m to 4:00 p.m.
Friday	8:00 a.m. to 11:30 am. by Appointment Only
Closed	Lunch, Holidays, and Training Days

Staff

Indigent Health Care Director	Dianna Spieker, Tom Green County Treasurer
Supervisor	Chastin Powell
Caseworker	Sandra Crespo
Caseworker	Amy Bellido

Public Notice

Not later than September 1st of each year, the county shall specify the procedure it will use to determine eligibility and the documentation required to support a request for assistance and shall post on the county website said procedures to notify the public of the procedure.

The Technical Assistance page of this handbook may be updated at any given time without notice.

Disclaimer: Not all situations are covered in this manual and thereby the Indigent Health Care Director has administrative control over the Tom Green County Indigent Health Care procedures and is authorized to make management decisions for special circumstances, as deemed necessary and cost effective.

GENERAL ADMINISTRATION

Tom Green County Responsibility

The county will:

- Administer a county wide Indigent Health Care program
- Serve all of and only Tom Green County's indigent inhabitants
  - Indigent inhabitants is defined by the county as any individual who meets the eligibility criteria for the plan as defined herein and who meet an income level up to 21% of FPIL – *See Appendix V*
- Provide basic health care services to eligible TGC residents who have a medical necessity for health care
- Follow the policies and procedures described in this document, save and accept that any contrary and/or conflicting provisions in any contract or agreement approved by the TGC Commissioners' Court shall supersede and take precedence over any conflicting provisions contained in these guidelines *(See Exclusions and Limitations section below)*
- Establish an application process
- Establish procedures for administrative hearings that provide for appropriate due process, including procedures for appeals requested by clients that are denied
- Adopt reasonable procedures:
  - For minimizing the opportunity for fraud,
  - For establishing and maintaining methods for detecting and identifying situations in which a question of fraud may exist, and
  - For administrative hearings to be conducted on disqualifying persons in cases where fraud appears to exist.
- Maintain the records relating to an application at least until the end of the third complete state fiscal year following the date on which the application is submitted
- The IHC office will validate the accuracy of all disclosed information, especially information that may appear fraudulent or dishonest. Additionally, any applicant may be asked to produce additional information or documentation for any part of the eligibility process
- Establish an optional work registration procedure that will contact the local Texas Workforce Commission (TWC) office to determine how to establish their procedure and to negotiate what type of information can be provided. In addition, must follow the guidelines below:
  1. May allow an exemption from work registration if applicants or eligible residents meet one of the following criteria:
     - Receive food stamp benefits,
     - Receive unemployment insurance benefits or have applied but not yet been notified of eligibility,
     - Physically or mentally unfit for employment,
     - Age 18 and attending school, including home school, or on employment training program on at least a half-time basis,
     - Age 60 or older,
     - Parent or other household member who personally provides care for a child under age 6 or a disabled person of any age living with the household,
     - Employed or self-employed at least 30 hours per week,
     - Receive earnings equal to 30 hours per week multiplied by the federal minimum wage,
     - A regular participant or outpatient in a drug addiction or alcoholic treatment or rehabilitation program that prohibits work,
     - Physician's Statement,
     - TWC office determines exempt status,
     - Full time college student, or
     - Three to nine months pregnant with a Physician's Statement.
  2. If a non-exempt applicant or TGC eligible resident fails without good cause to comply with work registration requirements, disqualify them from IHC coverage as follows:
     - For one month or until they agree to comply, whichever is later, for the first non-compliance;
     - For three consecutive months or until they agree to comply, whichever is later, for the second non-compliance; and

- For six consecutive months or until they agree to comply, whichever is later, for the third or subsequent non-compliance.

Behavior of Applicants

Applicants will be expected to follow certain behavioral guidelines throughout the duration of the time they are interacting with IHC staff. This is to ensure the safety of the IHC staff, as well as the applicant.

- Applicants will not be allowed to be violent or aggressive with IHC staff.
- Applicants will not be allowed to try to intimidate the IHC staff.
- Rude or abusive behavior towards IHC staff will not be tolerated.
- Profanity or loud talking is expressly prohibited.
- Applicants are expected to remain cordial and respectful at all times.

IHC staff is here to provide and for the applicant's convenience/comfort. IHC staff will not allow any of the above behavior and will not hesitate to enlist the help of local law enforcement agencies, should any applicant become intolerable by breaking the specific Behavioral Guidelines. Failure to follow the guidelines will result in definitive action and up to and including refusal of coverage or termination of existing benefits.

SECTION 2
ELIGIBILITY CRITERIA

RESIDENCE

General Principles

- Chapter 61, *Health and Safety Code*: http://www.statutes.legis.state.tx.us/Docs/HS/htm/HS.61.htm#61.003
- A person must live in the TGC prior to filing out an application.
  - Pursuant to Texas Health and Safety Code Chapter 61.003(d), A person is not considered a resident of the county if the person attempts to establish residency only to obtain health care.
- Individuals who reside at the male or female Court Residential Unit may not eligible for IHC
  - Pursuant to Texas Health and Safety Code Chapter 61.003(f), A person who is an inmate of a state agency is not considered a resident of the county, only a resident of the State or Federal Government.
- An inmate of the county adult correctional facility or the county juvenile correctional facility will be considered indigent for the duration of their respective incarceration time. They may apply for continued service upon release from stated incarceration facility.
- A person lives in TGC if the person's home or fixed place of habitation is located in the county and they intend to return to the county after any temporary absences.
  - A person does not lose their residency status because of a temporary absence from TGC.
- A person with no fixed residence or a new resident in the county who declares intent to remain in the county is also considered a county resident if intent is proven.
  - Examples of proof of intent can include the following: change of driver's license, change of address, lease agreement, or proof of employment.
- A person cannot qualify for more than one CIHCP from more than one county simultaneously.
- A valid Texas Driver's License or Identification Card reflecting a TGC address will be required to establish residency.
- A Social Security Card will be required for background checks.
- A homeless person may be considered a resident of TGC if they provide a letter supporting their homeless status from an entity that assists homeless persons, and said entity provides mailing address and phone number to use by homeless person.
- A TGC resident who is a student in another county and is intending to return to TGC maybe eligible.

Persons Not Considered Residents

- An inmate or resident of a state school or institution operated by any state agency
- An inmate, patient, or resident of a school or institution operated by a federal agency
- A minor student primarily supported by his parents whose home residence is in another county or state
- A person who moved into the county solely for the purpose of obtaining health care assistance

Verifying Residence

Verification of residence is mandatory for all applicants. Proof may include, but is not limited to:

- Mail addressed to the applicant, spouse, or children
  - PO Boxes are not considered as proof
  - Health care provider bills, invoices, or claims are not considered as proof of residency
  - Correspondence from TGC IHC office is not considered as proof of residency
- Texas Driver's License or other official identification
- Rent, mortgage payment, or utility receipt
- Property tax receipt
- Voting record
- School enrollment records
- Lease agreement

Documenting Residence

A caseworker will determine household and document all additional information/questions that are needed to determine residency. The following documentation may be required, if applicable, for verification purposes in the determining of the household:

- Copy of current lease, dated and with all appropriate signatures
- Copy of PHA/HUD contract
- Copy of current year Tax Return
- Marriage License or Divorce Decree (Official with appropriate signatures and embossed)
- Copy of current Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF) Award letter
- Proof of spouse or dependent child's Medicaid Coverage
- Documentation of joint owned assets or resources (Bank accounts, credit cards, vehicles, land, etc.)
- Other documentation as revealed necessary or required by caseworker on individual case basis

CITIZENSHIP

General Principles

- A person must be a natural born citizen, a naturalized citizen, or a documented alien with a current legal residency status in compliance with state and federal law.

HOUSEHOLD

General Principles

- A household is a person living alone, or two or more persons living together where legal responsibility for support exists, excluding disqualified persons.
- Legal responsibility for support exists between:
  - Persons who are legally married (including common-law marriage),
  - A legal parent and a minor child (including unborn children), or
  - A managing conservator and a minor child

Disqualified Persons

- A person who receives (or is categorically eligible to receive) Medicaid
- A person who receives Temporary Assistance for Needy Families (TANF) benefits
- A person who receives SSI benefits
- A person who receives Qualified Medicare Beneficiary (QMB), Medicaid Qualified Medicare Beneficiary (MQMB), Specified Low-Income Medicare Beneficiary (SLMB), Qualified Individual-1 (QI-1), or Qualified Disabled and Working Individuals (QDWI)
- A Medicaid recipient who partially exhausts some component of his Medicaid benefits

A disqualified person is not a CIHCP household member, regardless of their legal responsibility for support.

One-Person Household

- A person living alone
- An adult living with others who are not legally responsible for the adult's support
- A minor child living alone or with others who are not legally responsible for the child's support
- A Medicaid-ineligible spouse
- A Medicaid-ineligible parent whose spouse and/or minor children are Medicaid-eligible
- A Medicaid-ineligible foster child
- An inmate in a county jail or detention facility (not state or federal)

Group Households

Two or more persons who are living together and meet one of the following descriptions:

- Two persons legally married to each other
- One or both legal parents and their legal minor children
- A managing conservator and a minor child and the conservator's spouse and other legal minor children, if any
- Minor children, including unborn children, who are siblings
- Both Medicaid-ineligible parents of Medicaid-eligible children

Verifying Household

All households are verified and information provided may require additional proof for determination. Proof may include, but is not limited to:

- Lease agreement
- Statement from a landlord, a neighbor, or other reliable source
- Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF) Award letter
- Copy of last year's Tax Return

RESOURCES

General Principles

- A household must pursue all resources to which the household is legally entitled, unless it is unreasonable to pursue the resource. Reasonable time (at least three months) must be allowed for the household to pursue the resource, which is not considered accessible during this time.
- The resources of all household members are considered.
- Resources are either countable or exempt.
- Resources from disqualified and non-household members are excluded, but may be included if processing an application for a sponsored alien.
- A household is not eligible if the total countable household resources exceed:
  - $3,000.00 – when a person living in the home is aged, has disabilities, lives in the home, and meets relationship requirements
  - $2,000.00 – for all other households
- A household is not eligible if their total countable resources exceed the limit on or after the first interview date or the process date for cases processed without an interview.
- In determining eligibility for a prior month, the household is not eligible if their total countable resources exceed the limit any time during the prior month.
- Consider a joint bank account with a non-member as inaccessible if the money in the account is used solely for the non-member's benefit. The household must provide verification that the bank account is used solely for the non-member's benefit and that no household member uses the money in the account for their benefit. If a household member uses any of the money for their benefit, or if any household member's money is also in the account, consider the bank account accessible to the household.

TYPES OF RESOURCES

ALIEN SPONSOR'S RESOURCES

Calculate the total resources accessible to the alien sponsor's household according to the same rules and exemptions for resources that apply for the sponsored alien applicant. The total countable resources for the alien sponsor household will be added to the total countable resources of the sponsored alien applicant. Please refer to Chapter 61, *Health and Safety Code*, §61.012.

BANK ACCOUNTS

Count the cash value of checking and savings accounts unless exempt for another person.

BURIAL INSURANCE (PREPAID)

Exempt up to $7,500 cash value of a prepaid burial insurance policy, funeral plan, or funeral agreement for each certified household member. Count the cash value exceeding $7,500 as a liquid resource.

BURAL PLOTS

Exempt all burial plots.

CRIME VICTIM'S COMPENSATION PAYMENTS

Exempt.

ENERGY ASSISTANCE PAYMENTS

Exempt payments or allowances made under any federal law for the purpose of energy assistance.

EXEMPTION: RESOURCE/INCOME PAYMENTS

If a payment or benefit counts as income for a particular month, count it as a resource in the same month. If you prorate a payment income over several months, do not count any portion of the payment resource during that time. A benefit may not be counted more than once. An amount will either be income or a resource.

Example: Income of students or self-employed persons that is prorated over several months. If the client combines this money with countable funds, such as a bank account, exempt the prorated amounts for the time you prorate it.

HOMESTEAD

Exempt the household's usual residence and surrounding property not separated by property owned by others. The exemption remains in effect if public rights of way, such as roads, separate the surrounding property from the home. The homestead exemption applies to any structure the person uses as a primary residence, including additional buildings on contiguous land, a houseboat, or a motor home, as long as the household lives in it. If the household does not live in the structure, count it as a resource.

- *Houseboats and Motor Homes* – Count houseboats and motor homes according to vehicle policy, if not considered the household's primary residence or otherwise exempt.
- *Own or Purchasing a Lot* – For households that currently do not own a home, but own or are purchasing a lot on which they intend to build, exempt the lot and partially completed home.
- *Real Property Outside of Texas* – Households cannot claim real property outside of Texas as a homestead, except for migrant and itinerant workers who meet the residence requirements.
- *Homestead Temporarily Unoccupied* – Exempt a homestead temporarily unoccupied because of employment, training for future employment, illness (including health care treatment), casualty (fire, flood, state of disrepair, etc.), or natural disaster, if the household intends to return.
- *Sale of a Homestead* – Count money remaining from the sale of a homestead as a resource.

INCOME-PRODUCING PROPERTY

Exempt property that:

- Is essential to a household member's employment or self-employment (**Examples**: tools of a trade, farm machinery, stock, and inventory). Continue to exempt this property during temporary periods of unemployment if the household member expects to return to work.

- Annually produces income consistent with its fair market value, even if used only on a seasonal basis.
- Is necessary for the maintenance or use of a vehicle that is exempt as income-producing or as necessary for transporting a physically disabled household member. Exempt the portion of the property used for this purpose.

For farmers or fishermen, continue to exempt the value of the land or equipment for one year from the date that the self-employment ceases.

INSURANCE SETTLEMENT

Count, minus any amount spent or intended to be spent for the household's bills for burial, health care, or damaged/lost possessions.

LAWSUIT SETTLEMENT

Count, minus any amount spent or intended to be spent for the household's bills for burial, legal expenses, health care expenses, or damaged/lost possessions.

LIFE INSURANCE

Exempt the cash value of life insurance policies.

LIQUID RESOURCES

Count, if readily available. Examples include, but are not limited to: cash, checking accounts, savings accounts, certificates of deposit (CDs), notes, bonds, and stocks.

LOANS (NON-EDUCATIONAL)

Exempt these loans from resources. Consider financial assistance as a loan if there is an understanding that the loan will be repaid and the person can reasonably explain how they will repay it. Count assistance not considered a loan as unearned income (contribution).

LUMP-SUM PAYMENTS

Count lump-sum payments received once a year, or less frequently, as resources in the month received, unless specifically exempt. Countable lump-sum payments include, but are not limited to: lump-sum insurance settlements, lump-sum payments on child support, public assistance, refunds of security deposits on rental property or utilities, retirement benefits, and retroactive lump-sum RSDI.

Effective January 1, 2013, exempt federal tax refunds permanently as income and resources for 12 months after receipt. Exempt the Earned Income Credit (EIC) for a period of 12 months after receipt through December 31, 2018.

Count lump-sum payments received, or anticipated to be received, more often than once a year as unearned income in the month received.

Exception: Count contributions, gifts, and prizes as unearned income in the month received regardless of the frequency of receipt.

PERSONAL POSSESSIONS

Exempt.

REAL PROPERTY

Count the equity value of real property unless it is otherwise exempt. Exempt any portion of real property directly related to the maintenance or use of a vehicle necessary for employment or to transport a physically disabled household member. Count the equity value of any remaining portion, unless it is otherwise exempt.

- *Good Faith Effort to Sell* – Exempt real property if the household is making a good effort to sell it
- *Jointly Owned Property* – Exempt property jointly owned by the household and other individuals not applying for or receiving benefits if the household provides proof that he cannot sell or divide the property without consent of the other owners and the other owners will not sell or divide the property

REIMBURSEMENT

Exempt a reimbursement in the month received. Count as a resource in the month after receipt. Exempt a reimbursement earmarked and used for replacing and repairing an exempt resource. Exempt the reimbursement indefinitely.

RETIREMENT ACCOUNTS

A retirement account is one in which an employee and/or their employer contribute money for retirement. There are several types of retirement plans.

Some of the most common plans authorized under Section 401 (a) of the Internal Revenue Services (IRS) Code are: 401K, Keogh, Roth IRA, and Pension/traditional benefit plan.

- *401(K) plan* – A 401K plan allows an employee to postpone receiving a portion of current income until retirement.
- *Keogh* – A Keogh plan is an IRA for a self-employed individual.
- *Roth Individual Retirement Account (IRA)* – An individual retirement account (IRA) is an account in which an individual contributes an amount of money to supplement his retirement income (regardless of his participation in a group retirement plan).
- *Pension/traditional benefit plan* – A pension or traditional defined benefit plan is employed based and promises a certain benefit upon retirement regardless or investment performance.

Common plans under Section 408 of the IRS Code are: IRA, Simple IRA and Simplified Employer Plan.

- *Simplified Employee Pension (SEP)* – An SEP plan is an IRA owned by an employee to which an employer makes contributions or an IRA owned by a self-employed individual who contributes for himself.

Exclude all retirement accounts or plans established under:

- Internal Revenue Code of 1986, Sections 401(a), 403(a), 403(b), 408, 408A, 457(b), 501(c)(18)
- Federal Thrift Savings Plan, Section 8439, Title 5, United States Code
- Other retirement accounts determined to be tax exempt under the Internal Revenue Code of 1986

Count any other retirement accounts not established under plans or codes listed above.

TRUST FUND

Exempt a trust fund if all of the following conditions are met:

- The trust arrangement is unlikely to end during the certification period
- No household member can revoke the trust agreement or change the name of the beneficiary during the certification period
- The trustee of the fund is either a:
  - Court, institution, corporation, or organization not under the direction or ownership of a household member, or
  - Court-appointed individual who has court-imposed limitations placed on the use of the funds
- The trust investments do not directly involve or help any business or corporation under the control, direction, or influence of a household member. Exempt trust funds established from the household's own funds if the trustee uses the funds
  - Only to make investments on behalf of the trust, or
  - To pay the education or health care expenses of the beneficiary

VEHICLES

Exempt a vehicle necessary to transport physically disabled household members, even if disqualified and regardless of the purpose of the trip. Exempt no more than one vehicle for each disabled member. There is no requirement that the vehicle be used primarily for the disabled person.

Exempt vehicles if the equity value is less than $4,650, regardless of the number of vehicles owned by the household. Count the value in excess of $4,650 toward the household's resource limit.

Refer to *Appendix V*.

- *Income-producing Vehicles* – Exempt the total value of all licensed vehicles used for income-producing purposes. This exemption remains in effect when the vehicle is temporarily not in use. A vehicle is considered income-producing if it:
  - Is used as a taxi, a farm truck, or fishing boat
  - Is used to make deliveries as part of the person's employment
  - Is used to make calls on clients or customers
  - Is required by the terms of employment
  - Produces income consistent with its fair market value

- *Solely Owned Vehicles* – A vehicle, whose title is solely in one person's name, is considered an accessible resource for that person. This includes the following situations:
  - Consider vehicles involved in community property issues to belong to the person whose name is on the title.
  - If a vehicle is solely in the household member's name and the household member claims he purchased it for someone else, the vehicle is considered as accessible to the household member.

    Exceptions: The vehicle is inaccessible if the titleholder verifies (complete documentation is required in each of the situations below):
  - That they sold the vehicle but has not transferred the title. In this situation, the vehicle belongs to the buyer. **Note**: Count any payments made by the buyer to the household member or the household member's creditors (directly) as self-employment income.
  - That they sold the vehicle but the buyer has not transferred the title into the buyer's name
  - That the vehicle was repossessed
  - That the vehicle was stolen
  - That they filed for bankruptcy (Title 7, 11, or 13) and that the household member is not claiming the vehicle as exempt from the bankruptcy. **Note**: In most bankruptcy petitions, the court will allow each adult individual to keep one vehicle as exempt for the bankruptcy estate. This vehicle is a countable resource.

A vehicle is accessible to a household member even though the title is not in the household member's name if the household member purchases (or is purchasing) the vehicle from the person who is the titleholder, or if the household member is legally entitled to the vehicle through an inheritance or divorce settlement.

- *Jointly Owned Vehicles* – Consider vehicles jointly owned with another person not applying for or receiving benefits as inaccessible, if the other owner is not willing to sell the vehicle.
- *Leased Vehicles* – When a person leases a vehicle, they are not generally considered the owner of the vehicle because the:
  - Vehicle does not have any equity value,
  - Person cannot sell the vehicle, and
  - Title remains in the leasing company's name.

Exempt a leased vehicle until the person exercises his option to purchase the vehicle. Once the person becomes the owner of the vehicle, count it as a resource. The person is the owner of the vehicle if the title is in their name, even if the person and the dealer refer to the vehicle as leased. Count the vehicle as a resource.

- *How to Determine Fair Market Value of Vehicles*
  - Determine the current fair market value of licensed vehicles using the average trade-in or wholesale value listed on a reputable automotive buying resource website (i.e., National Automobile Dealers Association (NADA), Edmunds, or Kelley Blue Book). **Note**: If the household claims that the listed value does not apply because the vehicle is in less-than-average condition, allow the household to provide proof of the true value from a reliable source, such as a bank loan officer or a local licensed car dealer.
  - Do not increase the basic value because of low mileage, optional equipment, or special equipment for the handicapped.
  - Accept the household's estimate of the value of a vehicle no longer listed on an automotive buying resource website unless it is questionable and would affect the household's eligibility. In this case, the household must provide an appraisal from a licensed car dealer or other evidence of the vehicle's value, such as a tax assessment or a newspaper advertisement indicating the sale value if similar vehicles.

Determine the value of new vehicles not listed on an automotive buying resource website by asking the household to provide an estimate of the average trade-in or wholesale value from a new car dealer or a bank loan officer. If this cannot be done, accept the household's estimate, unless it is questionable and would affect eligibility. Use the vehicle's loan value only if other sources are unavailable. Request proof of the value of licensed antique, custom made, or classic vehicles from the household if you cannot make an accurate appraisal.

VERIFYING RESOURCES

Verify all countable resources. Proof may include but is not limited to:

- Bank account statements
- Award letters

DOCUMENTING RESOURCES

On Form 101, *Worksheet*, document whether a resource is countable or exempt and why resources are verified.

Penalty for Transferring Resources

A household is ineligible if, within three months before application or any time after certification, they transfer a countable resource for less than its fair market value to qualify for health care assistance. This penalty applies if the total of the transferred resource added to other resources affects eligibility.

Base the length of denial on the amount by which the transferred resource exceeds the resource maximum when added to other countable resources. IHC staff will use the chart below to determine the length of denial.

Amount in Excess of Resource Limit	Denial Period
$0.01 to $249.99	1 month
$250.00 to $999.99	3 months
$1,000.00 to $2,999.99	6 months
$3,000.00 to $4,999.99	9 months
$5,000.00 or greater	12 months

If the spouses separate and one spouse transfers his property, it does not affect the eligibility of the other spouse.

INCOME

General Principles

- A household must pursue and accept all income to which the household is legally entitled, unless it is unreasonable to pursue the income. Reasonable time (at least three months) must be allowed for the household to pursue the income, which is not considered accessible during this time.
- The income of all household members is considered.
- Income is either countable or exempt.
- If attempts to verify income are unsuccessful because the payer fails or refuses to provide information and other proof is not available, the household's statement is used as best available information.
- Income of disqualified and non-household members is excluded, but may be included if processing an application for a sponsored alien.

TYPES OF INCOME

ADOPTION PAYMENTS

Exempt.

ALIEN SPONSOR'S INCOME

Calculate the total income accessible to the alien sponsor's household according to the same rules and exemptions for income that apply for the sponsored alien applicant. The total countable income for the alien sponsor household will be considered unearned income and added to the total countable income of the sponsored alien applicant.

CASH GIFTS AND CONTRIBUTIONS

Count as unearned income, unless they are made by a private, non-profit organization on the basis of need and total $300 or less per household in a federal fiscal quarter. The federal fiscal quarters are January - March, April - June, July - September, and October - December. If these contributions exceed $300 in a quarter, count the excess amount as income in the month received.

Exempt any cash contribution for common household expenses, such as food, rent, utilities, and items for home maintenance, if it is received from a non-certified household member who:

- Lives in the home with the certified household member,
- Shares household expenses with the certified household member, and
- No landlord/tenant relationship exists.

If a non-certified household member makes additional payments for use by a certified member, it is a contribution.

CHILD'S EARNED INCOME

Exempt a child's earned income if the child, who is under age 18 and not an emancipated minor, is a full-time student (including a home schooled child) or a part-time student employed less than 30 hours a week.

CHILD SUPPORT PAYMENTS

Count as unearned income after deducting up to $75 from the total monthly child support payments the household receives.

Count payments as child support if a court ordered the support, or the child's caretaker or the person making the payment states the purpose of the payment is to support the child.

Count ongoing child support income as income to the child, even if someone else living in the home receives it.

Count child support arrears as income to the caretaker.

Exempt child support payments as income if the child support is intended for a child who receives Medicaid, even though the parent actually receives the child support.

- *Child Support Received for a Non-Member* – If a caretaker receives ongoing child support for a non-member (or a member who is no longer in the home) but uses the money for personal or household needs, count it as unearned income. Do not count the amount actually used for or provided to the non-member for whom it is intended to cover.
- *Lump-Sum Child Support Payments* – Count lump-sum child support payments (on child support arrears or on current child support) received, or anticipated to be received more often than once a year, as unearned income in the month received. Consider lump-sum child support payments received once a year or less frequently as a resource in the month received.
- *Returning Parent* – If an absent parent is making child support payments but moves back into the home of the caretaker and child, process the household change.

CRIME VICTIM'S COMPENSATION PAYMENTS

Exempt. These are payments from the funds authorized by state legislation to assist a person who has been a victim of a violent crime; was the spouse, parent, sibling, or adult child of a victim who died as a result of a violent crime; or is the guardian of a victim of a violent crime. The payments are distributed by the Office of the Attorney General in monthly payments or in a lump-sum.

Exception: IHC will pay for medical expenses for someone injured in a violent crime, unless the Crime Victims Unit has already assumed the responsibility. It will be the duty of the caseworker to contact Crime Victims Assistance to verify if the applicant is receiving their services.

DISABILITY INSURANCE PAYMENTS

Count disability payments as unearned income, including Social Security Disability Insurance (SSDI) payments and disability insurance payments issued for non-medical expenses. **Exception**: Exempt Supplemental Security Income (SSI) payments.

DIVIDENDS AND ROYALTIES

Count dividends as unearned income. **Exception**: Exempt dividends from insurance policies as income.

Count royalties as unearned income, minus any amount deducted for production expenses and severance taxes.

EDUCATIONAL ASSISTANCE

Exempt educational assistance, including educational loans, regardless of source. Educational assistance also includes college work-study.

ENERGY ASSISTANCE

Exempt the following types of energy assistance payments:

- Assistance from federally-funded, state or locally-administered programs, including HEAP, weatherization, Energy Crisis, and one-time emergency repairs of a heating or cooling device (down payment and final payment)
- Energy assistance received through HUD, USDA's Rural Housing Service (RHS), or Farmer's Administration (FmHA)
- Assistance from private, non-profit, or governmental agencies based on need

If an energy assistance payment is combined with other payments of assistance, exempt only the energy assistance portion from income (if applicable).

FOSTER CARE PAYMENTS

Exempt.

GOVERNMENT DISASTER PAYMENTS

Exempt federal disaster payments and comparable disaster assistance provided by states, local governments and disaster assistance organizations if the household is subject to legal penalties when the funds are not used as intended. **Example**: Payments by the Individual and Family Grant Program, Small Business Administration, and/or FEMA.

IN-KIND INCOME

Exempt. An in-kind contribution is any gain or benefit to a person that is not in the form of money/check payable directly to the household, such as clothing, public housing, or food.

INTEREST

Count as unearned income.

JOB TRAINING

Exempt payments made under the Workforce Investment Act (WIA).

Exempt portions of non-WIA job training payments earmarked as reimbursements for training-related expenses. Count any excess as earned income.

Exempt on-the-job training (OJT) payments received by a child who is under age 19 and under parental control of another household member.

LOANS (NON-EDUCATIONAL)

Count as unearned income, unless there is an understanding that the money will be repaid and the person can reasonably explain how they will repay it.

LUMP-SUM PAYMENTS

Count as income in the month received if the person receives it, or expects to receive it, more often than once a year.

Consider retroactive, or restored payments, to be lump-sum payments and count as a resource. Separate any portion that is ongoing income from a lump-sum amount and count it as income.

Exempt lump-sums received once a year or less, unless specifically listed as income. Count them as a resource in the month received.

Effective January 1, 2013, exempt federal tax refunds permanently as income and resources for 12 months after receipt. Exempt the Earned Income Credit (EIC) for a period of 12 months after receipt through December 31, 2018.

If a lump-sum reimburses a household for burial, legal, or health care bills, or damaged/lost possessions, reduce the countable amount of the lump-sum by the amount earmarked for these items.

MILITARY PAY

Count military pay and allowances for housing, food, base pay, and flight pay as earned income, minus pay withheld to fund education under the G.I. Bill.

MINERAL RIGHTS

Count payments for mineral rights as unearned income.

PENSIONS

Count as unearned income. A pension is any benefit derived from former employment, such as retirement benefits or disability pensions.

REIMBURSEMENT

Exempt a reimbursement (not to exceed the individual's expense) provided specifically for a past or future expense. If the reimbursement exceeds the individual's expenses, count any excess as unearned income. Do not consider a reimbursement to exceed the individual's expenses, unless the individual or provider indicates the amount is excessive.

Exempt a reimbursement for future expenses only if the household plans to use it as intended.

RETIREMENT, SURVIVORS, AND DISABILITY INSURANCE (RSDI) PAYMENTS

Count the Retirement, Survivors, and Disability Insurance (RSDI) benefit amount including the deduction for the Medicare premium, minus any amount that is being recouped for a prior RSDI overpayment, as unearned income.

If a person receives an RSDI check and an SSI check, exempt both checks since the person is a disqualified household member.

If an adult receives a Social Security survivor's benefit check for a child, this check is considered the child's income.

SELF-EMPLOYMENT INCOME

Count as earned income, minus the allowable costs of producing the self-employment income.

Self-employment income is earned or unearned income available from one's own business, trade, or profession rather than from an employer; however, some individuals may have an employer and receive a regular salary. If an employer does not withhold FICA or income taxes, even if required to do so by law, the person is considered self-employed.

Types of self-employment include:

- Odd jobs or contracts included, but not limited to: mowing lawns, babysitting, and cleaning houses
- Owning a private business, such as a beauty salon or auto mechanic shop
- Farm income
- Income from property, which may be from renting, leasing, or selling property on an installment plan. Property includes equipment, vehicles, and real property.

If the person sells the property on an installment plan, count the payments as income. Exempt the balance of the note as an inaccessible resource.

SUPPLEMENTAL SECURITY INSURANCE (SSI) PAYMENTS

Only exempt SSI benefits when the household is receiving Medicaid. A person receiving any amount of SSI benefits who also receives Medicaid is, therefore, a disqualified household member.

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) PAYMENTS

Exempt TANF benefits. A person receiving TANF benefits also receives Medicaid and is, therefore, a disqualified household member.

TERMINATED INCOME

Count terminated income in the month received. Use actual income and do not use conversion factors if terminated income is less than a full month's income.

Income is terminated if it will not be received in the next usual payment cycle.

Income is not terminated if:

- Someone changes jobs while working for the same employer
- An employee of a temporary agency is temporarily not assigned
- A self-employed person changes contracts or has different customers without having a break in normal income cycle
- Someone received regular contributions, but the contributions are from different sources

THIRD-PARTY PAYMENTS

Exempt the money received that is intended (and used for) the maintenance of a person who is not a member of the household.

If a single payment is received for more than one beneficiary, exclude the amount actually used for the non-member up to the non-member's identifiable portion or prorated portion, if the portion is not identifiable.

TIP INCOME

Count the actual (not taxable) gross amount of tips as earned income. Add tip income to wages before applying conversion factors.

Tip income is income earned in addition to wages that is paid by patrons to people employed in service-related occupations, such as beauticians, waiters, valets, pizza delivery staff, etc.

Do not consider tips as self-employment income, unless related to a self-employment enterprise.

TRUST FUND

Count as unearned income trust fund withdrawals or dividends that the household can receive from a trust fund that is exempt from resources.

UNEMPLOYMENT COMPENSATION PAYMENTS

Count the gross amount as unearned income, minus any amount being recouped for an Unemployment Insurance Benefit (UIB) overpayment.

Count the cash value of UIB in a UI debit account, less amounts deposited in the current month, as a resource. Account inquiry is accessible to a UIB recipient online at *www.myaccount.chase.com* or at any Chase Bank automated teller machine free of charge. **Exception**: Count the gross amount if the household agreed to repay a food stamp overpayment through voluntary garnishment.

VETERANS BENEFITS ADMINISTRATION (VA) PAYMENTS

Count the gross VA payment as unearned income, minus any amount being recouped for a VA overpayment.

Exempt VA special needs payments, such as annual clothing allowances or monthly payments for an attendant for disabled veterans.

VACATION PAY

If an individual receives vacation pay…	Consider it…
During or before termination of employment	Earned income
After termination of employment in one lump-sum	A liquid resource in the month received
After termination of employment in multiple checks	Unearned income

VENDOR PAYMENTS

Exempt vendor payments if made by a person or organization outside the household directly to the household's creditor or person providing the service. **Exception**: Count as income money that is legally obligated to the household, but which the payer makes to a third party for a household expense.

WAGES, SALARIES, COMMISSIONS

Count the actual (not taxable) gross amount as earned income.

If a person asks their employer to hold their wages (or the person's wages are garnished), count this money as income in the month the person would otherwise have been paid. If, however, an employer holds his employees' wages as a general practice, count this money as income in the month it is paid. Count an advance in the month the person receives it.

WORKERS' COMPENSATION PAYMENTS

Count the gross payment as unearned income, minus any amount being recouped for a prior workers' compensation overpayment or paid for attorney's fees. **Note**: The Texas Workforce Commission or a court sets the amount of the attorney's fee to be paid.

Do not allow a deduction from the gross benefit for court-ordered child support payments. **Exception**: Exclude workers' compensation benefits paid to the household for out-of-pocket health care expenses. Consider these payments as reimbursements.

OTHER TYPES OF BENEFITS AND PAYMENTS

Exempt benefits and payments from the following programs:

- AmeriCorps
- Child Nutrition Act of 1966
- Food Stamp Program – SNAP (Supplemental Nutrition Assistance Program)
- Foster Grandparents
- Funds distributed or held in trust by the Indian Claims Commission for Indian tribe members under Public Laws 92-254 or 93-135
- Learn and Serve
- National School Lunch Act
- National Senior Service Corps (Senior Corps)
- Nutrition Program for the Elderly (Title III, Older American Act of 1965)
- Retired and Senior Volunteer Program (RSVP)
- Senior Companion Program
- Tax-exempt portions of payments made under the Alaska Native Claims Settlement Act
- Uniform Relocation Assistance and Real Property Acquisitions Act (Title II)
- Volunteers in Service to America (VISTA)
- Women, Infants, and Children (WIC) Program

VERIFYING INCOME

Verify countable income, including recently terminated income, at initial application and when changes are reported. Verify countable income at review, if questionable.

Proof may include, but is not limited to:

- Last four (4) consecutive paycheck stubs (for everyone in the household)
- Form 128, *Employment Verification Form* (provided by IHC)
- W-2 forms (may include other members of household)
- Notes for cash contributions
- Business records
- Social Security Award letter
- Court orders or public decrees
- Sales records
- Income tax returns
- Form 149, *Statement of Self-Employment Income Form* completed, signed, and dated by the self-employed person (provided by IHC)

DOCUMENTING INCOME

On the Form 101 document the following items:

- Exempt income and the reason it is exempt
- Unearned income, including the following items:
  - Date income is verified
  - Type of income
  - Check or document seen
  - Amount recorded on check or document
  - Frequency of receipt
  - Calculations used
- Self-employment income, including the following items:
  - The allowable costs for producing the self-employment income (receipts must be provided)
  - Other factors used to determine the income amount
- Earned income, including the following items:
  - Payer's name and address
  - Dates of each wage statement or pay stub used
  - Date paycheck is received
  - Gross income amount
  - Frequency of receipt
  - Calculations used
- Allowable deductions

A household is ineligible for a period of 6 months if they intentionally alter their income to become eligible for the TGC IHC plan. **Example**: Have employer lower their hourly or salary amount.

BUDGETING INCOME

General Principles

- Count income already received and any income the household expects to receive. If the household is not sure about the amount expected, or when the income will be received, use the best estimate.
- Income, whether earned or unearned, is counted in the month that it is received.
- Count terminated income in the month received. Use actual income, and do not use conversion factors if terminated income is less than a full month's income.
- View at least two pay amounts in the time period beginning 45 days before the interview date, or the process date for cases processed without an interview. However, do not require the household to provide verification of any pay amount that is older than two months before the interview date or the process date for cases processed without an interview. **Exception**: If prior coverage is requested, then prior 3 months verification is required.
- When determining the amount of self-employment income received, verify four recent pay amounts that accurately represent their pay. Verify one month's pay amount that accurately represents their pay for self-employed income received monthly. Do not require the household to provide verification of self-employment income and expenses for more than two calendar months before the interview date or the case process date if not interviewed, for income received monthly or more often. **Exception**: If prior coverage is requested, then prior 3 months verification is required.
- Accept the applicant's statement as proof if there is a reasonable explanation of why documentary evidence or a collateral source is not available, and the applicant's statement does not contradict other individual statements or other information received by the entity.
- The self-employment income projection, which includes the current month and 3 months prior, is the period of time that the household expects the income to support the family.
- There are deductions for earned income that are not allowed for unearned income.
- The earned income deductions are not allowed if the income is gained from illegal activities, such as prostitution and selling illegal drugs.

Steps for Budgeting Income

Step 1 – *Determine countable income.*

Evaluate the household's current and future circumstances and income and decide if changes are likely during the current or future months. If changes are likely, then determine how the change will affect eligibility.

Step 2 – *Determine how often countable income is received (yearly, monthly, twice a month, every other week, or weekly).*

- *All income, excluding self-employment* – Based on verifications, or the person's statement as best available information, determine how often income is received. If the income is based hourly or for piecework, determine the amount of income expected for one week of work.

- *Self-employment Income* – Compute self-employment income, using one of these methods:
  - Annual – Use this method if the person has been self-employed for at least the past 12 months.
  - Monthly – Use this method if the person has at least one full representative calendar month of self-employment income.
  - Daily – Use this method when there is less than one full representative calendar month of self-employment income, and the source or frequency of the income is unknown or inconsistent.

    - Determine if the self-employment income is monthly, daily, or seasonal, since that will determine the length of the projection period.
      - The projection period is monthly if the self-employment income is intended to support the household for at least the next 6 months. The projection period is the last 3 months and the current month.
      - The projection period is seasonal if the self-employment income is intended to support the household for less than 12 months, since it is available only during certain months of the year. The projection period is the number of months the self-employment is intended to provide support.
    - Determine the allowable costs of producing self-employment income by accepting the deductions listed on the 1040 U.S. Individual Income Tax Return or by allowing the following deductions:
      - Capital asset improvements
      - Fuel
      - Identifiable costs of seed/fertilizer
      - Insurance premiums
      - Labor
      - Linen service
      - Property tax
      - Raw materials
      - Rent
      - Sales tax
      - Stock
      - Supplies
      - Utilities
      - Interest from business loans on income-producing property
      - Payments of the principal of loans for income-producing property
      - Repairs that maintain income-producing property
      - Capital asset purchases – such as real property, equipment, machinery and other durable goods (Items expected to last at least 12 months)
      - Transportation costs (The person may choose to use the IRS standard mileage rate of .58¢ per mile, instead of keeping track of individual transportation expenses. Do not allow travel to and from the place of business.)

NOTE: If the applicant conducts a self-employment business in their home, consider the cost of the home (rent, mortgage, utilities) as shelter costs, not business expenses, unless these costs can be identified as necessary for the business separately. The only businesses that do not fall under these guidelines are those that are considered "store-front," meaning that you are not allowed to operate a store environment in your home.

- The following are not allowable costs of producing self-employment income:
  - Costs not related to self-employment
  - Costs related to producing income gained from illegal activities, such as prostitution and the sale of illegal drugs
  - Depreciation
  - Net loss which occurred in a previous period
  - Work-related expenses, such as federal, state, and local income taxes, and retirement contributions

Step 3 – *Convert countable income to monthly amounts*, if income is not received monthly.

When converting countable income to monthly amounts, use the following conversion factors:

- Multiply weekly amounts by 4.33
- Multiply amounts received every other week by 2.17
- Add amounts received twice a month (semi-monthly)
- Divide yearly amounts by 12

Step 4 – *Convert self-employment allowable costs to monthly amounts.*

When converting the allowable costs for producing self-employment to monthly amounts, use the conversion factors in Step 3 above.

Step 5 – *Determine if countable income is earned or unearned*.

For earned income, proceed with Step 6. For unearned income, skip to Step 8.

Step 6 – *Subtract converted monthly self-employment allowable costs, if any, from converted monthly self-employment income.*

Step 7 – *Subtract earned income deductions, if any.*

Subtract these deductions, if applicable, from the household's monthly gross income, including monthly self-employment income after allowable costs are subtracted:

- Deduct $120.00 per employed household member for work-related expenses.
- Deduct 1/3 of remaining earned income per employed household member.
- Dependent childcare or adult with disabilities care expenses shall be deducted from the total income when determining eligibility, if paying for the care is necessary for the employment of a member in the TGC household. This deduction is allowed even when the child or adult with disabilities is not included in the TGC household. Deduct the actual expenses up to:
  - $200 per month for each child under age 2
  - $175 per month for each child age 2 or older
  - $175 per month for each adult with disabilities

Exception: For self-employment income from property, when a person spends an average of less than 20 hours per week in management or maintenance activities, count the income as unearned and only allow deductions for allowable costs of producing self-employment income.

Step 8 – *Subtract the deduction for Medicaid individuals, if applicable.*

This deduction applies when the household has a member who receives Medicaid, and therefore, is disqualified from the TGC household.

Use the Deduction chart in *Appendix V* to deduct an amount for support of the Medicaid member(s) as follows: Subtract an amount equal to the deduction for the number (#) of Medicaid eligible individuals.

Consider the remainder as the monthly gross income for the TGC household.

Step 9 – *Subtract the Deduction for Child Support, Alimony, and Other Payments to Dependents outside the Home, if applicable.*

Allow the following deductions from members of the household group, including disqualified members:

- The actual amount of child support and alimony a household member pays to persons outside the home.
- The actual amount of a household member's payments to persons outside the home that a household member can claim as tax dependents or is legally obligated to support.

Consider the remaining income as the monthly net income for the TGC household.

Step 10 – *Compare the household's monthly net income to the 21% FPG monthly income standard.*

A household is eligible if its monthly net income, after rounding down cents, does not exceed the monthly income standard for the TGC household's size. Refer to *Appendix V*.

SECTION 3
CASE PROCESSING

CASE PROCESSING

General Principles

- Use the application, documentation, and verification procedures as established by TGC.
- Issue the Form 100, *Application for Health Care Assistance*, to the applicant, or their representative, on the same date that the request is received.
- Accept an identifiable application.
- A caseworker may provide assistance in completing the Form 100 due to medical/educational reasons, if the applicant requests help in completing the application process. The caseworker will explain to the applicant that she/he is only filling in the information based on what is being provided by the applicant. The applicant must be aware that any and all information provided to caseworker has to be accurate. Anyone who helps fill out the Form 100 must sign and date it.
- If the applicant is incompetent or incapacitated, someone acting responsibly for the client (a Power of Attorney) may represent the applicant in the application and the review process, including signing and dating the Form 100 on the applicant's behalf. The Power of Attorney must be knowledgeable about the applicant and their household. Document the specific reason for designating this representative.
- Determine eligibility based on residence, household, resources, income, and citizenship.
- Allow at least 14 days for requested information to be provided, unless the household agrees to a shorter timeframe, when issuing the Form 103, *Request for Information*.
- Use any information received from the provider of service when making the eligibility determination, but further eligibility information from the applicant may be required.
- The date that a complete application is received is the application completion date, which counts as Day 0 (Zero).
- Determine eligibility not later than the 14th day after the application completion date based on the residence, household, resources, income, and citizenship guidelines.
- Issue written notice on appropriate TDHSH forms. If the county denies health care assistance, the written notice shall include the reason for the denial and an explanation of the procedure for appealing the denial.
- Review each eligible case record at least once every six months.
  - Approved applications are valid for a period not to exceed six (6) months, but no less than one (1) month.
  - On the first business day of the expiration month, all clients will receive a notice by mail that their benefits will expire at the end of the month.
  - All clients must start the eligibility process all over again at the time of re-application.
- Use the "Prudent Person Principle" in situations where there are unusual circumstances and document evidence that determines eligibility.
- Current eligibility continues until a change resulting in ineligibility occurs and a Form 117, *Notice of Ineligibility*, is issued to the household.
- Consult the county's legal counsel to develop procedures regarding disclosure of information.
- The applicant has the right to:
  - Have their application considered without regard to race, color, religion, creed, national origin, age, sex, disability, or political belief;
  - Request a review of the decision made on their application or re-certification for health care assistance; and
  - Request, orally and in writing, a fair hearing about actions affecting receipt or termination of health care assistance.
- The applicant is responsible for:
  - Completing the application accurately and truthfully.
    - Applications are available at the TGC IHC office located at 19 N. Irving St., San Angelo, Texas 76903.
  - Providing all needed information requested by staff.
    - If information is not available or is not sufficient, the applicant may designate a collateral contact for the information. A collateral contact could be any objective third party who can provide reliable information. A collateral contact does not need to be separately and specifically designated if that source is named either on Form 100 or during the interview.

- Attending the scheduled interview appointment.
  - All appointments will be set automatically by the TGC IHC staff and will be the applicant's responsibility to attend the scheduled appointment; failure to attend the appointment will result in denial of assistance.
  - The client's application is valid for 30 days from the identifiable date and it is within that 30-day period that the client may reschedule another appointment with the TGC IHC office. After the 30-day period, the client would have to fill out another application and begin the application process all over again.
- Reporting changes, which affect eligibility, within 14 days after the date that the change actually occurred. Failure to report changes could result in repayment of expenditures paid.
  - Any changes in income, resources, residency other than federal cost of living adjustments mandates reapplication and/or reconsideration of determination.
- To cooperate or follow through with an application process for any other source of medical assistance before being processed for the TGC IHC plan, since TGC is a payor of last resort.

Note: Misrepresentation of facts or any attempt by any applicant, or interested party, to circumvent the policies of the county in order to become or remain eligible is grounds for immediate and permanent refusal of assistance. Furthermore, if a client fails to furnish any requested information or documentation, the application will be denied.

PROCESSING AN APPLICATION

SCREENER

Step 1 – *New Client*

- Receives Texas Driver's License/ID with current address (must be TGC), Social Security Card, and Form 108, *Case Record Information Release*.
- Asks series of questions regarding employment, marital status, work history, living arrangements, Primary Care Provider, income, resources, as well as medical needs at current time.
- If determined the applicant might be eligible for IHC coverage, date Form 100, *Application for Health Care Assistance*, and request the applicant to complete the application.

Renewal Client

- Receives Texas Driver's License/ID with current address, Social Security card, IHC Card, and Form 108.
- Date Form 100 and request the client to complete the application.

Step 2 – *Accept Form 100 from applicant.*

- Date the application upon receiving.
  - This date starts the 14 day process clock.

Step 3 – *Check that all information is complete, consistent, and sufficient to make an eligibility determination.*

- Decision Pended for an SSI applicant
  - Application can be considered as long as proof of SSI application is on file with client application for eligibility requirements. Proceed with Step 4 whether or not the SSI denial is appealed.

Step 4 – *Request needed information pertaining to eligibility criteria – residence, household, resources, and income.*

- Process a Form 103, *Request for Information.*
  - Notate all items the applicant must bring in to confirm eligibility.

Step 5 – *Schedule appointment to interview the applicant, or their Power of Attorney, face-to-face.*

- Process a Form 102, *Appointment Notice.*
  - Appointment must be within fourteen (14) days.
- Provide both forms (Form 102 & 103) to the applicant, as well as written and verbal instructions indicating the date, time, place of the interview, and name of interviewer.

Note: Misrepresentation of facts or any attempt by any applicant, or interested party, to circumvent the policies of the county in order to become or remain eligible is grounds for immediate and permanent refusal of assistance. Furthermore, if a client fails to furnish any requested information or documentation, the application will be denied.

CASEWORKER

Step 6 – *Interview Appointment*

- Applicants may only be up to 10 minutes late to their interview appointment before they **must** reschedule.
  - If the applicant calls to reschedule, allow them one additional appointment no later than seven (7) days after their first scheduled appointment.
    - If the applicant misses their second appointment, process a denial notification, which includes the date they are eligible to start the process over.
  - If the applicant is a no call/no show, process denial notification.
- If information is received – process application
  - The application is not considered complete until all requested information in received.
- If information is not received by due date – process denial

Step 7 – *Determine eligibility based on eligibility criteria.*

- Document information in the case record to support the approval or denial decision.

Step 8 – *Notify the client of application status both verbally and in writing.*

- If approved, provide the client with a TGC IHC card. The client will also need to sign "Rights and Responsibilities."

Note: *The TGC IHC Identification Card is owned by TGC and is not transferable. TGC IHC may revoke or cancel it at any time after notice has been sent out explaining the reason for termination.*

Denial Decision

If any one of the eligibility criteria is not met, the applicant is not eligible. Issue a Form 117, including the reason for denial, the effective date for the denial, if applicable, and an explanation of the procedure for appealing the denial.

Reasons for denial include, but are not limited to:

- Not a resident of Tom Green County
- A recipient of Medicaid
- Resources exceed the resource limit
- Income exceeds the income limit
- Failed to keep an appointment
- Failed to provide information requested
- Failed to return the review application
- Failed to comply with requirements to obtain other assistance
- Voluntarily withdrawal

Eligible Decision

If all of the eligibility criteria is met, the applicant is eligible.

Determine the applicant's Eligibility Effective Date.

- Current eligibility begins on the first calendar day in the month that an identifiable application is filed or the earliest, subsequent month in which all eligibility criteria are met. **Exception**: Eligibility effective date for a new county resident begins the date the applicant is considered a county resident. **Example**: If the applicant meets all four eligibility criteria, but doesn't move to the county until the 15th of the month, the eligibility effective date will be the 15th of the month, not the first calendar day in the month that an identifiable application is filed.

- Issue a Form 109, *Notice of Eligibility*, including the Eligibility Effective Date, along with the TGC IHC card.

All active cases will be reviewed (at minimum) every 6 months as determined by the IHC Supervisor.

Prior Coverage

The applicant may be retroactively eligible in any of the three calendar months before the month the identifiable application is received if all eligibility criteria is met.

- Issue a Form 109, including the Eligibility Effective Date, along with the TGC IHC card.

Expiration of Coverage

All active clients are given TGC IHC coverage for a specified length of time. On the first business day of the termination month, a notification will be sent to the client reminding them that their benefits will be expiring.

Termination of Coverage

In certain circumstances, a client may have their benefits revoked before their coverage period expires. Clients will be notified by mail with the explanation for termination. Coverage will terminate on the date listed on the Form 117.

Note: Clients who are found to have proof of another source of health care coverage will be terminated on the day that the other payor source is identified.

Note: Clients who are found to have reached the maximum county liability in a fiscal year will be terminated on the day that the cap has been reached.

Inmate Coverage

Inmates are covered during their incarceration. Their coverage expires upon release date.

APPEAL PROCESSING

Application Denied

If a denial decision is disputed by the household, the following may occur:

- The household may submit another application to have their eligibility re-determined
- The household may appeal the denial
- The County Treasurer may re-open a denied application based on new information

Appeal Process

- The household may appeal any eligibility decision by signing the bottom of Form 117 within ~~30~~ 90 days from the date of denial.
- The county will have 14 days from the date Form 117 was received in the TGC IHC office, with the appropriate signature, to respond to the client to let them know that TGC received their appeal. At this time, the client will be notified as to the next step in the appeal process by either:
    1. An appeal hearing is not necessary, as a mistake has been made on TGC's behalf. TGC and the client will take the appropriate steps required to remedy the situation; or
    2. An appeal hearing is necessary, and the Hearing Officer, or appointee, will schedule a date and time for the appeal hearing.
- The decision as to whether or not an appeal is necessary is decided upon by the Hearing Officer after reviewing the case. Anytime during the 14 day determination period further information may be requested from the client by the county.
- If an appeal is necessary, the county will have 30 days to schedule the appeal hearing.

- Should a client choose not to attend their scheduled appeal hearing, leave a hearing, or become disruptive during a hearing, the case will be dropped and the appeal denied.
- After the date of the appeal hearing, the designated county representative (County Treasurer) will have 30 days to make a decision. The client will be notified of the county's decision in writing.
- An Administrative Review of the appeal hearing can be conducted through the IHC Supervisor.

SECTION 4
SERVICE DELIVERY

SERVICE DELIVERY

General Principles

- TGC shall follow State Statute pursuant to Chapter 61, *Health and Safety Code***.**
- The basic health care services are:
  - Physician services
  - Annual physical examinations
  - Immunizations
  - Medical screening services
    - Blood pressure
    - Blood sugar
    - Cholesterol screening
  - Laboratory and x-ray services
  - Family planning services
  - Skilled nursing facility services
  - Prescription drugs
  - Rural health clinic services
  - Inpatient hospital services
  - Outpatient hospital services
- In addition to providing basic health care services, TGC currently provides the following extended health care services:
  - Advanced Practice Nurse (APN) services provided by:
    - Nurse Practitioner services (NP)
    - Clinical Nurse Specialist (CNS)
    - Certified Nurse Midwife (CNM)
    - Certified Registered Nurse Anesthetist (CRNA)
  - Colostomy Medical Supplies and Equipment
  - Diabetic Medical Supplies and Equipment
  - Federally Qualified Health Center services (FQHC)
  - Physician Assistant services (PA)
  - Any other appropriate health care service/supplies identified by department rule that may be determined to be cost-effective. Authority is given to the TGC Treasurer/IHC Director to confirm to be cost effective and the best interest of the county.
- Services and supplies must be usual, customary, and reasonable, as well as medically necessary for diagnosis and treatment of an illness or injury.
- As prescribed by Chapter 61, *Health and Safety Code*, a county shall provide health care assistance to each eligible resident in its service area who meets:
  - The basic income and resources requirements established by the department under Sections 61.006 and 61.008 and in effect when the assistance is requested; or
  - A less restrictive income and resources standard by the county serving the area in which the person resides.
- The maximum county liability for each fiscal year for health care services provided by all assistance providers, including Hospital and Skilled Nursing Facilities (SNF), to each TGC client is:
  - $30,000; or
  - The payment of 30 days of hospitalization or treatment in an SNF (or both), or $30,000, whichever occurs first.
    - 30 days of hospitalization refers to Inpatient Hospitalization.
- TGC is the payor of last resort and shall provide assistance only if other adequate public or private sources of payment are not available. In addition, TGC is not secondary to any insurance benefits or exhausted benefits.
- For claim payment to be considered, a claim should be received:
  - Within 95 days from the approval date for services provided before the household was approved; or
  - Within 95 days from the date of service for services provided after the approval date.
- The payment standard is determined by the date the claim is paid.
- TGC mandated providers must provide services and supplies.

BASIC HEALTH CARE SERVICES

Health and Safety Code Sec. 61.028. BASIC HEALTH CARE SERVICES.

A county shall, in accordance with department rules adopted under Section 61.006, provide the following basic health care services:

- Primary and preventative services designed to meet the needs of the community, including:
  - Immunizations;
  - Medical screening services; and
  - Annual physical examinations;
- Inpatient and Outpatient Hospital services;
- Rural Health Clinics;
- Laboratory and X-ray services;
- Family Planning services;
- Physician services;
- Payment for no more than three prescription drugs a month; and
- Skilled Nursing Facility services, regardless of the patient's age.

The county may provide additional health care services, but may not credit the assistance toward eligibility for state assistance, except as provided by Section 61.0285.

Annual Physical Examinations

These are examinations are provided once per fiscal year (per client) by a mandated provider. Associated testing, such as mammograms, is covered if provided by a mandated provider.

Family Planning Services

These are preventative health care services that assistant an individual in controlling fertility and achieving optimal reproductive and general health.

Immunizations

These are given when appropriate. A client must have a current prescription from a physician for the immunization. Immunizations covered are those that are provided by mandated providers.

- Immunizations and vaccines:
  - Pneumococcal vaccines appropriate for high risk clients, and Influenza vaccines, may be covered once a year.
  - Other immunizations covered are those that can be administered by a mandated provider.

Inpatient Hospital Services

Inpatient hospital services must be medically necessary and be:

- Provided in an acute care hospital,
- Provided to hospital inpatients,
- Provided under the direction of a Texas licensed physician in good standing, and
- Provided for the medical care and treatment of patients.

The date of service for an inpatient hospital claim is the discharge date.

Laboratory and X-Ray Services

These are professional and technical laboratory and radiological services ordered and provided by, or under the direction of, a Texas licensed physician in an office or a similar facility other than a hospital outpatient department or clinic.

Medical Screening Services

These health care services include blood pressure, blood sugar, and cholesterol screening.

Outpatient Hospital Services

Outpatient hospital services must be medically necessary and be:

- Provided in an acute care hospital or hospital-based ambulatory surgical center (HASC),
- Provided to hospital outpatients,
- Provided under the direction of a Texas licensed physician in good standing, and
- Diagnostic, therapeutic, or rehabilitative.

Physician Services

Physician services include services ordered and performed by a physician that are within the scope of practice of their profession as defined by Texas state law. Physician services must be provided in the doctor's office, the patient's home, a hospital, a Skilled Nursing Facility, or elsewhere.

Prescription Drugs

This service includes up to three prescription drugs per month. New and refilled prescriptions count equally toward the three prescription drugs per month total. Drugs must be prescribed by a Texas licensed physician or other practitioner within the scope of practice under law. Prescriptions are dispensed through Shannon Pharmaceutical Assistance Program.

The quantity of drugs prescribed depends on the prescribing practice of the physician and the needs of the patient; however, each prescription is limited to a 30-day supply and dispensing only.

Refer to *Appendix IV* for more information about the Shannon Pharmaceutical Assistance Program.

Asthma Chambers – Active clients with a diagnosis of Asthma or COPD will be allowed under the RX program to have one (1) Asthma Chamber per year (per client), with a co-pay, and will not count against the 3 per month prescription limit.

Rural Health Clinic Services

Services must be:

- Provided in a freestanding or hospital-based rural health clinic, and
- Provided by a Texas licensed physician in good standing, a Physician Assistant, an Advanced Practice Nurse (including a Nurse Practitioner, a Clinical Nurse specialist, and a Certified Nurse Midwife), or a visiting nurse.

Skilled Nursing Facility Services

Services must be:

- Medically necessary,
- Ordered by a Texas licensed physician in good standing, and
- Provided in a Skilled Nursing Facility that provides daily services on an inpatient basis.

EXTENDED HEALTH CARE SERVICES

Tom Green County has approved items (1) (3) (6) (9) (13) (15) ONLY

Health and Safety Code Sec. 61.0285. OPTIONAL HEALTH CARE SERVICES

In addition to basic health care services provided under Section 61.028, a county may, in accordance with department rules adopted under Section 61.006, provide other medically necessary services or supplies that the county determines to be cost-effective. *See Form 120 on page 34 for approved items and page 35 for definition of approved items.*

TEXAS Health and Human Services

OPTIONAL HEALTH CARE SERVICES NOTIFICATION

Mark an "X" in the appropriate column to indicate each optional health care service the county chooses to provide or chooses to discontinue providing.

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

Dianna M Spieker — Signature of County Judge/Designee

7-16-2019 — Date

Printed Name of Person Signing This Form 120	Title
Dianna M. Spieker	County Treasurer/IHC Director
County Tom Green County	**Mailing Address** 112 W. Beauregard
Telephone Number (Include area code.) 325-659-6504	**City/State/ZIP** San Angelo, Texas 76903

March 2017

Definitions of CIHCP Optional Health Care Services

1. **Advanced Practice Nurse (APN)** services must be medically necessary and provided within the scope of practice of an APN and covered by the Texas Medicaid Program when provided by a licensed physician.

2. **Ambulatory Surgical Center (ASC)** services must be provided in a freestanding ASC, and are limited to items and services furnished in reference to an ambulatory surgical procedure, including those services on the Center for Medicare and Medicaid Services (CMS)-approved list and selected Medicaid-only procedures.

3. **Colostomy medical supplies and/or equipment** must be medically necessary and prescribed by a physician or an APN if this is within the scope of their practice in accordance with the standards established by the Board of Nurse Examiners and published in 22 TAC §221.13. Items covered are colostomy bags/pouches, cleansing irrigation kits, paste or powder, and skin barriers with flange/wafers. The county may require the supplier to receive prior authorization.

4. **Counseling (psychotherapy)** services must be medically necessary based on a referral from a physician or an APN if this is within the scope of their practice in accordance with the standards established by the Board of Nurse Examiners and published in 22 TAC §221.13. Psychotherapy services must be provided by a Licensed Clinical Social Worker (LCSW), Licensed Marriage Family Therapist (LMFT), Licensed Professional Counselor (LPC), or a Ph.D. Psychologist.

5. **Dental care** must be medically necessary and provided by a DDS, DMD, or DDM. Items covered are: an annual routine exam, annual routine cleaning, one set of annual x-rays, and the least costly service for emergency dental conditions for the removal or filling of a tooth due to abscess, infection, or extreme pain. The county may require prior authorization.

6. **Diabetic supplies and/or equipment** must be medically necessary and prescribed by a physician or an APN if this is within the scope of their practice in accordance with the standards established by the Board of Nurse Examiners and published in 22 TAC §221.13. Items covered are: test strips, alcohol prep pads, lancets, glucometers, insulin syringes, humulin pens, and the needles required for the humulin pens. The county may require the supplier to receive prior authorization.

7. **Durable medical equipment (DME)** must be medically necessary; meet the Medicare/Medicaid requirements; and be provided under a written, signed and dated prescription from a physician or an APN if this is within the scope of their practice in accordance with the standards established by the Board of Nurse Examiners and published in 22 TAC §221.13. Items may be purchased or rented, whichever is least costly. Items covered are: blood pressure measuring appliances that are reasonable and appropriate, canes, crutches, home oxygen equipment (including masks, oxygen hose, and nebulizers), hospital beds, walkers, and standard wheelchairs. The county may require the supplier to receive prior authorization.

8. **Emergency medical service** covers ground transportation only for medically necessary, life-threatening conditions.

9. **Federally Qualified Health Center (FQHC)** services must be provided in an approved FQHC by a physician, physician's assistant, nurse practitioner, clinical psychologist, or clinical social worker.

10. **Occupational therapy** services must be medically necessary and may be covered if provided in a physician's office, a therapist's office, in an outpatient rehabilitation or free-standing rehabilitation facility, or in a licensed hospital. Services must be within the provider's scope of practice, as defined by Occupations Code, Chapter 454.

11. **Physical therapy** services must be medically necessary and may be covered if provided in a physician's office, a therapist's office, in an outpatient rehabilitation or free-standing rehabilitation facility, or in a licensed hospital. Services must be within the provider's scope of practice, as defined by Occupations Code, Chapter 453.

12. **Home and community health care** must be medically necessary, meet the Medicare/Medicaid requirements;,and be provided by a certified home health agency. A plan of care must be recommended, signed, and dated by the recipient's attending physician prior to care being given. Items covered are R.N. visits for skilled nursing observation, assessment, evaluation, and treatment provided by a physician who specifically requests the R.N. visit for this purpose. A home health aide to assist with administering medication is also covered. Visits made for performing housekeeping services are not covered. A county may require prior authorization.

13. **Physician Assistant (PA)** services must be medically necessary and provided by a PA under the direction of an M.D. or a D.O. and must be billed by and paid to the supervising physician.

14. **Vision care** covers one exam by refraction and one pair of prescribed glasses every 24 months that meet Medicaid criteria.

15. **Other** medically necessary services or supplies that the local governmental municipality/entity determines to be cost effective.

March 2017

A county must notify the department of the county's intent to provide services specified by Subsection (a). If the services are approved by the department under Section 61.006, or if the department fails to notify the county of the department's disapproval before the 31st day after the date the county notifies the department of its intent to provide the services, the county may credit the services toward eligibility for state assistance under this subchapter.

A county may provide health care services that are not specified in Subsection (a), or may provide the services specified in Subsection (a) without actual or constructive approval of the department, but may not credit the services toward eligibility for state assistance.

DESCRIPTION OF BASIC AND OPTIONAL HEALTH CARE SERVICES

Advanced Practice Nurse (APN) Services

An APN must be licensed as a Registered Nurse (RN) within the categories of practice, specifically, a Nurse Practitioner, a Clinical Nurse Specialist, a Certified Nurse Midwife (CNM), and a Certified Registered Nurse Anesthetist (CRNA), as determined by the Board of Nurse Examiners. APN services must be medically necessary and provided within the scope of practice of the APN and covered in the Texas Medicaid Program.

Colostomy Medical Supplies and Equipment

These supplies and equipment must be medically necessary and prescribed by a Texas licensed physician, PA, or an APN in good standing, within the scope of their practice in accordance with the standards established by their regulatory authority. The county requires the supplier to receive prior authorization.

Colostomy items covered are:

- Cleansing irrigation kits
- Colostomy bags/pouches
- Paste or powder
- Skin barriers with flange (wafers)

Diabetic Medical Supplies and Equipment

These supplies and equipment must be medically necessary and prescribed by a Texas licensed physician, PA, or an APN in good standing, within the scope of their practice in accordance with the standards established by their regulatory authority. The county requires the supplier to receive prior authorization.

Diabetic items covered are:

- Test strips, alcohol prep pads, lancets, glucometers, insulin syringes, humulin pens, and needles required for the humulin pens.
    - Insulin syringes, humulin pens, and the needles required for humulin pens are dispensed with a National Dispensing Code (NDC) number and are paid as prescription drugs; they do not count toward the three prescription drugs per month limitation. Insulin and humulin pen refills are prescription drugs (not optional services) and count toward the three prescription drugs per month limitation.

Federally Qualified Health Center (FQHC) Services

La Esperanza Clinic – These services must be provided in an approved FQHC by a Texas licensed physician, a Physician's Assistant, or an Advanced Practice Nurse, a Clinical Psychologist, or a Clinical Social Worker.

Physician Assistant (PA) Services

These services must be medically necessary and provided by a PA under the supervision of a Texas licensed physician and billed by and paid to the supervising physician.

SERVICE DELIVERY APPEALS

Client vs Health Care Provider

Any dispute with services, charges, etc., needs to be addressed by the client with the health care provider or facility themselves and not TGC. TGC has no authority to settle any disputes regarding these matters and will not contact the provider or facility on behalf of the client.

Network of Mandated Providers

TGC has established a network of health care providers to provide services to our active clients.

- Shannon Hospital/Clinics
  - Shannon affiliates as determined by Shannon Medical Center
- Shannon Pharmaceutical Assistance Program
- La Esperanza Clinics
- Myers Drug (for Diabetic & Colostomy supplies only)

Continuity of Care

It is the intent of the county to assure continuity of care is received by the patients who are on the Active Client List. For this purpose, mandated provider relationships have been established and maintained for the best interest of the patient's health status. The client/patient has the network of mandated providers explained to them and signs a document to this understanding at the time of eligibility processing in the IHC office. Additionally, they demonstrate understanding in a like fashion that failure to use mandated providers, unless otherwise authorized, will result in them bearing independent financial responsibility for their actions.

Prior Approval

A non-mandated health care provider must obtain approval from the TGC IHC office before providing health care services to an active TGC patient. Failure to obtain prior approval, or failure to comply with the notification requirements below, will result in rejection of financial reimbursement for services provided.

Mandatory Notification Requirements

- The non-mandated provider shall attempt to determine if the patient resides within the county's service area when the patient first receives services, if not beforehand as the patient's condition may dictate.
- The provider, the patient, and the patient's family shall cooperate with the county in determining if the patient is an active IHC client before services are provided.
- Each individual provider is independently responsible for their own notification on each case as it presents.
- If a non-mandated provider delivers emergency or non-emergency services to an indigent patient who the provider suspects might be an active IHC client with TGC, the provider shall notify the TGC IHC office that services have been or will be provided to the patient. The provider will use email IHCNotify@co.tom-green.tx.us to submit notifications of services to be rendered. Notification must be on file before TGC IHC will pay for services rendered.
  - The notice shall be made:
    - By telephone not later than the 72nd hour after the provider determines that the patient resides in the county's service area and is suspect of being an active IHC client on the county's TGC IHC plan; and
    - By mail postmarked no later than the fifth working day after the date on which the provider determines that the patient resides in the county's service area.

Authorization

The TGC IHC office may authorize health care services to be provided by a non-mandated provider to a TGC patient only:

- In an emergency (as defined below and interpreted by the county);
- When it is medically inappropriate for the county's mandated provider to provide such services; or
- When adequate medical care is not available through the mandated provider.

Emergency Defined

An "emergency medical condition" is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the patient's health in serious jeopardy;
- Serious impairment of bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency Medical Services

Clients are to (as conditions allow) notify EMS about their mandated provider as a preferred destination. This service is not eligible for payment.

Reimbursement

In such event, the county shall provide written authorization to the non-mandated provider to provide such health care services as are medically appropriate, and thereafter the county shall assume responsibility for reimbursement for the services rendered by the non-mandated provider at the reimbursement rates approved for the county's mandated provider, generally but not limited to, being those reimbursement rates approved by the TDSHS pursuant to the County Indigent Health Care and Treatment Act. Acceptance of reimbursement by the non-mandated provider will indicate payment in full for services rendered.

If a non-mandated provider delivers emergency or non-emergency services to a patient who is on the TGC IHC and fails to comply with this policy, including the mandatory notice requirements, the non-mandated provider is not eligible for reimbursement for the services from the county.

Return to Mandated Provider

Unless authorized by TGC IHC office to provide health care services, a non-mandated provider, upon learning that the county has selected a mandated provider, shall see that the patient is transferred to the county's selected mandated provider of health care services.

SECTION 5
APPENDIX

APPENDIX I. FORMS

Forms may exist online in electronic form through TGC's Indigent Healthcare Solutions (IHS) software.

- Form 100 Application for Health Care Assistance
- Form 101 Worksheet
- Form 102 Appointment Notice
- Form 103 Request for Information
- Form 108 Case Record Information Release
- Form 109 Notice of Eligibility
- Form 117 Notice of Ineligibility
- Form 120 Annual Optional Health Care Service Notification
- Form 128 Employment Verification
- Form 149 Statement of Self-Employment Income

APPENDIX II. LAWS AND STATUTES

Chapter 61, *Health and Safety Code*, is a law passed by the First Called Special Session of the 69th Legislature in 1985 that:

- Defines who is indigent,
- Assigns responsibilities for Indigent Health Care,
- Identifies health care services eligible people can receive, and
- Establishes a state assistance fund to match expenditures for counties that exceed certain spending levels and meet state requirements.

Chapter 61, *Health and Safety Code*, is intended to ensure that needy Texas residents, who do not qualify for other state or federal health care assistance programs, receive health care services.

Chapter 61, *Health and Safety Code*, may be accessed at: https://statutes.capitol.texas.gov/Docs/HS/htm/HS.61.htm

The Texas Administrative Code (TAC) is the compilation of all state agency rules in Texas.

The County Indigent Health Care Program (CIHCP) rules are in: TAC, Title 25 (Health Services), Part 1 (TDSHS), Chapter 14 (CP), and the following Subchapters:

A. Program Administration
B. Determining Eligibility
C. Providing Services

The CP rules may be accessed at: http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=4&ti=25&pt=1&ch=14

APPENDIX III. COUNTY INMATE ELIGIBILITY

RESOLUTION
Tom Green County Commissioners Court

A WRITTEN RESOLUTION AUTHORIZING SENDING NOTICE TO ALL HEALTHCARE PROVIDERS AUTHORIZING INDIGENT AND MEDICAID RATES FOR THE CARE OF ADULTS OR JUVENILES INCARCERATED BY AND/OR IN THE CUSTODY OF TOM GREEN COUNTY

On this the 2nd Day of July 2019 the Tom Green County Commissioners Court met in regular session at the Commissioners Court Room in the Edd B. Keyes building located at 113 West Beauregard, San Angelo, Texas to pass the following resolution:

Tom Green County Commissioners Court reaffirms, resolves and authorizes the original resolution approved on the 7th day of July, 2009 as stated:

Be it resolved, pursuant to prior Commissioner Court action and applicable law, the Commissioners Court of Tom Green County hereby resolves and authorizes that effective as of July 1st, 2009, Tom Green County finds that all juveniles or adults who are incarcerated by and/or are in the custody of Tom Green County are designated as indigent and Tom Green County will only pay current Indigent or Medicaid rates for all healthcare provided to juveniles or adults who are incarcerated by and/or are in the custody of Tom Green County so long as they are incarcerated by and/or in the custody of Tom Green County.

Approved on this the 2nd day of July, 2019

Stephen C. Floyd, County Judge

Ralph Hoelscher, Comm. Pct 1

Sammy Farmer, Comm. Pct. 2

Absent

Rick Bacon, Comm. Pct 3

Bill Ford, Comm. Pct 4

COMMISSIONERS COURT, TOM GREEN COUNTY, TEXAS

ATTEST:

Elizabeth "Liz" McGill, Tom Green County Clerk

APPENDIX IV. SHANNON PHARMACEUTICAL ASSISTANCE PROGRAM

Shannon Medical Center Pharmacy Assistance Program

Some individuals need assistance with their prescription medications over and above what the TGC IHC program provides. Residents over 18 who cannot afford all of their necessary medications may be able to receive assistance through the Shannon Medical Center Pharmaceutical Assistance Program (PAP). Through the PAP, Shannon pharmacists assist qualified individuals with free or reduced price medications by accessing a variety of private and government assistance programs. Participation in the PAP is based on household financial qualification requirements. The type and amount of assistance varies with each patient's individual medical needs.

To learn more about the program, and whether or not you may be eligible for assistance with your prescription medications, call 325-481-6403. The Shannon PAP office is located at the Shannon St. John's Campus – 2030 Pulliam, Suite 16, San Angelo, Texas, 76905.

APPENDIX V. GRAPHS

Value of Vehicle: Use the chart below to determine the countable resource amount

$15,000	(FMV)
-12,450	(Amount still owed)
$2,550	(Equity Value)
- 4,650	
$ 0	(Countable resource)

$9,000	(FMV)
- 0	(Amount still owed)
$9,000	(Equity Value)
- 4,650	
$4,350	(Countable resource)

Deductions for Medicaid-Eligible Individuals

# of Medicaid-Eligible Individuals	Single Adult or Adult with Children	Minor Children Only
1	$ 78	$ 64
2	$ 163	$ 92
3	$ 188	$ 130
4	$ 226	$ 154
5	$ 251	$ 198
6	$ 288	$ 214
7	$ 313	$ 267
8	$ 356	$ 293

Income Guidelines

A household is eligible if its monthly net income does not exceed 21% of the Federal Poverty Guideline (FPG). Counties may choose to increase the monthly income standard to a maximum of 50% FPG, and still qualify to apply for state assistance funds.

CIHCP Monthly Income Standards Effective April 2019 Based on the 2019 Federal Poverty Guideline		
# of Individuals in the CIHCP Household	**21% FPG Minimum Income Standard**	**50% Maximum Income Standard**
1	$219	$521
2	$296	$705
3	$374	$889
4	$451	$1,073
5	$528	$1,258
6	$606	$1,442
7	$683	$1,626
8	$761	$1,810
9	$838	$1,994
10	$915	$2,178
11	$993	$2,363
12	$1,070	$2,547

APPENDIX VI. COMMISSIONERS' COURT ACTIONS

FY15 – Approved in Commissioners' Court – July 29, 2014
FY16 – Approved in Commissioners' Court – July 21, 2015
FY17 – Approved in Commissioners' Court – July 26, 2016
FY18 – Approved in Commissioners' Court – August 1, 2017
FY19 – Approved in Commissioners' Court – August 14, 2018
FY20 – Approved in Commissioners' Court – July 30, 2019

Chapter 61, Sec. 61.0285, Optional Health Care Services

(a) In addition to basic health care services provided under Section 61.028, a county may, in accordance with department rules adopted under Section 61.006, provide other medically necessary services or supplies that the county determines to be cost-effective, including:

(2) Diabetic and Colostomy Medical Supplies and Equipment;

(7) Services provided by Physician Assistants, Nurse Practitioners, Certified Nurse Midwives, Clinical Nurse specialists, and Certified Registered Nurse Anesthetists;

(10) Services provided by Federally Qualified Health Centers, as defined by 42 U.S.C. Section 1396d (1)(2)(B);

(13) Any other appropriate health care service identified by department rule that may be determined to be cost-effective.

Excerpt from TDSHS

Diabetic Items covered are: test strips, alcohol prep pads, lancets, glucometers, insulin syringes, humulin pens and needles required for the humulin pens.

Insulin syringes, humulin pens, and the needles required for humulin pens are dispensed with a National Dispensing Code (NDC) number and are paid as prescription drugs; they do not count toward the three prescription drugs per month limitation. Insulin and humulin pen refills are prescription drugs (not optional services) and count toward the three prescription drugs per month limitation.

Colostomy Items covered are: cleansing irrigation kits, colostomy bags/pouches, paste or powder, and skin barriers with flange (wafers).

Note: Dental procedures are covered by Oral Surgeons only. Eye Exam for Diabetes Care are covered by mandated provider only. Services or supplies must be reasonable and medically necessary for diagnosis and treatment – the TGC Treasurer/IHC Director has authority to make these determinations.

Tom Green County has established procedures:

Local Rules Effective June 1, 2013

1) Requiring an Indigent Health Care applicant to find and maintain a Primary Care Physician; (060113)

2) Requiring Physician Specialist to be used only if referred by the client's Primary Care Physician; (060113)

3) Mandated providers may only refer patients to non-mandated providers when the service is not available within the mandated provider's service ability; (060113)

4) Eligible expense – Emergency Room use for Emergencies, as defined by a Physician, will be covered under the Indigent Health Care program; (060113)

5) Excluded expense – Emergency Room use for non-emergencies, as defined by a Physician, will not be covered under the Indigent Health Care program; (060113)

6) UPL/Waiver Participants will report Quarterly per the Affiliations Agreements and will only include data up to $30,000.00 per client in a calendar year from 1st Date of Service. Services to be included are limited to section 61.028 and 61.0285 and the TGC IHC Guideline Book; (060113)

Effective October 1, 2013

7) Limit the usage of prescription classification of pain pill type drugs to include a written statement of medical necessity per prescription by authorizing Physician and requires pre-approval; (100113)

Effective September 1, 2015

8) Tom Green County Indigent Care Office Procedures and Guidelines posted on website; (090115)

9) Pursuant to AG Opinion KP-59, determination of an alien is eligible for Indigent Health Care Services depends on relevant provisions of the Federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 governing the specific benefits at issue; (012516)

APPENDIX VII. EXCLUSIONS AND LIMITATIONS

Services, Supplies, and Expenses that are not covered under this plan include, but are not limited to, the following:
Note: This list is not all inclusive.

- Autopsies
- Care and treatment related to any condition for which benefits are provided or available under Workers' Compensation laws
- Cellular therapy
- Charges exceeding the specified limit per client in the plan
- Charges made by a nurse for services which can be performed by a person who does not have the skill and training of a nurse
- Chemolase injection (chymodiactin, chymopapain)
- Cosmetic (plastic) surgery to improve appearance, rather than to correct a functional disorder; here, functional disorders do not include mental or emotional distress related to a physical condition. All cosmetic surgeries require TGC authorization
- Dental care; **Except** for reduction of a jaw fracture or treatment of an oral infection when a physician determines that a life-threatening situation exists and refers the patient to a dentist
- Dentures or endosteal implants for adults
- Drugs that are:
  - Not approved for sale in the United States
  - Over-the-counter drugs
  - Outpatient prescription drugs not purchased through the prescription drug program
  - Not approved by the Food and Drug Administration (FDA)
  - Dosages that exceed the FDA approval
  - Approved by the FDA but used for conditions other than those indicated by the manufacturer
- Durable Medical Equipment supplies, unless they are pre-authorized by the TGC IHC Director
- Ergonovine provocation test
- Excise tax
- Experimental or Investigational programs, procedures, or services
- Fabric wrapping of abdominal aneurysms
- Family planning services
- For care or treatment furnished by:
  - Christian Science Practitioner
  - Homeopath
  - Marriage, Family, Child Counselor (MFCC)
  - Naturopath
- Genetic counseling or testing
- Hair analysis
- Hearing Aids
- Heart-lung monitoring during surgery
- Histamine therapy-intravenous
- Hormonal disorders (male or female)
- Hospice Care
- Hospital admission for diagnostic or evaluation procedures, unless the test could not be performed on an outpatient basis without adversely affecting the health of the patient

- Hospital beds
- Hyperthermia
- Hysterectomies performed solely to accomplish sterilization
- Hysteroscopy for infertility
- Immunotherapy for malignant diseases
- Infertility (Quest test)
- Inpatient hospital services to a client in an institution for tuberculosis, mental disease, or a nursing section of a public institutions for persons with intellectual disabilities
- Inpatient hospital tests that are not specifically ordered by a provider who is responsible for the diagnosis or treatment of the client's condition
- Intragastric balloon for obesity
- Joint sclerotherapy
- Keratoprosthesis/refractive keratoplasty
- Laetrile
- Legal services
- Mammoplasty for gynecomastia
- Marriage counseling or family counseling when there is not an identified patient
- Medical services, supplies, or expenses as a result of a motor vehicle accident or assault
- More than one physical exam per year (per client)
- Obsolete diagnostic tests
- Oriental pain control (Acupuncture or Acupressure)
- Orthoptics
- Other CPT codes with zero payment or those not allowed by county indigent guidelines
- Outpatient psychiatric services (Counseling)
- Parenting skills
- Podiatric care, unless the service is covered as a physician service when provided by a licensed physician
- Private room facilities, except when:
  - A critical or contagious illness exists that results in disturbance to other patients and is documented as such
  - It is documented that no other rooms are available for an emergency admission
  - The hospital only has private rooms
- Prosthetic or orthotic devices
- Prosthetic eye or facial quarter
- Psychiatric services (Behavioral Health)
- Recreational therapy
- Review of old X-ray films
- Routine cardiovascular and pulmonary function monitoring during the course of a surgical procedure under anesthesia
- Separate payments for services and supplies to an institution that receives a vendor payment or has a reimbursement formula that includes the services and supplies as a part of institutional care
- Services or supplies for which claims were not received within the filing deadline
- Services or supplies furnished for the purpose of breaking a "habit" including, but not limited to: overeating, smoking, thumb sucking
- Services or supplies provided in connection with cosmetic surgery, unless they are authorized by a licensed health care provider and deemed medical necessary, and services can only be done by a mandated health care provider for specific purposes before the services or supplies are received, and are:
  - Required for the prompt repair of an accidental injury
  - Required for improvement of the functioning of a malformed body member
- Services or supplies that are not reasonable and necessary for diagnosis or treatment
- Services or supplies provided outside of the United States
- Services rendered as a result of (or due to complications resulting from) any surgery, services, treatments or supplier specifically excluded from coverage under these guidelines

- Services that are payable by any health, accident, other insurance coverage, or any private or other governmental benefit system, or any legally liable third party
- Services that are provided by ineligible, suspended, or excluded providers
- Services that are provided by an immediate relative or household member
- Sex change operations
- Sex therapy, hypnotics training (including hypnosis), any behavior modification therapy (including biofeedback), education testing and therapy (including therapy intended to improve motor skill development delays), or social services
- Silicone injections
- Social and educational counseling
- Spinograph or thermograph
- Surgical procedures to reverse sterilization
- Take-home and self-administered drugs
- Transplants, including Bone Marrow
- Treatment for sexual dysfunctions of inadequacy, which includes implants and drug therapy
- Treatment of flat foot (flexible pes planus) conditions and the prescription of supportive devices (including special shoes), the treatment of subluxations of the foot and routing foot care more than once every six months, including the cutting or removal of corns, warts, or calluses, the trimming of nails, and other routine hygienic care
- Treatment of obesity and/or for weight reduction services or supplies (including weight loss programs)
- Vision Care, including eyeglasses, contacts, and glass eyes
    - **Exception**: One (1) **diabetic** eye examination only may be covered as a physician service every twelve (12) months
- Vocational evaluation, rehabilitation or retraining
- Voluntary self-inflicted injuries or attempted voluntary self-destruction while sane or insane

APPENDIX VIII. GLOSSARY

Adult – A person at least age 18 or a younger person who is or has been married or had the disabilities of minority removed for general purposes.

Accessible Resources – Resources legally available to the household.

Adoption Payment – Payment by the State of Texas to any parents wishing to adopt a special needs child.

Aged Person – Someone age 60 or older as of the last day of the month for which benefits are being requested.

Alien Sponsor – a person who signed an Affidavit of Support (INS Form I-864 or I-864-A) on or after December 19, 1997, agreeing to support an alien as a condition of the alien's entry into the United States. Not all aliens must obtain a sponsor before being admitted into the U.S.

Application Completed Date – The date the Form 100, *Application for Health Care Assistance*, and all information necessary to make an eligibility determination is received.

Approval Date – The date that the caseworker issues the Form 109, *Notice of Eligibility*, and TGC Identification Card to the client.

Assets – All items of monetary value owned by an individual.

Budgeting – The method used to determine eligibility by calculating income and deductions using the best estimate of the household's current and future circumstances and income.

Citizen/Citizenship – A person having the right to live there, work, vote, and pay taxes.

Claim – Completed CMS-1500, UB-04, or pharmacy statement with detailed documentation, or an electronic version thereof.

Claim Pay Date – The date that the County Treasurer writes a check to pay a claim.

Client – Eligible resident who is actively receiving health care benefits from TGC.

Common Law Marriage – Relationship in which the parties age 18 or older are free to marry, live together, and "hold out" to the public that they are spouses. A minor child in Texas is not legally allowed to enter a common law marriage unless the claim of common law marriage began before September 1, 1997.

- A valid common law marriage is where a man and woman become husband and wife without getting a marriage license and having a marriage ceremony. Once proved, a common law marriage has the same legal effect as a ceremonial marriage.
- To have a common law marriage in Texas, the couple must:
  - Agree to be married,
  - Live together in Texas as husband and wife, and
  - Tell other people that they are married ("hold out").
- A couple that wishes to formalize a common law marriage can file a Declaration of Marriage. To do this, the couple should get a form for filing a Declaration of Marriage, sign it, and file it with the County Clerk in the county where the couple lives.
- You cannot have a common law marriage if you are already legally married to someone else. You must end your current marriage by getting a divorce or annulment before entering into a common law marriage.
- People "hold out" that they are married by telling others that they are married. Examples of telling other people you are married include:
  - Introducing yourselves as a married couple, or
  - Doing something that made people think you were married like signing credit applications as a married couple.

Complete Form 100, *Application for Health Care Assistance* – A complete application includes validation of these components:

- The applicant's full name and address,
- The applicant's county of residence is Tom Green County,
- The names of everyone who lives in the house with the applicant and their relationship to the applicant,
- The type and value of the TGC household's resources,
- The TGC household's monthly gross income,
- Information about any health care assistance that household members may receive,
- The applicant's Social Security number,
- The applicant's signature with the date the Form 100 is signed, and
- All needed information, such as verifications.

The date that the Form 100 and all information necessary to make an eligibility determination is received is the application completion date.

Co-pay – The amount requested from the client to help contribute to their health care expenses.

Crime Victims Compensation – The amount of money paid from the Crime Victim's Unit towards all medical bills of the victim involved in an act of violence. The only time this money will not be paid is when the victim signs an affidavit of non-prosecution.

Days – All days are calendar days, except as specifically identified as workdays.

Denial Date – The date that the Form 117, *Notice of Ineligibility*, is issued to the candidate.

Disabled Person – Someone who is physically or mentally unfit for employment.
Definition of Disability: Federal laws define a person with a disability as "Any person who has a physical or mental impairment that substantially limits one or more major life activities; has a record of such impairment; or is regarded as having such an impairment."

Disqualified Member – A person receiving or is categorically eligible to receive Medicaid.

Earned Income – Income a person receives for a certain degree of activity or work. Earned income is related to employment and, therefore, entitles the person to work-related deductions not allowed for unearned income.

Eligible County Resident – An eligible county resident must reside in Tom Green County and meet the resource, income, and citizenship requirements.

Eligibility Effective Date – The date that a client's eligibility begins.

Eligibility End Date – The date that a client's eligibility ends.

Emancipated Minor – A person under age 18 who has been married as recognized under Texas law. The marriage must not have been annulled.

Equity – The amount of money that would be available to the owner after the sale of a resource. Determine this amount by subtracting from the fair market value any money owed on the item and the costs normally associated with the sale and transfer of the item.

Expenditure – Funds spent on basic or department-established optional health care services.

Expenditure Tracking – The IHS software shall track monthly basic and extended health care expenditures.

Extended Services – Extended optional health care services that have been approved by TGC Commissioners' Court and have been reported to the State.

Fair Market Value – The amount a resource would bring if sold on the current local market.

Gross Income – Income before deductions.

GRTL – The county's General Revenue Tax Levy (GRTL) is used to determine eligibility for state assistance funds.

Identifiable Application – An application is identifiable if it includes:
- The applicant's name,
- The applicant's address,
- The applicant's social security number,
- The applicant's date of birth,
- The applicant's signature, and
- The date the applicant signed the application.

Identifiable Application Date – The date on which an identifiable application is received from an applicant.

Inaccessible Resources – Resources not legally available to the household. Examples include, but are not limited to: irrevocable trust funds, property in probate, security deposits on rental property, utilities, or having a lien.

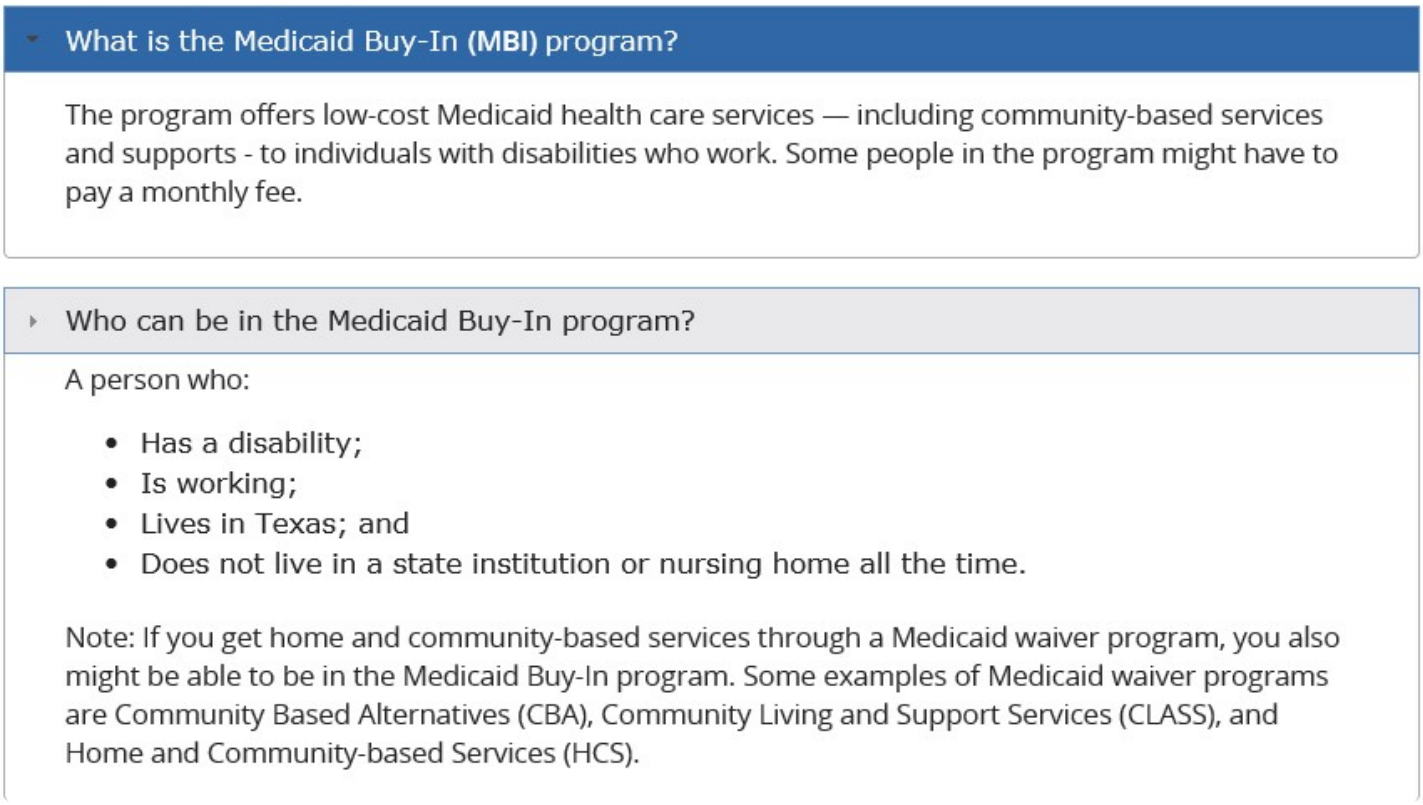
Income – Any type of payment that is of gain or benefit to a household.

Managing Conservator – A person designated by a court to have daily responsibility for a child.

Mandated Provider – A health care provider, selected by the county, who agrees to provide health care services to eligible clients.

Married Minor – An individual, age 14-17, who is married and such is recognized under the laws of the State of Texas. These individuals must have parental consent or court permission. An individual under age 18 may not be a party to an informal (common law) marriage.

Medicaid – The Texas state-paid insurance program for recipients of Supplemental Security Income (SSI), Temporary Assistance for Needy Families (TANF), and health care assistance programs for families and children.



Minor Child – A person under age 18 who is not or has not been married and has not had the disabilities of minority removed for general purposes.

Net income – Gross income minus allowable deductions.

Person with Disabilities – Someone who is physically or mentally unfit for employment.

Personal Possessions – Appliances, clothing, farm equipment, furniture, jewelry, livestock, and other items if the household uses them to meet personal needs essential for daily living.

Real Property – Land and any improvements on it.

Reimbursement – Repayment for a specific item or service.

Relative – A person who has one of the following relationships biologically or by adoption:

- Mother or father
- Child, grandchild, stepchild
- Grandmother or grandfather
- Sister or brother

- Aunt or uncle
- Niece or nephew
- First cousin
- First cousin once removed
- Stepmother or stepfather

Relationship also extends to:

- The spouse of the relatives listed above, even after the marriage is terminated by death or divorce
- The degree of great-great aunt/uncle and niece/nephew
- The degree of great-great-great grandmother/grandfather

Resources – Both liquid and non-liquid assets a person can convert to meet his needs. Examples include, but are not limited to: bank accounts, boats, bonds, campers, cash, certificates of deposit, gas rights, livestock (unless the livestock is used to meet personal needs essential for daily living), mineral rights, notes, oil rights, real estate (including buildings and land, other than a homestead), stocks, and vehicles.

Service Area – The geographic region in which a county has a legal obligation to provide health care services.

Sponsored Alien – A sponsored alien means a person who has been lawfully admitted to the United States for permanent residence under the Immigration and Nationality Act (8 U.S.C. Section 1101 et seq.) and who, as a condition of admission, was sponsored by a person who executed an Affidavit of Support on behalf of the person.

State Fiscal Year – The twelve-month period beginning September 1 of each calendar year and ending August 31 of the following calendar year.

TDSHS – Texas Department of State Health Services

Temporary Absence – When a client is absent from TGC for less than or equal to 30 days.

Tip Income – Income earned in addition to wages that is paid by patrons to people employed in service-related occupations, such as beauticians, waiters, valets, pizza delivery staff, etc.

Unearned Income – Payments received without performing work-related activities.

Veteran – A veteran must have served at least 1 day of active duty military time prior to September 7, 1980, and if service was after that date, at least 24 months of active duty military time to eligible for medical services through the Department of Veteran Affairs (Form DD214 may be requested).